STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001074	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... 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
K0000	INITIAL COMMENTS A Life Safety Code Recertification Survey was constructed by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/19/25 Facility Number: 009567 Provider Number: 15C0001074 AIM Number: 200177420A At this Life Safety Code survey, Surgery Center of Ophthalmology Consultants 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 Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This one-story facility with a lower level was determined to be of Type III (111) and was fully sprinklered. The facility is located on the lower level and has a fire alarm system with smoke detection in the corridors. Quality Review completed on 02/25/25	K0000		
K0372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K0372		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001074	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/19/2025

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K0372	Continued from page 1 21.3.7.5, 21.3.7.6, 8.5 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. This deficient practice could affect all occupants. 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.	K0372		
K0711	Evacuation and Relocation Plan	K0711		

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K0711 Bldg. 01	Continued from page 2 CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 20/21.7.2.1.2 and provides for all of the fire safety plan components per 20/21.7.2.2. 20.7.1.1 through 20.7.1.3, 20.7.1.8 through 20.7.2.3.3 21.7.1.1 through 20.7.1.3, 21.7.1.8 through 20.7.2.3.3 This STANDARD is NOT MET as evidenced by: Based on records review and interview the facility 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. This deficient practice affects all occupants. 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.	K0711		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54. Survey Date: 02/19/25 Facility Number: 009567 Provider Number: 15C0001074 AIM Number: 200177420A At this Emergency Preparedness survey, the Surgery Center of Ophthalmology Consultants was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. Quality Review completed on 02/25/25	E0000		

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