

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER MERIDIAN PLASTIC SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 170 W 106TH ST , INDIANAPOLIS, Indiana, 46290	
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Q0000	INITIAL COMMENTS This visit was for a Federal Recertification survey of an Ambulatory Surgery Center. Facility Number: 005406 Survey Date: 05/14/25 – 05/15/25, and 5/29/25 QA: 06/10/2025	Q0000		
Q0100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is NOT MET as evidenced by: Based on record review, interview, and observation, the facility failed to ensure testing for 5 of 5 emergency battery powered lighting units was conducted and failed to document sprinkler system inspections in accordance with NFPA 25. Findings Include: The accumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	Q0100		
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1) The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in	Q0101		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Q0101	<p>Continued from page 1 a manner that protects the lives and assures the physical safety of all individuals in the area.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review, interview, and observation, the facility failed to ensure testing for 5 of 5 emergency battery powered lighting units was conducted. NFPA 1012 2012 edition 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds.</p> <p>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the test.</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction</p> <p>Based on a review of the Life Safety Code survey conducted on 12/15/2021, it was noted that the facility had five battery power emergency lights in use. Based on record review with the facility Director and Administrator on 05/29/25 at 11:55 a.m., the Director was asked if she could provide records to indicate the 30-second and 90-minute testing of these lights, but it was determined that it could not be located. Based on interview on 05/29/25 at 11:57 a.m., the Director acknowledged there was no written record of 30-second and 90-minute test regarding the battery-operated emergency lights available for review as of the time of this survey. Based on observations made during a tour of the facility, there were indeed five battery power emergency lights in use.</p> <p>This finding was reviewed with the Director and the facility Administrator at the exit conference on 05/29/25.</p>	Q0101		
Q0106	<p>SPRINKLER SYSTEM</p> <p>CFR(s): 416.44(b)(5)</p>	Q0106		

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Q0106	<p>Continued from page 2</p> <p>(5) When a sprinkler system is shut down for more than 10 hours, the ASC must:</p> <p>(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or</p> <p>(ii) Establish a fire watch until the system is back in service.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review, observation, and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.</p> <p>Based on review of the Ryan Fire Protection documentation entitled "Joint Commission Fire System Inspection Report" dated 03/21/25, 06/28/14, 09/27/24, and 12/20/24 with the facility Director and Administrator Maintenance Director and the facility Administrator during record review on 05/29/25 at 11:50 a.m., weekly sprinkler gauge inspection documentation was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves was also not available for review. Based on an interview on 05/29/25 at 11:52 a.m. with the Director, he/she verified that documentation was not available for review as of the time of this survey in reference to weekly control valve and monthly gauge inspections adding that she would have those items documented as soon as possible.</p> <p>This finding was reviewed with the Director and the facility Administrator at the exit conference on 05/29/25.</p>	Q0106		
Q0122	REAPPRAISALS	Q0122		

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Q0122	<p>Continued from page 3</p> <p>CFR(s): 416.45(b)</p> <p>Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on document review and interview, the facility failed to have Medical Staff delineated privileges reappraised for 5 of 5 credential files reviewed (MD1, MD2, MD3, MD4, and MD5 [all Medical Doctors]).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled Credentialing Requirements: Chapter 2 Policy 6, indicated under Policy: 4. Credential files are maintained for each member of the facility, including the initial application, reapplication, verifications, privileges granted, and other pertinent information. 2. Review of credential files for MD1, MD2, MD3, MD4, and MD5 lacked reappraisal of Medical Staff delineated privileges. 3. Interview on 05/15/2025 at approximately 4:45 pm with A1 (Administrator), confirmed 5 out of 5 credential files reviewed, did not have delineated privileges reappraised. 	Q0122		
Q0141	<p>ORGANIZATION AND STAFFING</p> <p>CFR(s): 416.46(a)</p> <p>Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on document review, observation, and interview, nursing services failed to ensure patient care responsibilities followed state licensure rules for 1 of 7 (C1, Scrub Tech) personnel files reviewed.</p> <p>Findings include:</p>	Q0141		

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Q0141	Continued from page 4 1. Review of Patient's 6, 7, and 20 medical record indicated that C1 was a Certified Surgical Technician (CST) on the intraoperative record. 2. Review of C1's personnel file indicated that C1's job description was for a CST. C1's personnel file lacked documentation of a current CST certification. 3. Observation on 05/15/2025 at approximately 10:20 a.m. observed C1's name tag which indicated C1 was a CST. 4. Interview with A2 (Director) on 05/14/2025 at approximately 12:10 p.m. indicated that C1 did not have a certification and was not a CST and on 05/15 2025 at approximately 10:20 a.m. confirmed the above.	Q0141		
Q0241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure a clean environment in 2 of 3 operating rooms (Operating Room 1 and 2). Findings include: 1. Facility policy titled Chapter 5 Contracts-Housekeeping Service, Policy 5, indicated under Policy: After each surgical day "Cleaning" will be performed: a. Overhead surgical lights. 2. Tour of facility on 05/15/2025 at approximately 10:15 a.m. with A1 (Director) copious amounts of visible and wipeable dust on overhead surgical lights in operating rooms 1 and 2 was observed. 3. Interview with A1 on 05/15/2024 at approximately 10:15 a.m. confirmed dust on surgical lights in operating room 1 and 2.	Q0241		
Q0242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and	Q0242		

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Q0242	<p>Continued from page 5 communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on document review and interview, the facility failed to ensure contract personnel had proof of required immunization documentation in 2 of 2 (H1 and H2, Contract Housekeepers) personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled, Employment Application and Record, Policy No. 3.021, last revision date, 06/24/2020, indicated under Practices & Procedures, B. Personnel Record, 2.e. Evidence of required vaccinations: Hepatitis B, measles, mumps, rubella, pertussis, and varicella. 2. Review of H1 and H2's personnel file lacked documentation of varicella, rubella, and rubeola vaccination or immunity. 3. Interview with A2 (Director) on 05/15/2025 at approximately 4:40 p.m. confirmed H1 and H2's personnel file lacked documentation of evidence of varicella, rubella, and rubeola vaccinations. 	Q0242		