STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001086	A. BUILDING B. WING	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELTWAY SURGERY CENTERS LLC	151 PENNSYLVANIA PKWY, CARMEL, IN, 46280

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q0000	INITIAL COMMENTS This visit was for a recertification survey of an Ambulatory Surgery Center and the OMNIBUS (COVID 19) Health care staff Vaccine survey in accordance with QSO-22-09-ALL Memorandum. Facility Number: 002277 Survey Dates: 4-18-2022 to 4-19-2022, and 4/26/2022. The OMNIBUS [COVID-19] Health Care Staff Vaccination survey in accordance with QSO-22-09-All Memorandum. The Indiana Department of Health has evaluated this facility and determined that it is in compliance with federal certification requirements. QA: 4/21/2022 and 5/4/2022	Q0000		2022-07-18
Q0100	ENVIRONMENT 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.	Q0100	K131 1. How the deficiency will be or has been corrected. Door was repaired and is self closing. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to	2022-07-18

	Based on record review, observation and interview; the facility failed to ensure 1 of 3 doors in the second floor waiting room separated the facility from other tenants and occupancies (see tag K131), failed to ensure 1 of 3 self-closing doors to the SIMS Room in the basement would self-close to form a smoke resistant barrier (see tag K223), failed to ensure 3 of 8 battery powered emergency lights were maintained (see tag K291), failed to document monthly and annual testing for 8 of 8 battery backup lights (see tag K291), failed to maintain 16 of 20 fire-rated door locations (see tag K761), failed to ensure documentation of electrical outlet receptacle testing was available for review (see tag K914), failed to ensure 2 of 2 emergency generator annunciator panels was in proper operating condition (see tag K916), and failed to exercise the generator for 11 of 12 months (see tag K918). The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.		rounding and monthly assessment will be completed. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/14/22 K223 1. How the deficiency will be or has been corrected. The door was repaired. 5/14/22 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Testing/ rounding will occur to ensure that the door is in proper working order. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and Building engineer. The Team members are to notify the engineer of any issues with the door. 4. By what date are you going to have the deficiency corrected? 5/14/22 K291a and b 1. How the deficiency will be or has been corrected. Monthly testing will be completed and documented on the new sheet created. Annual testing will be noted as well. New batteries were installed in deficient emergency lights. A new light was exchanged to the non working light in the basement SIMS area. Completed 5/18/22.	

			2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. A new document will be used to specify individual emergency lights, as well as the testing occurring each month and annually. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/18/22 K761 1. How the deficiency will be or has been corrected. Door inspection and repairs completed. Lead time for door hardware is 7/18/22. Door 1-011 is not a Surgery center door. 5/18/22- inspection completed on doors 6/18/22- Awaiting door panels/ hardware 7/18/22- expected completion date for door hardware install. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Facility manager and building engineer will round and complete door assessments monthly. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 7/18/22	

			K914 1. How the deficiency will be or has been corrected. The space heaters were removed from the center. Receptacle testing was completed on 4/27/22. Repairs to noted deficiencies were completed on 5/14/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The annual receptacle testing has been entered into the PM schedule for the building engineer. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. The facility manager and building engineer will be responsible to ensure the annual testing is completed. 4. By what date are you going to have the deficiency corrected? 5/14/22 K916 1. How the deficiency will be or has been corrected. The old annunciator panel that was not in use has been removed and covered. The new Cat remote annunciator was repaired and is working as of 5/13/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The facility manager and building engineer for HTA will be responsible to ensure the panel is working on daily walk throughs. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer for HTA. 4. By what date are you going to have the	

			deficiency corrected? 5/13/22 K918 1. How the deficiency will be or has been corrected. The KW load test numbers will be calculated going forward on the generator testing sheet. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The Facility Manager and the Building Engineer for HTA agreed documentation for the load percentage achieved during monthly load testing prior to 03/26/22 was not noted, but will be going forward. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. The facility manager and building engineer for HTA will be responsible for the KW load test numbers each month. 4. By what date are you going to have the deficiency corrected? 5/17/22	
Q0104	SAFETY FROM FIRE	Q0104	1. How the deficiency will be or has been	2022-07-18

	416.44(b)(1)-(3) (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. 1. Based on observation and interview, the facility failed to ensure 1 of 3 doors in the second floor waiting room separated the facility from other tenants and occupancies. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the entry door to the IVF corridor in the second floor tenant separation wall was equipped with a self-closing device and latching hardware but the door failed to fully self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Building Engineer for HTA agreed the door to the IVF corridor in the tenant separation wall on the second floor failed to fully self-close and latch into the door frame when tested to close multiple times. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the		corrected. The doors that were deficient were repaired 5/14/22. Fire door rating/ inspection was completed. Door 1-011 is not a part of the surgery center. We are waiting on door hardware which has a lead time until July 18, 2022 5/18/22- door inspection completed and repairs made 6/18/22- Awaiting final door hardware 7/18/22- door completion upon receipt of hardware. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Annual inspection of all fire doors will be added to the PM schedule for the building. Door assessment will be done monthly/ daily. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 7/18/22	

	Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 3 self-closing doors to the SIMS Room in the basement would self-close to form a smoke resistant barrier. This deficient practice could affect all staff and visitors in the basement. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the corridor door to the SIMS Room where the wall mounted battery-operated light is installed was held in the fully open position with a wedge placed under the door. The door was also equipped with a magnetic hold open release device set to self-close or automatic close with fire alarm system activation. The wall mounted magnetic release device was energized and held the door in the fully open position when the wedge was removed from under the door. Based on interview at the time of the observations, the Building Engineer for HTA agreed the wedge for the aforementioned corridor door prevented the door from self-closing or automatic closing if the fire alarm system was activated. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. 3. Based on record review and interview, the facility failed to maintain 16 of 20 fire-rated door locations. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. This deficient practice could affect all patients, staff and visitors. Findings include:			

	Based on review of the fire door inspection contractor's "Annual Door Inspection 2020 Summary Report" documentation dated 10/12/20 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, sixteen of twenty fire door locations in the surgery center failed inspection. Fire door locations identified as #0-001, #0-002, #1-001, #1-005, #1-006, #1-008, #1-009, #1-010, #1-011, #1-012, #2-001, #2-002, #2-003, #3-001, #3-002 and #3-003 were listed as failing the fire door inspection. Based on interview at the time of record review, the Facility Manager stated inspection and/or repair/replace documentation on or after 10/12/20 was not available for review. The Facility Manager stated some fire door inspection issues have been corrected but he did not know which doors were corrected and which doors still needed correction. The Facility Manager provided an e-mail from a fire door inspection contractor that facility fire doors were scheduled for re-inspection in May 2022. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
Q0108	BUILDING SAFETY 416.44(c) (c) Standard: Building Safety. Except as otherwise provided in this section, the ASC must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code (NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC. (2) If application of the Health Care Facilities	Q0108	1. How the deficiency will be or has been corrected. New batteries were installed in 2 of the units, and a new unit was replaced in the basement SIMS area. Documentation of individual emergency lights has been completed using a new document specifying each unit and location. Functional testing was completed. 5/14/22 Receptacle testing and repairs complete. Annunciator panels are repaired/ complete. Generator testing completed with monthly, annual testing. Load information has been added to the monthly testing sheets. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Monthly assessment and testing will occur and be documented on	2022-05-18

	Code required under paragraph (c) of this section would result in unreasonable hardship for the ASC, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. 1. Based on record review, observation and interview; the facility failed to ensure 3 of 8 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Preventive Maintenance Task: Battery-Powered Emergency Light Test" documentation with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, the facility has 8 battery operated lighting systems which are not located in operating rooms. A total of 17 battery operated lighting systems are in the facility which includes 9 operating room locations. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the wall mounted battery operated emergency lighting system identified as #10 at the second floor nurse's station, the wall mounted battery operated emergency lighting system identified as #13 in the third floor PACU by Bay 6 and the wall mounted battery operated emergency lighting system in the basement SIMS room each failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Building Engineer for HTA agreed the battery-operated emergency lighting systems each failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Director		new sheet. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Building engineer, facility manager, director. 4. By what date are you going to have the deficiency corrected? 5/18/22	

	ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. 2. Based on record review, observation, and interview; the facility failed to document monthly and annual testing for 8 of 8 battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (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, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of "Preventive Maintenance Task: Battery-Powered Emergency Light Test" documentation dated January 2021 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, the facility has 8 battery operated lighting systems which are not located in operating rooms. A total of 17 battery operated lighting systems are in the facility which includes 9 additional operating room locations. Documentation of monthly functional testing for all eight battery backup lights itemized by location for the most recent twelve-month period was not available for review. In addition, annual 90-minute functional testing documentation for the eight battery operated lighting systems conducted within the most recent twelve-month period was also not available for review. Review of "Work Order: Generator Powered Emergency Lights" testing documentation for the most recent twelve-month period did not itemize			

	emergency light testing by the light location. Based on interview at the time of record review, the Building Engineer for HTA stated he tests battery lighting systems on a monthly basis for 30 seconds but agreed additional monthly and annual testing documentation for testing conducted within the most recent twelve-month period was not available for review at the time of the survey. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, all eight wall mounted battery operated emergency lighting systems functioned when it's respective test button was pushed except for the lighting system identified as #10 at the second floor nurse's station, the lighting system identified as #13 in the third floor PACU by Bay 6 and the lighting system in the basement SIMS room. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. 3. Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all patients, staff and visitors in the facility.			

Findings include:

Based on records review and interviews with the Clinical Director, OR Manager, Regional Facilities Manager, Clinical Operations Manager and HTA Facilities Engineer on 04/26/22 between 9:35 a.m. and 2:10 p.m., an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Furthermore, no documentation of receptacle testing prior to January 2020 and the onset of the COVID-19 Pandemic were available for review. Based on interview with the Regional Facilities Manager during record review he stated this facility had not done receptacle testing recently and acknowledged that documentation verifying past receptacle testing was not available.

This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.

4. Based on observation and interview, the facility failed to ensure 2 of 2 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all the patients, staff and visitors.

Findings include:

Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the remote annunciator panel located at the third-floor overnight nurse's station had no electrical power and did not function when its respective test button was pushed multiple times. The remote annunciator panel was identified as a "Dynagen" panel. In addition, the remote annunciator panel located at the second-floor nurse's station identified as a "CAT" panel also had no electrical power and did not function when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Building Engineer for HTA stated the facility replaced its emergency generator in 2021, the Dynagen panel was for the old emergency generator and is no longer in use. The Building Engineer for HTA stated the CAT panel is for the new generator, the remote annunciator panel should be active

and in use but agreed the CAT panel had no electrical power at the time of the observations. The Facility Manager agreed the Dynagen panel should be removed if it is no longer in use.

This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.

5. Based on record review and interview, the facility failed to exercise the generator for 11 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:
(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer
(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.
Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all patients, staff and visitors.

Findings include:

Based on review of "Work Order: Generator-M" documentation for the most recent twelve-month period with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, load information to show the available (actual) load percentage for the diesel-powered generator during monthly load testing was not documented. Review of "MMPN-OPC Monthly Generator Load Test" documentation for the monthly load test conducted on 03/26/22 indicated a load of 19 kW was achieved for the 125-kW diesel fired

	emergency generator. Based on interview at the time of record review, the Facility Manager stated the facility just started using the 03/26/22 format to document monthly load testing. The Facility Manager and the Building Engineer for HTA agreed documentation for the load percentage achieved during monthly load testing prior to 03/26/22 was not available for review. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
Q0162	FORM AND CONTENT OF RECORD 416.47(b) The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination (as applicable); (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. Based on document review and interview, the facility failed to ensure complete documentation of the immediate post-operative report in 16 of 30 (patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and	Q0162	1. How the deficiency will be or has been corrected. - A process improvement Plan will be initiated. The 10-step QI project (attached) will begin 5/16/22 and end 6/10/22. All OR case charts will be audited the day of surgery by the business associate- to review date/ time on the Immediate post op note. Education to the medical staff and to the clinical staff will be conducted by May 16th. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. - Review and spot audits of the charts will be completed to ensure improvements have been sustained. The business associates/ PACU team members will review each chart by the end of day of surgery. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The managers of the PACU and the Operating room will be responsible to review the process and spot audits. 4. By what date are you going to have the deficiency corrected? 5/16/22.	2022-05-16

	Findings Include: 1. Review of policy titled: Content of Medical Records (PolicyStat ID: 9866384) last approved 06/02/2021, indicated that all entries in the MR (medical record) must reflect date and time. 2. Review of patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and 28's MRs indicated lack of documentation of time on the Surginet Intraop Document which is used for the immediate post-operative note. Next to the line in which "time" is to be documented, there is an asterik which was defined as "*Indicates Required Segment and/or Field". 3. Interview on 04/18/22 with S2 (Manager of Assessment and Recovery) at 2:40 pm, confirmed lack of documentation of time on the Surginet Intraop Document in patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and 28' MRs.			
Q0181	ADMINISTRATION OF DRUGS 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review, observation, interview, nursing failed to ensure that spiked intravenous (IV) bags of fluid were labeled with date and time in 2 of 2 IV bags (pre-operative room 3 and nursing station) observed. Findings Include: 1. Review of policy titled: Safe Medication Management last approved 02/11/22, indicated all medications removed from the original container or packaging will be labeled with expiration date and time and initials of person transferring the drug. 2. Tour with S2 (Manager of	Q0181	1. How the deficiency will be or has been corrected.- Deficiency was completed with the addition of a label/ tags on each bag of IV fluid. Date and time, as well as initials of person transferring the drug will be on the label/tag. Training and education was completed with the staff to ensure knowledge and compliance. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur.- Review and spot audits by the Pre/ Post manager will be completed to ensure compliance. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The Pre/Post Nurse Manager. 4. By what date are you going to have the deficiency corrected? 5/9/22	2022-05-09

	Assessment/Recovery) on 04/19/22 at approximately 10:00 am, this surveyor observed a spiked IV bag of 1000 milliliters of Lactated Ringers hanging on IV pole in room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station. The bags lacked documentation of time and date of when the bags were spiked. 3. Interview on 04/19/22 at approximately 10:00 am with S2 confirmed a spiked IV bag of 1000 milliliters of Lactated Ringers hanging on IV pole in room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station; both IV bags lacked documentation of a label with the expiration date and time when the bags were spiked.			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001086	A. BUILDING 00 B. WING	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELTWAY SURGERY CENTERS LLC	151 PENNSYLVANIA PKWY CARMEL, IN 46280

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assessment/Recovery) on 04/19/22 at approximately 10:00 am, this surveyor observed a spiked IV bag of 1000 milliliters of Lactated Ringers hanging on IV pole in room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station. The bags lacked documentation of time and date of when the bags were spiked. 3. Interview on 04/19/22 at approximately 10:00 am with S2 confirmed a spiked IV bag of 1000 milliliters of Lactated Ringers hanging on IV pole in room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station; both IV bags lacked documentation of a label with the expiration date and time when the bags were spiked.		Pre/ Post manager will be completed to ensure compliance. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The Pre/Post Nurse Manager. 4. By what date are you going to have the deficiency corrected? 5/9/22	
S 0000 Bldg. 00	This visit was for a State licensure survey of an Ambulatory Surgery Center. Facility Number: 002277 Survey Date: 4-18-2022 to 4-19-2022. QA: 4/21/2022	S 0000		
S 0310 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001086	A. BUILDING 00 B. WING	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELTWAY SURGERY CENTERS LLC	151 PENNSYLVANIA PKWY CARMEL, IN 46280

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility offsite F#003329, failed to include a monitor and standard for 2 contract travel registered nurses as part of the QAPI program over the last 12 calendar months. Findings include: 1. Review of quarterly QAPI reports did not include a monitor or standard for 2 contract travel registered nurses over the last 12 calendar months. 2. In interview on 4-20-2022 at 11:45 pm, employee #S2, Manager, Registered Nurse, confirmed all the above and no other documentation was provided prior to exit.	S 0310	1. How the deficiency will be or has been corrected.- The contracts form has been corrected with the additions of the travel nurses company. See uploaded document with changes. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. - The manager will ensure the contracts review is completed quarterly and the form/template has been changed. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The manager in the pre/post area. 4. By what date are you going to have the deficiency corrected? 5/9/22	05/09/2022
S 0640 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1) (e) All entries in the medical record must be as follows: (1) Legible and complete.			

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	Based on document review and interview, the facility failed to ensure complete documentation of the immediate post-operative report in 16 of 30 (patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and 28) medical records reviewed at main facility and 4 of 30 (patients 1, 10, 20 and 27) medical records reviewed at offsite facility. Findings Include: 1. Review of policy titled: Content of Medical Records (PolicyStat ID: 9866384) last approved 06/02/2021, indicated that all entries in the MR (medical record) must reflect date and time. 2. Review of patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and 28's MRs at main facility and patients 1, 10, 20 and 27's MRs at offsite facility indicated lack of documentation of time on the Surginet Intraop Document which is used for the immediate post-operative note. Next to the line in which "time" is to be documented, there is an asterik which was defined as "*Indicates Required Segment and/or Field". 3. Interview on 04/18/22 with S2 (Manager of Assessment and Recovery at main facility) at 2:40 pm, confirmed lack of documentation of time on the Surginet Intraop Document in patients 1, 2, 4, 5, 6, 7, 8, 9, 15, 16, 17, 19, 22, 26, 27 and 28' MRs. 4. Interview on 04/19/22 with S3 (Manager of Assessment at offsite) at 9:15 pm confirmed lack of documentation of time on the Surginet Intraop Document in patients 1, 10, 20 and 27's MRs at offsite facility.	S 0640	1. How the deficiency will be or has been corrected. - A process improvement Plan will be initiated. The 10-step QI project (attached) will begin 5/16/22 and end 6/10/22. All OR case charts will be audited the day of surgery by the business associate- to review date/ time on the Immediate post op note. Education to the medical staff and to the clinical staff will be conducted by May 16th. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. - Review and spot audits of the charts will be completed to ensure improvements have been sustained. The business associates/ PACU team members will review each chart by the end of day of surgery. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The managers of the PACU and the Operating room will be responsible to review the process and spot audits. 4. By what date are you going to have the deficiency corrected? 5/16/221.	05/16/2022
S 1010 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)			

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	Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug handling, storing, labeling, and dispensing. Based on document review, observation and interview, nursing failed to ensure that spiked intravenous (IV) bags of fluid were labeled with expiration date and time in 2 of 2 IV bags (pre-operative room 3 and nursing station) observed at main facility and 1 of 1 IV bag (pre-operative room 8) observed at offsite facility. Findings Include: 1. Review of policy titled: Safe Medication Management last approved 02/11/22, indicated all medications removed from the original container or packaging will be labeled with expiration date and time and initials of person transferring the drug. 2. Tour with S2 (Manager of Assessment/Recovery at main facility) on 04/19/22 at approximately 10:00 am, this surveyor observed a spiked IV bag of 1000 milliliters of Lactated Ringers solution hanging on IV pole in room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers solution with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station. The bags lacked documentation of expiration time and date of when the bags were spiked.	S 1010	1. How the deficiency will be or has been corrected.- Deficiency was completed with the addition of a label/ tags on each bag of IV fluid. Date and time, as well as initials of person transferring the drug will be on the label/tag. Training and education was completed with the staff to ensure knowledge and compliance. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. - Review and spot audits by the Pre/ Post manager will be completed to ensure compliance. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.- The Pre/Post Nurse Manager. 4. By what date are you going to have the deficiency corrected? 5/9/22	05/09/2022

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	3. Tour of offsite facility with S3 (Manager of Assessment at offsite) on 04/20/22 at 9:40 am, this surveyor observed a 1000 milliliter bag of Lactacted Ringers solution hanging on IV pole in pre-operative room 8 and not attached to a patient. The bag lacked documentation of expiration date and time of when the bag was spiked. 4. Interview on 04/19/22 at approximately 10:00 am with S2 confirmed a spiked IV bag of 1000 milliliters of Lactated Ringers hanging on IV pole in pre-operative room 3 and not attached to a patient; and a spiked 1000 milliliter bag of Lactated Ringers with a spiked 250 milliliter bag of Toradol 50 milligrams piggy-backed, in the nursing station; both IV bags lacked documentation of a label with the expiration date and time when the bags were spiked. 5. Interview on 04/20/22 with S3 at 9:40 am confirmed a spiked IV bag of 1000 milliliters of Lactated Ringers solution hanging on IV pole in pre-operative room 8 and not attached to a patient; IV bag lacked documentation of a label with the expiration date and time when the bag was spiked.			