STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF OPHTHALMOLOGY CONSULTANTS	7232 ENGLE RD , FORT WAYNE, Indiana, 46804

(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
Q0000	INITIAL COMMENTS This visit was for a Federal Recertification survey of an Ambulatory Surgery Center. Facility Number: 009567 Survey Dates: 2/04/25, 2/05/25 and 2/19/2025 QA: 2/25/2025	Q0000		
Q0100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is NOT MET as evidenced by: Based on record review, observation and interview, the facility failed to ensure penetrations through 2 of 2 smoke barriers' smoke resistance was properly maintained; and failed to ensure 1 of 1 written fire safety plans for the protection of all patients and their evacuation in the event of an emergency, and a copy of the plan is readily available with the telephone operator or with security in accordance with LSC chapter 21 section 7.2 and provides for all of the fire safety plan components per 7.2.2. Findings Include: The accumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	Q0100		03/25/2025
Q0104	SAFETY FROM FIRE CFR(s): 416.44(b)(1)-(3) (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care	Q0104		03/25/2025

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 reverse for further 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.

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

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Q0104	Continued from page 1 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). (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. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure penetrations through 2 of 2 smoke barriers' smoke resistance was properly maintained. LSC Section 21.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, 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 smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. Based on records review and interview the facility failed to ensure 1 of 1 written fire safety plans for	Q0104		

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Q0104	Continued from page 2 the protection of all patients and their evacuation in the event of an emergency, and a copy of the plan is readily available with the telephone operator or with security in accordance with LSC chapter 21 section.7.2 and provides for all of the fire safety plan components per 7.2.2. Based on observation during a tour of the facility with the RN Supervisor and the Administrator on 02/19/25 at 11:23 a.m., above the ceiling tiles of the entire length of both one-hour smoke barriers contained multiple unsealed holes, gaps, and penetrations filled with drywall mud. Based on an interview at the time of observations, the RN Supervisor and the Administrator agreed there were unsealed gaps and holes in the smoke barriers, and drywall mud was used to seal penetrations instead of a firestop system or device tested in accordance with ASTM E 814. This finding was reviewed with the RN Supervisor and the Administrator during the exit conference. Based on records review with the RN Supervisor and the Administrator on 02/19/25 at 10:23 a.m., the written fire safety plan was not provided during the time of the survey. Based on an interview at the time of observation, the RN Supervisor and the Administrator stated the fire safety plan could not be located. This finding was reviewed with the RN Supervisor and the Administrator during the exit conference.	Q0104		