

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>15C0001011</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - SURGICAL CARE CENTER INC</b><br><br>B. WING _____               |                      | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>03/09/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SURGICAL CARE CENTER INC</b>   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9202 N MERIDIAN STREET SUITE 150</b><br><b>INDIANAPOLIS, IN 46260</b> |                      |   |
| (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 |   |
| {K 000}   | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 01/29/21 was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 03/09/21</p> <p>Facility Number: 005392<br/>Provider Number: 15C0001011<br/>AIM Number: 100274160A</p> <p>At this PSR survey, Surgery Care Center Inc. was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This facility, located on the first floor of a two-story building with a basement, was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all patient care areas.</p> <p>Quality Review completed on 03/10/21</p> | {K 000}   |   |                      |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  |   | TITLE   |                      | (X6) DATE   |
|   |  |   |   |                      | 03/12/2021  |

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 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.