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	15C0001071	A. BUILDING 00 B. WING	02/19/2021

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MICHIANA ENDOSCOPY CENTER	53830 GENERATIONS DR STE A SOUTH BEND, IN 46635

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Q 0000 Bldg. 00	This visit was for a Re-certification survey and a Focused Infection Control Survey of an Ambulatory Surgery Center. Dates of Survey: 2/17-19/2021 and 2/22/2021 Facility Number: 009761 Michiana Endoscopy Center was found in compliance with the CMS Focused Infection Control Survey for Acute & Continuing Care. QA: 2/23/21 and 2/26/21	Q 0000		
Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 Occupancy Separation walls was maintained to ensure the fire resistance of the barrier (see tag K131). 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.	O 0100	K 131 Q100: Plan of Correction The administrator shared the results of this survey with the staff and the governing board to ensure the life safety code for the ASC is met at all times and on-going compliance with Life Safety Code and to ensure the corrective actions are completed and included. The POC was reviewed and approved by the QAPI and the governing board to ensure ongoing compliance with CMS Conditions for Coverage, including the	03/09/2021

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

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			Environment of Care. a)The three unsealed penetrations identified above the lay-in ceiling tiles in the North wall in the file room around the communication cables were sealed with approved UL listed fire stopping material (Photo #1 and #2 Attachment uploaded) b) A subcontractor was hired to complete the wall located in the separation wall that was noted not to have been completed to roof deck . The wall was repaired to the roof deck and sealed with an approved fire-stop system to maintain the original fire resistance rating of the construction. see Photo #3 Attachment uploaded)-The Center Leader will document on attachment # 3	
Q 0104 Bldg. 00	416.44(b)(1)-(3) SAFETY FROM FIRE (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			

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	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. Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 Occupancy Separation walls was maintained to ensure the fire resistance of the barrier. LSC 6.1.14.4.2 requires occupancy separations to meet the requirements of Chapter 8. LSC 8.3.5.1 requires penetrations for cables, cable 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 wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all occupants.	Q 0104	Q104: Plan of Correction The administrator shared the results of this survey with the staff and the governing board to ensure the life safety code for the ASC is met at all times and on-going compliance with Life Safety Code and to ensure the corrective actions are completed and included. The POC was reviewed and approved by the QAPI and the governing board to ensure ongoing compliance with CMS Conditions for Coverage, including the Environment of Care. Multiple Occupancies CFR NFPA 101 Penetrations Plan of Correction The administrator is	03/09/2021

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	Findings include: During a facility tour with the Center Director on 02/22/2021 from 1:40 p.m. to 2:20 p.m., the following conditions were found: a) Three unsealed penetrations above the lay-in ceiling tile in the file room in the north wall around communications cable approximately 4 inches by 4 inches in size. b) One portion of the occupancy separation wall, approximately one foot by three feet was not completed up to the roof deck above it. c) The staff break room opened to the corridor, which was outside of the ASC Occupancy. The self-closing device had been removed from the door and it would not self-close. d) The office door to the same corridor, was equipped with a self-closing device, however, was propped open with a rubber wedge. Based on interview at the time of each observation, the Center Director agreed that there were unsealed penetrations, that the wall did not go up to the roof deck above, and that the specified doors in the occupancy separation would not self-close. These deficient findings were reviewed with the Center Director at the time of exit.		responsible to ensure ongoing compliance with Life Safety Code and to ensure the corrective actions are completed. a)The three unsealed penetrations identified above the lay-in ceiling tiles in the North wall in the file room around the communication cables were sealed with approved UL listed fire stopping material (Photo #1 and #2 Attachment uploaded) b) A subcontractor was hired to complete the wall located in the separation wall that was noted not to have been completed to roof deck . The wall was repaired to the roof deck and sealed with an approved fire-stop system to maintain the original fire resistance rating of the construction. (Photo #3 Attachment uploaded) c) A contractor was obtained to repair the self-latching device on the fire door closure in the staff break-room. The staff break-room opens to the corridor, the	

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			door was repaired. (Photo #4 Attachment uploaded) d) The rubber wedge was promptly removed to release the propped office door that was equipped with a self closing device. Center Leader educated all staff via in-service to reinforce it is unacceptable to use door stops or wedges for propping open fire doors System Change To prevent this from happening again, the administrator will monitor for above ceiling work order request to ensure any penetrations are identified and sealed promptly. The administrator held a staff meeting to discussed the finding of propped fire doors with wedges being prohibited and will conduct daily rounds for four consecutive weeks to ensure the doors are not propped with wedges or other objects. A signage on the door states to keep fire door closed at all times. Responsible Party and Monitoring: The administrator is responsible to ensure all corrective actions are complete	

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			and will report the results of all the repaired penetrations, completed wall to roof deck, and repair of the self-latching door assembly and daily monitoring for no use of door stops or wedge to the QAPI committee and Governing Board. Any episode of non-compliance.	
S 0000 Bldg. 00		S 0000		
	This visit was for a State licensure survey of an Ambulatory Surgery Center. Facility Number: 009761 Dates of Survey: 2/17/2021 to 2/19/2021 QA: 2/23/21			
S 0230 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5) The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:			

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	(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. Based on document review and interview, the ambulatory surgery center's (ASC) governing body failed to ensure the periodic review was provided by a committee composed of three (3) or more duly licensed physicians having no financial interest in the facility from September, 2020 to date of survey. Findings included: 1. Review of document titled: "Patient Rights & Notification of Ownership," revision "9-24-20," indicate the following physicians had a "financial and ownership interest" in the facility: MD#1; MD#2; MD#4; MD#7 and MD#8. 2. Review of "Medical Staff Bylaws," last approved by the governing board on 2-11-2020, indicated the medical staff was responsible for conducting "Medical Staff peer review, with input from other physicians as needed to complete a thorough, objective review." 3. Review of policy/procedure titled: "Peer Review," approved 1-14-2020, read: "The second stage review is a medical case review performed by a peer (medical staff member or Allied Health Professional) with knowledge and experience in that specialty/files to evaluate the quality of care provided, confirming variations and determining whether opportunities for improvement exist." 4. Review of peer review documentation, titled:	S 0230	S 230 : Governing Body Powers and Duties Plan of Correction The administrator will ensure the facility complies with the requirement for a functioning Utilization Review Committee and is supported by at least three physicians without financial interested or ownership in the facility. The Governing Board approved the structure of the committee and the Medical Director is recruiting three licensed physicians to serve on the quarterly UR Committee. Quarter 1, 2021 meeting has been set pending new physician recruitment on or before March 19, 2021. (Attachment #7, UM Committee Agenda and Attachment #8 UM Form,) System Change: To prevent this from happening again, the administrator informed the Governing Board of the survey findings and they approved the Utilization Review Committee structure, initial agenda, and UM review form. The UM committee is scheduled to meeting quarterly going forward and reported to the Governing Board. Responsible Party and Monitoring	03/09/2021

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	"Endoscopy Case Review," indicated the following: a. MD#1 performed the peer reviews for MD#2 (1-5-2021); MD#4 (11-6-2020); MD#7 (10-2-2020 and 2-9-2021); and MD#8 (1-5-2021). b. MD#2 performed the peer review for MD#1 (1-28-2021). c. MD#4 performed the peer reviews for MD#9 (10-20-2020 and MD#7 (1-15-2021). d. MD#7 performed the peer reviews for MD#1 (10-20-2020); MD#6 (10-20-2020 and 1-4-2021); and MD#9 (10-20-2020). e. MD#8 performed the peer reviews for MD#4 (1-4-2021) and MD#9 (1-4-2021). 5. In interview on 2-18-2021 at 1:59 PM, A#2, Center Director, indicated MD#1, MD#2, MD#4, MD#7. and MD#8 were owners of the facility and were performing peer reviews. It was also indicated in interview that the peer review is their Utilization Review (UR) committee and that the facility doesn't have a UR committee.		The administrator is responsible to ensure the initial and subsequent quarterly meetings of the UM committee are held and the results are reported to the Governing Board. The Administrator will report the names of the three physicians without financial interested to the Governing board. The results of each Utilization Committee meeting will be reported by the Administrator to the Governing Board quarterly.	

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