STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001151	A. BUILDING 01 B. WING	02/15/2021

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 11/24/2020 was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/15/2021 Facility Number: 011094 Provider Number: 15C0001151 AIM Number: 100274100A At this PSR survey, Broadwest Specialty Surgical Center LLC 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This facility was located on the first and second floors of a two story fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in corridors and hazardous areas. Quality Review completed on 02/16/21	K 0000		
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 Protectives. Non-rated doors, including corridor doors to			

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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	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 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 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.	K 0761	All doors will either be repaired or replaced that need to be fire rated. Jade Construction will be performing this will. PACU Manager will be responsible for making sure all doors are in compliance. See attached letter from J&L Doors regarding the delay in the door hardware.	03/10/2021

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	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 on 02/15/2021 at 10:10 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 agreed that the doors failed inspections and that the repairs have not been completed. She stated that the			

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	vendor is in the process of repairing the doors, however was unable to document his status. This deficient finding was reviewed with the PACU Manager at the time of exit. This deficiency was cited on 11/24/2020. The facility failed to implement a systemic plan of correction to prevent recurrence.			