STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001065	A. BUILDING -- B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SURGERY CENTER THE	7900 W JEFFERSON BOULEVARD, SUITE 102 FORT WAYNE, IN 46804

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54. Survey Date: 01/26/21 Facility Number: 009566 Provider Number: 15C0001065 AIM Number: 200138850A At this Emergency Preparedness survey, The Surgery Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. Quality Review completed on 02/01/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 01/26/21 Facility Number: 009566 Provider Number: 15C0001065 AIM Number: 200138850A At this Life Safety Code survey, The Surgery Center was found not 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 Protection Association (NFPA) 101, Life	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

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	Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. The facility is located on the first floor of a three story building determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and operating rooms. Quality Review completed on 02/01/21			
K 0761 Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 21.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance of LSC 21.1.1.4.1. communicating openings in dividing fire barriers required by 21.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door	K 0761	1. Life Safety Services has been contacted. They will be at our facility on 2-26-2021 to do a complete Fire Door Inspection. 2. The Annual Fire Door Inspection has been added to the annual PM list to be done every February. 3. Nikki Zwick, Director of TSC, will be responsible for making sure that this gets completed annually.	02/26/2021

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	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. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are		4. The deficiency will be corrected by 2-26-2021	

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	inspected to verify their presence and integrity. This deficient practice could affect all building occupants. Findings include: During records review with the Surgery Center Director on 01/26/21 at 11:13 a.m., no documentation of an annual inspection for the five fire door assemblies was available for review. Based on observation during the tour between 12:00 p.m. and 1:00 p.m., there were (4) 90-minute fire door assembly in the one-hour fire barrier and one fire door in the stairwell fire barrier. Based on interview at the time of records review and observation, the Surgery Center Director stated an annual fire door inspection for the five fire doors has not completed within the last year. The finding was review with the Surgery Center Director during the exit conference.			
K 0913 Bldg. 01	NFPA 101 Electrical Systems - Wet Procedure Locations Electrical Systems - Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2 Based on record review and interview, the facility failed to ensure 2 of 2 operating rooms (OR) contained either isolated power or ground-fault	K 0913	1. Votaw Electric has been contacted. They have submitted a quote to remove 10 duplex	02/26/2021

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	circuit interrupters (GFCI), unless otherwise determined by a risk assessment conducted by the facility governing body. This deficient practice could affect all patients in the event of an emergency in the facility's 2 ORs. Findings include: Based on observation with the Surgery Center Director on 01/26/21 between 12:13 p.m. and 12:35 p.m., the receptacles in the two operating rooms were not protected with isolated power or GFCIs. Based on record review with the Surgery Center Director at 11:00 a.m., no documentation of a risk assessment conducted by the facility governing body was available for review. Based on interview at the time of record review and observation, the Surgery Center Director stated no receptacles in the operating rooms contained isolated power or GFCIs, and a risk assessment for the ORs could not be found. The finding was review with the Surgery Center Director during the exit conference.		receptacles in OR #1 and OR #2 and replace them with 10 GFCI receptacles. 2. This deficiency should not reoccur due to the placement of the GFCI receptacles. 3. Nikki Zwick, Director of TSC will be responsible for making sure that is completed. 4. Expected to be completed by 2-23-2021	
K 0920 Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE			

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	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 2 Operating Rooms (OR) used flexible cords power strips powering medical equipment that met the required UL rating of 1363A or 60601-1. This deficient practice could affect one patient in OR #2. Findings include: Based on observation with the Surgery Center Director on 01/26/21 at 12:00 p.m., in OR #2 there was a power strip that did not meet 1363A or 60601-1 laying in the middle of the floor powering medical equipment that was in use. Based on interview at the time of observation, the Surgery Center Director agreed a power-strip was used to power medical equipment in OR #2 that did not meet 1363A or 60601-1. The finding was review with the Surgery Center Director during the exit conference.	K 0920	1. (2) Tripp Lite 1363A Medical-Grade Power Strips (Model# PS-615-HG-OEM UL) were ordered to replace the deficient power strips in OR#1 and OR#2. 2. The deficiency will not reoccur due to the fact that the proper power strips have been ordered. 3. Nikki Zwick, Director of TSC is responsible for correcting this deficiency. 4. The power strips were delivered on 2-5-2021 and put into place the same day.	02/05/2021