

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001022	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
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NAME OF PROVIDER OR SUPPLIER DIGESTIVE HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 AAA WAY CARMEL, IN 46032
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 05/19/14</p> <p>Facility Number: 005403 Provider Number: 15C0001022 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Digestive Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>The facility located in a one story building was determined to be of Type II (000) construction and was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 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.

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K010048	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1 Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 which requires the authority having jurisdiction be notified and the building evacuated or an approved fire watch provided until the fire alarm system has been returned to service. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include: Based on review of "Emergency</p>	K010048	<p>1. A policy was written and made effective on June 2, 2014 to correct this deficiency. The policy states the following: "If the fire alarm system is out of service for any reason, the Safety Director will notify all personnel and conduct facility walk-throughs every 30 minutes to monitor for potential fire hazards.If the fire alarm system is out of service for more than 4 hours, the Safety Director will evacuate the building of all patients, personnel, and visitors and will notify the Indiana Health Department. Once the fire alarm system is returned to service, the building may be occupied for regular business and the Health Department notified of the functioning fire alarm system."2. Recurrence of this deficiency will be</p>	06/02/2014

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K010050	<p>Preparedness" documentation with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, a written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the Administrator acknowledged a written policy for the fire alarm system being out of service for four hours or more in a twenty four hour period was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2 1. Based on record review and interview, the facility failed to document fire drills on the first shift for 1 of 4 quarters. This deficient practice affects all patients, staff and visitors in the facility.</p> <p>Findings include: Based on review of "Fire Drill Observer Evaluation", "Fire Drill Evaluation</p>	K010050	<p>prevented by the policy implemented above.3. The Safety Director is responsible for #1 and #2.4. This will be corrected on 6/2/14.</p> <p>1. For the finding regarding quarterly fire drills, the Safety Director has added quarterly alerts to an electronic calendar in order to provide notification when a fire drill is due. In addition, the Safety Checklist was modified to include a space exclusively to record quarterly fire drills. Another checklist form was created to ensure that all necessary items are documented during each quarterly fire drill.</p>	06/02/2014			

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	<p>Form" and "In-service Education Roster" documentation with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, documentation of a fire drill conducted on the first shift (7:30 a.m. to 5:00 p.m.) for the fourth quarter of 2013 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of a fire drill conducted on the first shift (7:30 a.m. to 5:00 p.m.) for the fourth quarter of 2013 was not available for review.</p> <p>2. Based on record review and interview, the facility failed to document transmission of the fire alarm signal for 1 of 4 first shift quarterly fire drills. LSC 21.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "In-service Education</p>		<p>This form includes, among other things, confirmation that the signal was transmitted, the time the drill was initiated and cleared, and the response time.2. The alerts, lines items on checklists, and fire drill checklist will prevent the deficiency from occurring in the future.3. The Safety Director is responsible for the above actions.4. This was completed on 6/2/14.</p>				

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K010051	<p>Roster" documentation with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, documentation for the fire drill conducted on the first shift (7:00 a.m. to 5:00 p.m.) on 03/28/14 did not include the transmission of the fire alarm signal and the time of day the fire drill was conducted. Based on interview at the time of record review, the Administrator stated the facility operates one shift per day, the "In-service Education Roster" was the only first quarter 2014 first shift fire drill documentation available for review and acknowledged documentation for the fire drill conducted on 03/28/14 did not include the transmission of the fire alarm signal and the time of day the fire drill was conducted.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1, 21.3.4.1</p>			
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	<p>1. Based on record review and interview, the facility failed to ensure documentation for 1 of 1 facility fire alarm system's annual testing was in accordance with NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 requires ambulatory health care facilities be provided with fire alarm systems in accordance with 9.6. LSC 9.6.1.4 states the fire alarm system shall be tested and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 7-5.2.2 refers to Figure 7-5.2.2 which requires fire alarm system initiating and supervisory device inspections to list the device location. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of General Alarm "Inspection and Testing Form" documentation dated 06/03/13, 11/27/13 and 02/26/13 during record review with the Administrator from 9:15 a.m. to 11:50 a.m. on 05/19/14, the fire alarm system inspection reports listed the total number of smoke detectors tested but did not list each device's location and the result of individual testing. A total of eight smoke detectors were listed on the aforementioned inspection reports. Based on interview at the time of record review, the Administrator stated no</p>	K010051	<p>1. During the review on 5/19/14, the Administrator contacted the alarm copany regarding sensitivity testing. As discussed with surveyor during the visit, the 2/27/14 inspection by the alarm company did include sensitivity testing of the smoke detectors, however, the documentation was different than previous records. The alarm comany provided a copy of the work order (which was made available to the survyror) stating smoke detector sensitivity had been completed on 2/27/14 but aknowledged the technician did not fill out a detailed test report as in previous records. Alarm company stated they would repeat the testing at the 6/12/14 inspection and fill out a detailed report to provide documentation and ensure compliance.2. Alarm company has stated they will provide more detailed documentation in the future.3. Administrator/Safety Director is responsible for #1 and #2.4. We will have complete testing and documentation on 6/12/14.</p>	06/12/2014			

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	<p>additional fire alarm system device inspection reports for the most recent twelve month period were available for review and acknowledged the aforementioned fire alarm system inspections report did not list each smoke detector alarm initiating device location and the result of individual testing.</p> <p>2. Based on record review and interview, it could not be assured the facility was maintaining and inspecting 8 of 8 smoke detectors in accordance with NFPA 72, National Fire Alarm Code. LSC Section 21.3.4.1 requires ambulatory health care facilities to be in accordance with LSC Section 9.6. LSC Section 9.6.1.4 requires a fire alarm system to be maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3 requires smoke detector testing to be in accordance Section 7-3, Inspection and Testing Frequencies. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance</p>			

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	<p>alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>NOTE: The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p>			
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K010144	<p>Based on review of General Alarm "Smoke Detector Test Report" documentation dated 04/04/12 with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, it has been more than two years since the most recent documented smoke detector sensitivity testing was performed. Based on interview at the time of record review, the Administrator stated smoke detector testing is due to be performed in the second calendar quarter of 2014 but acknowledged it has been more than two years since the most recent documented smoke detector sensitivity testing was performed.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2</p> <p>1. Based on record review and interview, the facility failed to ensure monthly load testing for the emergency</p>	K010144	1. We contacted MacAllister, the company that services our generator, regarding all three findings. On 6/11/14, MacAllister	06/11/2014
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	<p>generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. LSC 21.5.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.3 states emergency generators shall be tested and maintained in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>NFPA 110, 6-4.2.2 states diesel powered EPS installations which do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads for a total of two continuous hours.</p> <p>NFPA 110, 6-3.4 requires a written</p>		<p>will install an remote manual stop. At the same time, they will advise on on the best way to view and document one the three following methods during the weekly tests: under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading tha tmaintains the minimum exhaust gas temperatures. In addition, they will test the time it takes to transfer emergency power to the emergency generator and will provide appropriate documentation.2. Per our facility policy, the generator is inspected and services 2 times per year or as needed. We will request that MacAllister perform a power transfer test and document the results at all of the inspections. Also, with whichever of the 3 methods MacAllister recommends recording on a weekly basis, we will add that item to the weekly checklist to monitor and record the results.3. The Safety Director is responsible for #1 and #2.4. These will be corrected on 6/11/14.</p>		

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	<p>record of inspections, tests, exercising and repairs shall be regularly maintained on the premises. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "DHC MacAllister Generator Log 2013 & 2014" documentation with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, weekly load test documentation for the emergency generator for the period of 05/17/13 through 05/15/14 does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each weekly load test conducted. Based on interview at the time of record review, the Administrator stated a weekly load test is performed instead of monthly load test and acknowledged the aforementioned documentation does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each weekly load test conducted.</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12</p>			

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	<p>months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "DHC MacAllister Generator Log 2013 & 2014" documentation with the Administrator during record review from 9:15 a.m. to 11:50 a.m. on 05/19/14, weekly load test documentation for the emergency generator for the period of 05/17/13 through 05/15/14, emergency power transfer time to the emergency generator was not available for review. Based on interview at the time of record review, the Administrator stated a weekly load test is performed instead of monthly load test and acknowledged emergency power transfer time during weekly load testing for the aforementioned twelve month period was not available for review.</p>						

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	<p>3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level 2 installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 11:50 a.m. to 12:35 p.m. on 05/19/14, a remote shut off device was not found for the 20 kW propane fired emergency generator. The nameplate affixed to the Olympian Power System unit stated it was manufactured in 2004. Based on interview at the time of observation, the Administrator acknowledged the emergency generator was manufactured after 2003 and there is no remote emergency shut off device for the emergency generator.</p>			

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