STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001151	A. BUILDING 00 B. WING	11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROADWEST SPECIALTY SURGICAL CENTER LLC	315 W 89TH AVE MERRILLVILLE, IN 46410

(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
Q 0000 Bldg. 00	This visit was for a Re-certification survey and a Focused Infection Control Survey. Dates Of Survey: 11/18-20/2020 & 11/24/2020 Facility Number: 011094 Broadwest Specialty Surgical Center, LLC was found in compliance with the CMS Focused Infection Control Survey for Acute & Continuing Care. QA: 12/2/20 & 12/8/20	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 record review, observation and interview, the facility failed to ensure the humidity in 3 of 5 Operating Rooms were eater than 20 percent (see tag K323), failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72 (see tag K345), failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72 (see tag K345), failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70 (see tag K345), failed to ensure the spray pattern for sprinklers were not obstructed in	O 0100	Our Physical Environment policy SURG #408 has been revised on humidity in the ORs. Our OR Manager will be responsible for monitoring the humidity on a daily basis. The OR Manager has revised our policy and created a spreadsheet to monitor the OR humidity as well as the carts are placed in the correct place. All fire alarm tests and reports have been placed in the binder.	12/17/2020

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

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	1 of 1 PAT rooms and 1 of 1 EEG Room in accordance with NFPA 13 (see tag K351), and failed to ensure annual inspection and testing of 19 of 19 fire door assemblies were maintained (see tag K761). 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.		The final test was completed on December 23, 2020 and is uploaded to this deficiency so that we remain complaint. We were having email issues which is why those reports were not readily available. That problem has been rectified and all binders and reports are up to date. The Business Mgr along with Jade Construction will be monitoring and making sure all tests are done as required and the company performing the test will be providing us with an email copy and a hard copy in the mail. The sprinkler heads in PAT room 1 and the EEG Room will be relocated to be two separate sprinkler heads one for each room by 1-21.21. The fire door repairs will be completed by 1.21.21 and Jade Consturction along with the PACU manager will monitor to make sure all doors are repaired and inspected on a yearly basis.	
Q 0101 Bldg. 00	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and			

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	equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on record review and interview, the facility failed to ensure the humidity in 3 of 5 Operating Rooms were eater than 20 percent. NFPA 99 9.3.1.1 requires heating, cooling, ventilating, and process systems serving spaces or providing health care functions covered by this code or listed within ASHRAE 170, Ventilation of Health Care Facilities. ASHRAE 170, requires mechanical ventilation system supplying anesthetizing locations shall have the capability of controlling the relative humidity at a level of 20 percent or greater. This deficient practice could affect staff and up to 3 patients. Findings include: Based on record review with the PACU Manager, the OR Manager, and the Business Manager on 11/24/2020 at 11:40 a.m., the following were indicated in the Operating Room Humidity documentation: a. Operating Room #4 was under 20 percent for 2 of the last 365 days (11/02/20; 11/17/20). b. Operating Room #2 was under 20 percent for 5 of the last 365 days (01/17/20; 1/20/20; 02/14/20; 02/19/20; 02/20/20). c. Operating Room #1 was under 20 percent for 2 of the last 365 days (01/20/20; 02/21/20). No other further documentation was available to show what response was performed. Based on interview at the time of record review, the OR Manager, confirmed the operating rooms were under 20 percent on the dates indicated, stated that there was no documented response, nor written policy indicating which response should	Q 0101	Our Physical Environment policy SURG #408 has been revised on humidity in the ORs. Our OR Manager will be responsible for monitoring the humidity on a daily basis. The OR Manager has revised our policy and created a spreadsheet to monitor the OR humidity as well as the carts are placed in the correct place. The OR Manager is responsible for daily monitoring and documenting.	12/17/2020

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	occur. This deficient finding was reviewed with the Business Manager at the time of exit.			
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 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. 1) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having	O 0104	The reports were readily available because an email issue and this issue has been resolved and all reports are in the binder and are current. To prevent this from happening again the company will be	12/01/2020

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	jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:30 a.m. the facility could not provide documentation of a current semi-annual visual inspection of the fire alarm system. The most recent documented test and inspection was dated 12/20/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide the most recent inspection. This deficient finding was reviewed with the Business Manager at the time of exit. 2) Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm		emailing reports as well as sending a hard copy to the Business Manager in the mail. The Business Mgr will work with Jade Construction to make sure all reports and tests are done in a timely fashion and documented as such. All fire inspections were done in a timely fashion. The yearly reports were done on 6.7.19 and 6.12.20 but the reports were not in the binder. The reports were emailed to Broadwest but our emails were down so those reports have been delivered and placed in the Binder. The most recent fire inspection was completed on December 23, 2020 and is uploaded on this site for your review. All Fire Extinguishers were inspected on 3.12.20 and a copy of that report is also in the binder kept in the business office.	

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	notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all building occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:30 a.m. the facility could not provide documentation of a current annual test and visual inspection of the fire alarm system. The most recent documented test and inspection was dated 12/20/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide the most recent test or inspection. This deficient finding was reviewed with the Business Manager at the time of exit. 3) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. 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 Code. NFPA 72, 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. NFPA 72, 14.4.5.3.1 states smoke dtetector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include:			

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	During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:35 a.m. the facility could not provide documentation of a current smoke detector sensitivity test. The most recent documented sensitivity test was dated 01/04/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide most recent smoke detector sensitivity test. This deficient finding was reviewed with the Business Manager at the time of exit. 4) Based on observation and interview, the facility failed to ensure the spray pattern for sprinklers were not obstructed in 1 of 1 PAT rooms and 1 of 1 EEG Room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as required by LSC 19.3.5.1. NFPA 25 Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Section 5.2.1.3 states stock, furnishings, or equipment closer to the sprinkler deflector than permitted by the clearance rules of the installation standard shall be corrected. NFPA 13, 2011 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane less than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice			

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	could affect all building occupants. Findings include: During a facility tour with the PACU Manager and Business Manager on 11/24/2020 at 1:10 p.m. the walls of the PAT and EEG rooms was found to terminate approximately 6 inches below the ceiling and height of sprinklers. It could not be determined if this obstructed the sprinkler pattern, creating an unprotected area. Based on interview at the time of observation, the PACU Manager agreed that the spray pattern could be obstructed. This deficient finding was reviewed with the Business Manager at the time of exit. 5) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 19 of 19 fire door assemblies were maintained. LSC 4.6.12.1 requires that whenever or wherever any device, equipment, system, condiction, arrangement, level or protection, fire-resistive construction, or any other feature is required to compliance with the provision of this Code, such device, equipment, system, condiction, arrangement, level or protection, fire-resistive construction, or any other feature shall there after be continuously maintained. LSC 8.3.3.1 states that 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. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not			

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	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 inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: During record review with the PACU Manager			

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	and Business Manager on 11/24/2020 at 10:40 a.m., the annual inspection of the fire door assemblies, dated 8/20/2020, indicated 19 of 19 doors in fire rated assemblies failed inspections. Based on interview at the time of record review, the PACU Manager and Business Manager, agreed that the doors failed inspections and that the repairs have not been completed. This deficient finding was reviewed with the Business Manager at the time of exit.			
Q 0242 Bldg. 00	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on document review and interview, the facility failed to document immunization status in 4 of 10 personnel files reviewed (N3, N5, N7 and N9). Findings Include: 1. Review of policy titled: Employee Health last effective 06/09/06 indicated that "All employees shall have a pre-employment assessment...routine immunizations include Rebella, Measles, Varicella and Hepatitis B". 2. Review of N3 (Certified Surgery Technician), N5, N7 and N9's (Registered Nurses) personnel file lacked documentation of Rubella, Rubeola and Varicella immunizations; N7 lacked documentation of Hepatitis B.	O 0242	All personnel files for immunizations will be completed by 1.15.21. One of the employee files was completed on 12.16.20. The rest will be receiving a titer test by 1.15.21. The Business Mgr will be responsible for making sure all documentation and physicals are completed at the time of hire and will be placed in their employee file as it states in our policy. The Business Mgr will also be reviewing employees files on a quarterly basis to make sure that there are no missing documents in their employee files.	01/15/2021

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	3. Interview on 11/20/20 at 2:15 with A1 (Business Manager) confirmed N3, N5, N7 and N9's lack of documentation of Rubella, Rubeola and Varicella immunizations; and N7's lack of documentation of Hepatitis B.			
S 0000 Bldg. 00	This visit was for a State licensure survey Facility Number: 011094 Dates Of Survey: 11/18-20/2020 & 11/24/2020 QA: 12/2/20 & 12/8/20	S 0000		
S 0026 Bldg. 00	410 IAC 15-2.2-2 SURVEY PROCEDURES 410 IAC 15-2.2-2 (b) (b) The center shall maintain documents, registers, and reports which show ownership and compliance with local, state, and federal laws and regulations and adherence to bylaws and regulations of the facility. Based on document review and interview, the facility failed to follow Indiana Code in obtaining criminal history's on 3 of 10 personnel files reviewed (N3, N4, and N6). Findings Include:	S 0026	Every employee file has a criminal background check in their file and will have one completed upon hiring as our policy states. The Business Manager will bee responsible for making sure a criminal background check is done on every employee upon	12/01/2020

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	1. Review of Indiana Code 16-28-13-4, Sec. 4. (a) (2), indicated "...shall apply within three (3) business days from the date a person is employed as a nurse aide or unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another source allowed by law". 2. Interview on 11/19/20 with A1 (Business Manager) at 11:40 am confirmed lack of background checks on N3 and N4 (Certified Surgery Technician); and N6 (Housekeeping)...A1 confirmed "we don't do them".		hire. The Business Manager will be reviewing employee charts on a quarterly basis to make sure nothing has been missed.	
S 0172 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on document review and interview, the facility failed to complete personnel files in 5 of 10 personnel files reviewed (N1, N4, N5, N7 and N9). Findings Include:	S 0172	All personnel files for immunizations will be completed by 1.15.21. One of the employee files J has been completed as of 12.16.20. The rest will be	01/15/2021

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BROADWEST SPECIALTY SURGICAL CENTER LLC	315 W 89TH AVE MERRILLVILLE, IN 46410

(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
	1. Review of policy titled: Employee Health last effective 06/09/06 indicated that "A physical assessment shall be done for all employees...routine immunizations include Rebella, Measles, Varicella and Hepatitis B". 2. Review of N1, N5 (Registered Nurses) and N4's (Operating Room Technician) personnel file lacked signed documentation of a post offer physical. 3. Review of N3 (Certified Surgery Technician), N5, N7 and N9's (Registered Nurses) personnel file lacked documentation of Rubella, Rubeola and Varicella immunizations; N7 lacked documentation of Hepatitis B. 4. Interview on 11/20/20 at 2:15 with A1 (Business Manager) confirmed lack of documentation of N1, N5 and N4's signed documentation of a post offer physical; N5, N7 and N9's lack of documentation of Rubella, Rubeola and Varicella immunizations; and N7's lack of documentation of Hepatitis B.		receiving a titer test by 1.15.21 All employees have a signed physical in their employment files. The Business Manager will be responsible for monitoring all personnel files and making sure all files are complete and documented as such. The Business Manager will be reviewing all personnel files on a quarterly basis to make sure all records are complete and in order.	