

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

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAGLE HIGHLANDS SURGERY CENTER B. WING _____		(X3) DATE SURVEY COMPLETED R 04/28/2022
NAME OF PROVIDER OR SUPPLIER EAGLE HIGHLANDS SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6850 PARKDALE PLACE INDIANAPOLIS, IN 46254		
(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 03/24/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 04/28/22</p> <p>Facility Number: 004756 Provider Number: 15C0001149 AIM Number: 200848180A</p> <p>At this PSR survey, Eagle Highlands Surgery Center LLC 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 21, Existing Ambulatory Health Care Occupancies.</p> <p>This one-story facility building was fully sprinklered and was determined to be of Type II (111) construction. This ASC, which measures greater than 10,000 square feet in size and is not constructed to have two or more smoke compartments within its suite, is using the adjoining occupancy as the second smoke compartment. The adjoining occupancy consists of the main entrance lobby, a therapy room, restrooms, and a records room for radiology which is open to the main entrance lobby. The facility has a fire alarm system with smoke detection in the four operating rooms and in the two procedure rooms.</p> <p>Quality Review completed on 05/02/22</p>	{K 000}		

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

TITLE

(X6) DATE

05/02/2022

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.

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

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAGLE HIGHLANDS SURGERY CENTER B. WING _____		(X3) DATE SURVEY COMPLETED R 04/28/2022
NAME OF PROVIDER OR SUPPLIER EAGLE HIGHLANDS SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6850 PARKDALE PLACE INDIANAPOLIS, IN 46254		
(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