STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001086	A. BUILDING -- B. WING	04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELTWAY SURGERY CENTERS LLC	151 PENNSYLVANIA PKWY CARMEL, IN 46280

(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: 04/26/22 Facility Number: 002277 Provider Number: 15C0001086 AIM Number: 200255810A At this Emergency Preparedness survey, Beltway Surgery Centers LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. The facility has 9 certified operating rooms. Quality Review completed on 05/02/22	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: 04/26/22 Facility Number: 002277 Provider Number: 15C0001086 AIM Number: 200255810A At this Life Safety Code survey, Beltway Surgery Centers Llc was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b),	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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	Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). The facility, located on the first, second and third story of a three story building with a basement, was determined to be of Type II (000) construction and was fully sprinklered. The facility was surveyed with NFPA 101, LSC Chapter 21, Existing Ambulatory Health Care Occupancies. The facility has a fire alarm system with smoke detection at the first floor reception area, in the corridor outside the elevators, in the corridor outside the Operating Rooms and at the main fire panel on the second floor. Quality Review completed on 05/02/22			
K 0100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section, any LSC Section 20.1 and 20.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of over 10 doors on the second floor and the door would self-close per LSC 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all patients, staff and visitors on the second floor. Findings include:	K 0100	1. How the deficiency will be or has been corrected. Door was repaired. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Daily rounding and monthly assessment will be done on the door to ensure it is closing properly.	05/14/2022

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	Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the corridor door by the Staff Lounge on the second floor was equipped with a self-closing device and latching hardware but the door failed to self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Building Engineer for HTA agreed the aforementioned corridor door failed to latch into the door frame when tested to self-close multiple times. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/14/22	
K 0131 Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and			

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	occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44			
	Based on observation and interview, the facility failed to ensure 1 of 3 doors in the second floor waiting room separated the facility from other tenants and occupancies. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the entry door to the IVF corridor in the second floor tenant separation wall was equipped with a self-closing device and latching hardware but the door failed to fully self-close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Building Engineer for HTA agreed the door to the IVF corridor in the tenant separation wall on the	K 0131	1. How the deficiency will be or has been corrected. Door was repaired and is self closing. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Daily rounding and monthly assessment will be completed. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/14/22	05/14/2022

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	second floor failed to fully self-close and latch into the door frame when tested to close multiple times. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0223 Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 self-closing doors to the SIMS Room in the basement would self-close to form a smoke resistant barrier. This deficient practice could affect all staff and visitors in the basement. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from	K 0223	1. How the deficiency will be or has been corrected. The door was repaired. 5/14/22 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Testing/ rounding will occur to ensure that the door is in proper working order. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance	05/14/2022

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	2:15 p.m. to 4:20 p.m. on 04/26/22, the corridor door to the SIMS Room where the wall mounted battery-operated light is installed was held in the fully open position with a wedge placed under the door. The door was also equipped with a magnetic hold open release device set to self-close or automatic close with fire alarm system activation. The wall mounted magnetic release device was energized and held the door in the fully open position when the wedge was removed from under the door. Based on interview at the time of the observations, the Building Engineer for HTA agreed the wedge for the aforementioned corridor door prevented the door from self-closing or automatic closing if the fire alarm system was activated. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		maintained. Facility manager and Building engineer. The Team members are to notify the engineer of any issues with the door. 4. By what date are you going to have the deficiency corrected? 5/14/22	
K 0291 Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 1. Based on record review, observation and interview; the facility failed to ensure 3 of 8 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply	K 0291	1. How the deficiency will be or has been corrected. Monthly testing will be completed and documented on the new sheet created. Annual testing will be noted as well. New batteries were installed in deficient emergency lights. A new light was exchanged to the non working light in the basement SIMS area.	05/18/2022

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	with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Preventive Maintenance Task: Battery-Powered Emergency Light Test" documentation with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, the facility has 8 battery operated lighting systems which are not located in operating rooms. A total of 17 battery operated lighting systems are in the facility which includes 9 operating room locations. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the wall mounted battery operated emergency lighting system identified as #10 at the second floor nurse's station, the wall mounted battery operated emergency lighting system identified as #13 in the third floor PACU by Bay 6 and the wall mounted battery operated emergency lighting system in the basement SIMS room each failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Building Engineer for HTA agreed the battery-operated emergency lighting systems each failed to illuminate when its respective test button was pushed multiple times.		Completed 5/18/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. A new document will be used to specify individual emergency lights, as well as the testing occurring each month and annually. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/18/22	

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	This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. 2. Based on record review, observation, and interview; the facility failed to document monthly and annual testing for 8 of 8 battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of "Preventive Maintenance Task: Battery-Powered Emergency Light Test" documentation dated January 2021 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for			

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	Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, the facility has 8 battery operated lighting systems which are not located in operating rooms. A total of 17 battery operated lighting systems are in the facility which includes 9 additional operating room locations. Documentation of monthly functional testing for all eight battery backup lights itemized by location for the most recent twelve-month period was not available for review. In addition, annual 90-minute functional testing documentation for the eight battery operated lighting systems conducted within the most recent twelve-month period was also not available for review. Review of "Work Order: Generator Powered Emergency Lights" testing documentation for the most recent twelve-month period did not itemize emergency light testing by the light location. Based on interview at the time of record review, the Building Engineer for HTA stated he tests battery lighting systems on a monthly basis for 30 seconds but agreed additional monthly and annual testing documentation for testing conducted within the most recent twelve-month period was not available for review at the time of the survey. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, all eight wall mounted battery operated emergency lighting systems functioned when it's respective test button was pushed except for the lighting system identified as #10 at the second floor nurse's station, the lighting system identified as #13 in the third floor PACU by Bay 6 and the lighting system in the basement SIMS room. This finding was reviewed with the Director ASC			

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	Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0323 Bldg. 01	NFPA 101 Anesthetizing Locations Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's			

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	instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2 Based on record review, observation and interview; the facility failed to document monthly and annual testing of emergency lighting in 9 of 9 operating rooms where general anesthesia is administered in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.2.11.1 states one or more battery-powered lighting units shall be provided within locations where deep sedation and general anesthesia is administered. The lighting level of each unit shall be sufficient to terminate procedures intended to be performed within the operating room. The sensor for units shall be wired to the branch circuit(s) serving general lighting within the room. Units shall be capable of providing lighting for 90 minutes and shall be tested monthly for 30 seconds and annually for 30 minutes. Section 3.3.17 defines battery-powered lighting units as individual unit equipment for backup illumination consisting of a rechargeable battery, battery-charging means, provisions for one or more lamps mounted on the equipment, or with terminals for remote lamps, or both, and relaying device arranged to energize the lamps automatically upon failure of the supply to the unit equipment. This deficient practice could affect nine patients and staff in operating rooms where general anesthesia or life support equipment is used. Findings include: Based on review of "Preventive Maintenance Task: Battery-Powered Emergency Light Test" documentation dated January 2021 with the	K 0323	1. How the deficiency will be or has been corrected. A new documentation sheet has been created to document the assessment completed monthly and annually. The sheet shows each emergency lighting unit. 5/14/22 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The new sheet will be added to the PM reporting system for the center and will be used monthly to document locations of emergency lights and testing completed. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 5/14/22	05/14/2022

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	Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, monthly functional testing documentation for 9 of 9 battery backup lights in operating rooms where general anesthesia is used which was conducted within the most recent twelve month period was not available for review. Review of "OPC Light Check" documentation did not state the duration of the test to "Check Lights". In addition, 30-minute annual functional testing documentation for 9 of 9 battery backup lights in operating rooms where general anesthesia is used which was conducted within the most recent twelve-month period was not available for review. Review of "Work Order: Generator Powered Emergency Lights" testing documentation for the most recent twelve-month period did not itemize emergency light testing by the light location. Based on interview at the time of record review, the Director ASC Clinical Operations stated general anesthesia can be used in each of the 9 operating rooms. Based on interview at the time of record review, the Building Engineer for HTA stated he tests battery lighting systems on a monthly basis for 30 seconds but agreed additional monthly and annual testing documentation for testing conducted within the most recent twelve-month period was not available for review at the time of the survey. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, all operating rooms were occupied at the time of the survey except for OR 3. The wall mounted battery-operated lighting system in OR 3 operated			

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	when its respective test button was pushed. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, it could not be assured all facility fire alarm system initiating devices were functional tested annually. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states unless otherwise permitted by other sections of this code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Table 14.4.5 Testing Frequencies states initiating devices shall be functional tested annually. This deficient practice could affect all patients, staff and visitors. Findings include:	K 0345	1. How the deficiency will be or has been corrected. Functional testing was completed with documentation to a new sheet, showing location of each emergency light, as well as time of monthly and annual testing. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. New document will be completed that shows all individual locations. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and	05/18/2022

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	Based on review of the fire alarm system inspection contractor's "System's Service" documentation dated 01/29/22 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, fire alarm system initiating devices were tested within the most recent twelve-month period. However, an itemized list of the location of each initiating device tested and the result of each functional test was not available for review. Based on interview at the time of record review, the Building Engineer for HTA stated he had contacted the inspection contractor during the survey on 04/26/22 to obtain a detailed inspection report for testing done on 01/29/22 but agreed documentation of an itemized list of the location of each initiating device tested and the result of each functional test within the most recent twelve-month period was not available for review at the time of the survey. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		building engineer. 4. By what date are you going to have the deficiency corrected? 5/18/22	
K 0351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX,			

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	security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13 Based on observation and interview, the facility failed to maintain 1 of over 100 automatic sprinklers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. Cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect 9 patients, staff and visitors. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the recessed sprinkler located on the ceiling in the Clean Utility Room on the third floor was missing its cover plate. Based on interview at the time of the observations, the Building Engineer for HTA agreed the aforementioned recessed sprinkler location was missing its cover plate. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.	K 0351	1. How the deficiency will be or has been corrected. Escutcheon plates were replaced. 4/27/22 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Daily rounding by the building engineer will be done and missing plates noted and corrected. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and Building engineer. 4. By what date are you going to have the deficiency corrected? 4/27/22	04/27/2022

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K 0353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Problems Found" section	K 0353	1. How the deficiency will be or has been corrected. Gauges were replaced on 4/27/22. Internal review will be completed by 5/27/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The need for gauge inspection will be added to the PM schedule for the building engineer. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer.	05/27/2022

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	of "System's Service" documentation dated 01/29/22 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, "15 gauges need replaced with 2022". Based on interview at the time of record review, the Building Engineer for HTA stated the building has two separate sprinkler systems which include one for the surgery center and a separate sprinkler system for the Medical Office Building (MOB). Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, three of three gauges for the surgery center's supervised wet sprinkler system in the basement had the manufacture date of 2014 listed on the face of each gauge. No calibration documentation was affixed to the gauges. Based on interview at the time of the observations, the Building Engineer for HTA agreed documentation of sprinkler system gauge replacement or recalibration was not available for review for the three wet sprinkler system pressure gauges which were each more than five years old. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		4. By what date are you going to have the deficiency corrected? 5/27/22	
K 0511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping			

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	complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 electrical junction boxes in the basement automatic transfer switch room were maintained in a safe operating condition. LSC 21.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3)(c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, two of two electrical junction boxes each without a cover and with exposed electrical wiring were noted in the automatic transfer switch room in the basement above the electrical panel identified as "DPX-Ray". Based on interview at the time of the observations, the Building Engineer for HTA agreed the aforementioned two electrical junction box locations were not provided with a cover. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop	K 0511	1. How the deficiency will be or has been corrected. Junction box covers were replaced in the transfer switch room and the PACU bay #4 receptacle cover was replaced. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Education to team members to report broken receptacle plates was completed. Rounding daily by the building engineer will be completed and assessment of broken receptacles will be noted. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Building engineer, managers of the center, and director of the center. 4. By what date are you going to have the deficiency corrected? 5/14/22	05/14/2022

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	and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference. Based on observation and interview, the facility failed to ensure all electrical outlets were protected in the PACU area in according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect all patients, staff and visitors in the PACU area. Findings include: Based on interviews and observation during a facility tour with the Clinical Director, OR Manager, Regional Facilities Manager, Clinical Operations Manager and HTA Facilities Engineer on 04/26/22 between 2:10 p.m. 4:20 p.m., in the PACU Bay # 4 an outlet cover protecting the electrical outlet was not completely covering the receptacle and appeared to be broken with pieces missing. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0712 Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is			

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	aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on each shift in 4 of 4 quarters. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on records review and interviews with the Clinical Director, OR Manager, Regional Facilities Manager, Clinical Operations Manager and HTA Facilities Engineer on 04/26/22 between 9:35 a.m. and 2:10 p.m., all first shift fire drills (for each quarter) were held at 10:00 a.m. and all second shift fire drills (for each quarter) were held at 4:00 p.m. This condition does not allow fire drills to be conducted at unexpected times. Based on interview at the time of record review, the Clinical Director agreed the drill times were the same for each shift in each quarter. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.	K 0712	1. How the deficiency will be or has been corrected. Fire drills for the remainder of the year have been scheduled at different times/ days/ shifts per week. Dates for quarterly fire drills will be : Thurs, 7/7/22 12 pm; Friday 7/8/22 6:30 am; and Tuesday 10/3/22 9pm. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The deficiency will not recur due to scheduling ahead of time and Manager and Director ensuring the drills are on different days, shifts, and different times. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. The PACU manager and the Director of the facility. 4. By what date are you going to have the deficiency corrected? 5/10/22	05/10/2022
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			

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	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 record review and interview, the facility failed to maintain 16 of 20 fire-rated door locations. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door 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. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of the fire door inspection contractor's "Annual Door Inspection 2020 Summary Report" documentation dated 10/12/20 with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, sixteen of twenty fire door locations in the surgery center failed inspection. Fire door locations identified as #0-001, #0-002, #1-001, #1-005, #1-006, #1-008, #1-009, #1-010, #1-011, #1-012,	K 0761	1. How the deficiency will be or has been corrected. Door inspection and repairs completed. Lead time for door hardware is 7/18/22. Door 1-011 is not a Surgery center door. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Facility manager and building engineer will round and complete door assessments monthly. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. facility manager and building engineer. 4. By what date are you going to have the deficiency corrected? 7/18/22	07/18/2022

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	#2-001, #2-002, #2-003, #3-001, #3-002 and #3-003 were listed as failing the fire door inspection. Based on interview at the time of record review, the Facility Manager stated inspection and/or repair/replace documentation on or after 10/12/20 was not available for review. The Facility Manager stated some fire door inspection issues have been corrected but he did not know which doors were corrected and which doors still needed correction. The Facility Manager provided an e-mail from a fire door inspection contractor that facility fire doors were scheduled for re-inspection in May 2022. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0781 Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies. Except, when used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 20.7.8, 21.7.8 Based on record review, observation and interview; the facility failure to ensure 2 of 2 portable space heaters were not used in the health care portion of the facility. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review with the Director ASC Clinical Operations, the OR Manager, the Preop	K 0781	1. How the deficiency will be or has been corrected. The space heaters were removed from the center. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Education about the	05/10/2022

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	and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, a portable space heater policy was not available for review. Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for HTA during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, two portable space heaters were stored in the Clinical Manager's Office on the third floor. Manufacturer's documentation affixed to the portable space heaters did not state the maximum temperature achieved by the unit. Based on interview at the time of the observations, the Preop and Recovery Manager stated the portable space heaters are used when a patient complains of being cold. Based on interview at the time of the exit conference, the Building Engineer for HTA stated there is no space heater policy documentation but the policy is "don't use them". This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		regulatory requirements was completed and audits from leadership will ensure that the space heaters are not used in the center. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Managers from PACU and the OR , as well as the Director will ensure that no heaters are in use. 4. By what date are you going to have the deficiency corrected? 4/19/22	
K 0914 Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data.			

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	Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For, LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type	K 0914	1. How the deficiency will be or has been corrected. The space heaters were removed from the center. Receptacle testing was completed on 4/27/22. Repairs to noted deficiencies were completed on 5/14/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The annual receptacle testing has been entered into the PM schedule for the building engineer. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. The facility manager and building engineer will be responsible to ensure the annual testing is completed.	05/14/2022

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	15C0001086	A. BUILDING 01 B. WING	04/26/2022

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	receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on records review and interviews with the Clinical Director, OR Manager, Regional Facilities Manager, Clinical Operations Manager and HTA Facilities Engineer on 04/26/22 between 9:35 a.m. and 2:10 p.m., an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Furthermore, no documentation of receptacle testing prior to January 2020 and the onset of the COVID-19 Pandemic were available for review. Based on interview with the Regional Facilities Manager during record review he stated this facility had not done receptacle testing recently and acknowledged that documentation verifying past receptacle testing was not available. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.		4. By what date are you going to have the deficiency corrected? 5/14/22	
K 0916 Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the			

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	generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 2 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all the patients, staff and visitors. Findings include: Based on observations with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during a tour of the facility from 2:15 p.m. to 4:20 p.m. on 04/26/22, the remote annunciator panel located at the third-floor overnight nurse's station had no electrical power and did not function when its respective test button was pushed multiple times. The remote annunciator panel was identified as a "Dynagen" panel. In addition, the remote annunciator panel located at the second-floor nurse's station identified as a "CAT" panel also had no electrical power and did not function when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Building Engineer for HTA stated the facility replaced its emergency generator in 2021, the Dynagen panel was for the old emergency generator and is no longer in use. The Building Engineer for HTA stated the CAT panel is for the new generator, the remote annunciator panel should be active and in use but agreed the CAT	K 0916	1. How the deficiency will be or has been corrected. The old annunciator panel that was not in use has been removed and covered. The new Cat remote annunciator was repaired and is working as of 5/13/22. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The facility manager and building engineer for HTA will be responsible to ensure the panel is working on daily walk throughs. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Facility manager and building engineer for HTA. 4. By what date are you going to have the deficiency corrected? 5/13/22	05/13/2022

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	panel had no electrical power at the time of the observations. The Facility Manager agreed the Dynagen panel should be removed if it is no longer in use. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			
K 0918 Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to exercise the generator for 11 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Work Order: Generator-M" documentation for the most recent twelve-month period with the Director ASC Clinical Operations,	K 0918	1. How the deficiency will be or has been corrected. The KW load test numbers will be calculated going forward on the generator testing sheet. 2. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The Facility Manager and the Building Engineer for HTA agreed documentation for the load percentage achieved during monthly load testing prior to 03/26/22 was not noted, but will be going forward. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. The facility manager and building engineer for HTA will be responsible for the KW load test numbers each month. 4. By what date are you going to have the deficiency corrected? 5/17/22	05/17/2022

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	the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during record review from 9:35 a.m. to 2:15 p.m. on 04/26/22, load information to show the available (actual) load percentage for the diesel-powered generator during monthly load testing was not documented. Review of "MMPN-OPC Monthly Generator Load Test" documentation for the monthly load test conducted on 03/26/22 indicated a load of 19 kW was achieved for the 125-kW diesel fired emergency generator. Based on interview at the time of record review, the Facility Manager stated the facility just started using the 03/26/22 format to document monthly load testing. The Facility Manager and the Building Engineer for HTA agreed documentation for the load percentage achieved during monthly load testing prior to 03/26/22 was not available for review. This finding was reviewed with the Director ASC Clinical Operations, the OR Manager, the Preop and Recovery Manager, the Facility Manager and the Building Engineer for Health Care Trust of America (HTA) during the exit conference.			