

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
Q 0000 Bldg. 00	<p>This visit was for a recertification survey of an Ambulatory Surgery Center and Focused Infection Control survey.</p> <p>Facility Number: 003032</p> <p>Survey Date: 02/8-10/2021</p> <p>Center for Special Surgery LLC was in compliance with CMS Focused Infection Control Survey for Acute and Continuing Care.</p> <p>QA: 2/12/21</p>	Q 0000	<p>Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of a required regulatory response. This facility has a documented history of regulatory compliance and the Administrator will ensure that all vendors and staff will complete this plan of correction no later than 3/12/2021.</p>	
Q 0100 Bldg. 00	<p>416.44 ENVIRONMENT</p> <p>The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.</p> <p>Based on record review, observation and interview, the facility failed to ensure 1 of 1 fire barriers that separated other occupancies was protected to maintain the one hour fire resistance rating of the fire barrier (see tag K131), failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition (see tag K345), failed to maintain the ceiling construction in 1 of 1 Biohazard rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (see tag K351), failed to ensure a complete automatic sprinkler system was provided for 1 of 1 Elevator machine rooms (see tag K351), failed to maintain the ceiling construction in 1 of 1 IT</p>	O 0100	<p>1. Fire wall will be inspected and all findings will be fire stop by Cornerstone Construction by 3/12/2021. Cornerstone Construction will also provide to facility a guide for penetrations in a firewall that can be provided to all future contractors working in the space to prevent future unsealed penetrations. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>2. The property manager will</p>	03/12/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
	<p>rooms on Back hall. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction (see tag K353), failed to completely maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25 (see tag K353), failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with LSC 9.4.6, Elevator Testing (see tag K531), and failed to maintain testing of 1 of 1 central supply systems for nonflammable medical gases in accordance with NFPA 99, 2012 Edition (see tag K908).</p> <p>The cumulative effect of this systemic problem resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.</p>		<p>resolve the issue with the fire alarm control panel by 3/5/2021. "Observable Defects in the Fire Prevention System" is already an indicator for nursing safety inspections. Nurses will be instructed by the Quality Manager to include this panel in their inspection and to report any alerts to the property manager immediately. The Administrator will ensure this is completed by the property manager.</p> <p>3. Correction escutcheons will be installed by Cornerstone Construction by 3/12/2021. Escutcheons are already an item on the OR log safety checklist. Nursing will be instructed by the Quality Manager to open all doors and inspect all areas when completing the checklist. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>4. Fire sprinkler will be added to elevator equipment room by Cornerstone Construction by 3/12/2021. As part of the sprinkler system, these sprinklers will become part of any sprinkler inspections and testing. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>5. A vent had been removed and will be replaced by Cornerstone</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
			<p>Construction by 3/12/2021. This will not require monitoring once repaired. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>6. The log titled "CSS Sprinkler Gauges/Valve Log" was created in 06/2017, but was not replaced in the fire riser room after a flood in the facility. The Quality Manager gave the log to the OR Manager who put it into the OR Log book on 2/15/2021 for the nurses to complete monthly. The OR Manager also, physically showed the nurses what they are to inspect. Staff verbalized understanding of what is required.</p> <p>7. The property manager will have the firefighter recall tested by 3/12/2021, and monthly thereafter. Receipt of this testing will be added as an indicator to the QA Plan. The Administrator will ensure this is completed by the property manager.</p> <p>8. On 2-19-2021, a quote was requested from a Buckeye Power for annual inspection of our medical gas system. The service will include both an annual medical gas manifold PM and 6 months later medical gas evaluation testing to be done annually as well. The Quality Manager will ensure the PM is</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2021	
NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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			
Q 0104 Bldg. 00	<p>416.44(b)(1)-(3) SAFETY FROM FIRE</p> <p>(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).</p> <p>(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.</p> <p>(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.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers that separated other occupancies was protected to maintain the one hour fire resistance rating of the fire barrier. NFPA 101 2012 edition section 8.3.5.6.1 states membrane penetrations for cables cable</p>	O 0104	<p>done by Buckeye Power by Friday, 03-12-2021. Receipt of PM's and medical gas evaluations will be added an indicator to the QA Plan.</p> <p>1. Fire wall will be inspected and all findings will be fire stop by Cornerstone Construction by 3/12/2021. Cornerstone Construction will also provide to facility a guide for penetrations in a firewall that can be provided to</p>	03/12/2021			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
	<p>trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section 8.3.5.6.2 states, the firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Tech (MT) on 02/15/21 between 12:05 p.m. to 1:45 p.m., in the one hour fire wall which separates the surgery center from the clinic the following unsealed penetrations were observed:</p> <p>a) Above the ceiling tiles in the Employee breakroom, west wall there were dime size holes above and below two 1/2 inch copper pipes and a six by six inch opening top and bottom of a six inch diameter plastic pipe, both penetrating the fire wall and were unsealed with fire stop material.</p> <p>b) Above the ceiling tiles at the South firewall there were four steel trusses penetrating the firewall and the six by six inch opening at each steel truss was filled with insulation which the Maintenance tech could not verify its fire rating with documentation.</p> <p>c) Above the ceiling tiles at the Entrance firewall on the MRI hall, the drywall joints, the openings around pipes and conduits were all sealed with adhesive tape which the fire rating could not be verified by the Maintenance tech with documentation.</p>		<p>all future contractors working in the space to prevent future unsealed penetrations. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>2. The property manager will resolve the issue with the fire alarm control panel by 3/5/2021. "Observable Defects in the Fire Prevention System" is already an indicator for nursing safety inspections. Nurses will be instructed by the Quality Manager to include this panel in their inspection and to report any alerts to the property manager immediately. The Administrator will ensure this is completed by the property manager.</p> <p>3. Correction escutcheons will be installed by Cornerstone Construction by 3/12/2021. Escutcheons are already an item on the OR log safety checklist. Nursing will be instructed by the Quality Manager to open all doors and inspect all areas when completing the checklist. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>4. Fire sprinkler will be added to elevator equipment room by</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
	<p>This finding was discussed with the Executive Director at the exit conference.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm control panel on 02/15/21 at 2:10 p.m. with the Maintenance Tech (MT), there was a yellow light illuminated on the fire alarm control panel (FACP) located at the Front entrance. The FACP stated "First floor center core exam rm #3. During an interview at the time of observation, the MT did not know what this meant and stated he would call for assistance from their fire alarm inspection company. The yellow trouble light was still illuminated during the exit conference. This finding was discussed with the Executive Director during the exit conference.</p> <p>3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Biohazard rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff.</p> <p>Findings include:</p>		<p>Cornerstone Construction by 3/12/2021. As part of the sprinkler system, these sprinklers will become part of any sprinkler inspections and testing. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>5. A vent had been removed and will be replaced by Cornerstone Construction by 3/12/2021. This will not require monitoring once repaired. The Administrator will ensure this is completed by Cornerstone Construction.</p> <p>6. The log titled "CSS Sprinkler Gauges/Valve Log" was created in 06/2017, but was not replaced in the fire riser room after a flood in the facility. The Quality Manager gave the log to the OR Manager who put it into the OR Log book on 2/15/2021 for the nurses to complete monthly. The OR Manager also, physically showed the nurses what they are to inspect. Staff verbalized understanding of what is required.</p> <p>7. The property manager will have the firefighter recall tested by 3/12/2021, and monthly thereafter. Receipt of this testing will be added as an indicator to the QA Plan. The</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Based on observation with the Maintenance Tech (MT) on 02/15/21 at 1:05 p.m., the Biohazard room next to the East exit had one sprinkler head missing an escutcheon. Based on interview at the time of observation, the MT confirmed the escutcheon was missing, and indicated he may have a spare to replace the missing escutcheon. This finding was reviewed with the Executive Director at the exit conference.</p> <p>4. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 Elevator machine rooms. NFPA 13 at 8.15.10.3 requires Elevator machine rooms to be sprinklered. Electrical equipment rooms not meeting requirements of 8.15.10.3 are required to be sprinklered.</p> <p>8.15.10.3 Sprinklers shall not be required in electrical equipment rooms where all of the following conditions are met: (1) The room is dedicated to electrical equipment only. (2) Only dry-type electrical equipment is used. (3) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (4) No combustible storage is permitted to be stored in the room.</p> <p>Findings include:</p> <p>Based on observation on 02/15/21 at 2:20 p.m. with the Maintenance Tech, there was an elevator machine room adjacent to the Staff restroom which was not sprinklered. Based on interview with the Executive Director (ED), it was acknowledged she already surmised the elevator mechanical room would need to be sprinklered since she heard it happen at another facility. This</p>		<p>Administrator will ensure this is completed by the property manager.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
	<p>finding was reviewed with the ED at the exit conference.</p> <p>5. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 IT rooms on Back hall. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Tech (MT) on 02/15/21 at 1:22 p.m. the IT room had a 10 inch by 10 inch opening in the ceiling next to the entrance door. Based on interview at the time of observation, the MT acknowledged the opening in the ceiling and did not know its purpose or its potential effect on sprinkler response. This finding was reviewed with the Executive Director at the exit conference.</p> <p>6. Based on record review and interview, the facility failed to completely maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants.</p> <p>Findings include:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
Q 0108 Bldg. 00	<p>Based on record review with the Executive Director (ED), on 02/15/21 at 1:45 p.m., no documentation was available for the monthly gauges or control valves inspection. Based on interview at the time of record review, the ED acknowledged the sprinkler monthly valve and gauge inspections had not been done. This finding was reviewed with the Executive Director at the exit conference.</p> <p>7. Based on record review and interview the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with LSC 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators equipped with fire fighters' emergency operations in accordance with LSC 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director (ED) on 02/15/21 at 12:20 p.m., the last documentation for the monthly firefighter recall testing was 06/30/20. Based on interview at the time of record review, the ED acknowledged the lack of documentation. This finding was reviewed with the ED at the exit conference.</p> <p>416.44(c) BUILDING SAFETY (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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
	<p>(NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).</p> <p>(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC.</p> <p>(2) If application of the Health Care Facilities 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.</p> <p>Based on record review and interview the facility failed to maintain testing of 1 of 1 central supply systems for nonflammable medical gases in accordance with NFPA 99, 2012 Edition. NFPA 5.1.14.4.4 states the following:</p> <ol style="list-style-type: none"> 1. They shall be inspected annually. 2. They shall be maintained by a qualified representative of the equipment owner.. 3. A record of the annual inspection shall be available for review by the authority having jurisdiction. <p>This deficient practice could affect all patients.</p> <p>Findings include:</p> <p>Based on record review on 02/15/21 at 11:22 a.m. with the Executive Director (ED), the last inspection of the central supply systems for nonflammable medical gases was on 05/01/2012. Based on interview concurrent with record review it was acknowledged, the ED was unsure of the testing frequencies of the central supply systems for nonflammable medical gases. This was discussed with the ED during the exit</p>	Q 0108	On 2-19-2021, a quote was requested from a Buckeye Power for annual inspection of our medical gas system. The service will include both an annual medical gas manifold PM and 6 months later medical gas evaluation testing to be done annually as well. The Quality Manager will ensure the PM is done by Buckeye Power by Friday, 03-12-2021. Receipt of PM's and medical gas evaluations will be added an indicator to the QA Plan.	03/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
--	--

(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
S 0000 Bldg. 00	conference. This visit was for a state licensure survey of an Ambulatory Surgery Center. Facility Number: 003032 Survey Date: 02/08-10/2021. QA: 2/12/21	S 0000		
S 0153 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the facility failed to document orientation training was conducted for one (1) agency Registered Nurse (RN). Findings include: 1. Review of facility personnel record for agency Registered Nurse (#N6) indicated no documentation of facility orientation training was	S 0153	The Quality Manager completed the Orientation Checklist for this nurse. Moving forward all agency nurses will complete the same Orientation Checklist as employed staff. The Quality Manager will audit agency personnel files at day one, day seven and day 30 of employment to ensure that an orientation appropriate to the nurse's scope of practice within	02/25/2021

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

PRINTED: 04/12/2021
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2021
NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC			STREET ADDRESS, CITY, STATE, ZIP COD 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260		
(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	
	available for validation. 2. In interview on 02-09-2021 at 1545 hours, employee (#S2), Administration, confirmed that no documentation of orientation training was available for agency Registered Nurse (#N6).		the facility has been completed.		