STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	15C0001019	A. BUILDING 01 / B. WING	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/23/16 Facility Number: 005400 Provider Number: 15C0001019 AIM Number: 200007580A At this Life Safety Code survey, the Indiana Hand to Shoulder Beltway Surgery 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. The facility, located on the first floor of a two story building and a partial basement was determined to be of Type II (111) construction and was fully sprinklered except for the elevator machine room in the basement. The facility has a fire alarm system with smoke detection in the corridors.	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 determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review completed on 03/01/16 - DA			
K 0048 Bldg. 01	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 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. Findings include: Based on review of "Chapter 8 - Facilities & Environment: Fire Watch" documentation with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, the written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour	K 0048	*It is the responsibility of the clinical manager for ensuring correction of, and then compliance with the deficiency K048.* *Policy FP8.02, "Fire Watch" was updated to include Indiana State Department of Health and the insurance carrier to the notification list upon a system outage of more than 4 hours during a 24 hour period.* *This policy will be presented the governing body for approval at the April 2016 meeting.*	04/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	period did not include notification of the Indiana State Department of Health (ISDH) which is the authority having jurisdiction. Based on interview at the time of record review the Clinical Manager acknowledged the written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period did not include notification of ISDH. 2. Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 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. In addition, sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction also be notified. This			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of "Chapter 8 - Facilities & Environment: Fire Watch" documentation with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, the written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period did not include notification of the Indiana State Department of Health (ISDH) which is the authority having jurisdiction and the insurance carrier. Based on interview at the time of record review, the Clinical Manager acknowledged the written fire watch policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period did not include notification of ISDH and the insurance carrier.			
K 0051 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided in accordance with 9.6 to automatically warn the building occupants. Fire alarm system has initiation, notification and control functions. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	20.3.4.1, 21.3.4.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observation with the Clinical Manager and the Property Manager	K 0051	*It is the responsibility of the clinical manager for ensuring correction of, and then compliance with the deficiency K051.The fire alarm system will be maintained in accordance with NFPA 72, 1-5.2.5.2, including proper marking (in red) and identification of the dedicated circuit as FIRE ALARM CIRCUIT CONTROL. This will be enclosed in a sealed or locked cabinet. Documentation of repair of the fire alarm and smoke detector concerning "Inspection and Test Report" from Koorsen dated May 30, 2015 identifying conflicting information on FACP. The above will be in place by April 2, 2016.*	04/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	during a tour of the facility from 12:10 p.m. to 1:40 p.m. on 02/23/16, the fire alarm system breaker could not be located or identified. Based on interview at the time of observation, the Property Manager stated he did not know the location of the fire alarm system breaker in the facility and acknowledged the fire alarm system breaker could not be located or identified. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 refers to LSC 9.6.2.10.1 which refers to NFPA 72, the National Fire Alarm Code. NFPA 72, 7-1.1.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of Koorsen Fire & Security "Inspection & Test Report" documentation dated 05/30/15 with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, the fire alarm system smoke detector identified as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Above FACP" passed functional testing but was listed as reporting "On FACP Comes Up Surg El Shaft" in the "Comments" section of the report. Based on interview at the time of record review, the Property Manager stated documentation of smoke detector reporting repair of the FACP location smoke detector on or after 05/30/15 was not available for review.			
K 0105 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an essential electric system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2 Based on record review, observation and interview; the facility failed to provide emergency lighting in 3 of 3 operating rooms where general anesthesia or life support equipment is used. LSC Section 21.2.9.2 requires ambulatory health care facilities to provide emergency lighting where general anesthesia or life support equipment is used to be in accordance with NFPA 99. NFPA 99, 3-3.2.1.2(a)(5) (e) requires anesthetizing locations to be provided with battery-powered emergency lighting units. One or more battery-powered emergency lighting units shall be provided in accordance with NFPA 70, National Electrical Code, Section 700-12(e). NFPA 70, (e) Unit	K 0105	It is the responsibility of the clinical manager for ensuring correction of, and then compliance with the deficiency K105. Battery powered emergency lighting will be added to the three operating rooms in which general anesthesia is performed. The lighting will be in compliance of NFPA 99, 3-3.2.1.2. These lights will be in place by April 2, 2016	04/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Equipment. Individual unit equipment for emergency illumination shall consist of the following: 1. A rechargeable battery 2. A battery charging means 3. Provisions for one or more lamps mounted on the equipment, or shall be permitted to have terminals for remote lamps, or both, and 4. A relaying device arranged to energize the lamps automatically upon failure of the supply to the unit equipment The batteries shall be of suitable rating and capacity to supply and maintain at not less than 87 percent of the nominal battery voltage for the total lamp load associated with the unit for a period of at least 1 hours, or the unit equipment shall supply and maintain not less than 60 percent of the initial emergency illumination for a period of at least 1 hours. Storage batteries, whether of the acid or alkali type, shall be designed and constructed to meet the requirements of emergency service. Unit equipment shall be permanently fixed in place (i.e., not portable) and shall have all wiring to each unit installed in accordance with the requirements of any of the wiring methods in Chapter 3 of NFPA 70. Flexible cord and plug connection shall be permitted, provided that the cord does not exceed 3 feet (914 mm) in length. This deficient practice could affect three			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patients and staff. Findings include: Based on review of "Battery Operated Emergency Lights - Test Log for 2015/2016" documentation with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, no operating room battery operated lighting systems are identified as being monthly and annually functional tested in the listing of 15 battery operated lights for the facility in the most recent twelve month period. Based on interview at the time of record review, the Clinical Manager stated the facility has three operating rooms where general anesthesia is used. Based on observations with the Clinical Manager during a tour of the facility from 12:10 p.m. to 1:40 p.m. on 02/23/16, battery operated emergency lighting systems were not installed in each of three operating rooms where general anesthesia is used. Based on interview at the time of the observations, the Clinical Manager stated patients in each of the three operating rooms can be completely sedated and rendered immobile using general anesthesia, an emergency generator is utilized to provide emergency lighting for the facility but acknowledged battery			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	operated emergency lighting systems were not installed in the three operating rooms to provide continuous illumination.			
K 0114 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1 3/4 inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors shall be of fixed fire window assemblies in accordance with 8.2.3.2.2. 20.3.7.1, 21.3.7.1 Based on observation and interview, the facility failed to ensure 1 of 1 smoke barriers separating the facility from other occupancies were protected to maintain the one hour fire resistance rating of the smoke barrier. LSC Section 21.3.7.1 requires ambulatory health care facilities to provide fire barriers with one hour fire resistance rating for tenant separation. LSC 21.3.7.3 requires any smoke barrier to be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one hour. LSC Section 8.3.6.1 states annular spaces caused by penetrations in fire barriers from pipes and conduits shall be filled with a material capable of	K 0114	*It is the responsibility of the clinical manager for ensuring correction of, and then compliance with the deficiency K114. Repair to the smoke barrier between the clinic waiting area and the ASC waiting area above the ceiling will be completed by April 2, 2016.*	04/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observation with the Clinical Manager during a tour of the facility from 12:10 p.m. to 1:40 p.m. on 02/23/16, a three inch hole for the passage of twenty cables was noted in the one hour fire rated tenant separation smoke barrier wall above the suspended ceiling above the door separating the Surgery Center main lobby from the Clinic main lobby and was not filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. Based on interview at the time of observation, the Clinical Manager acknowledged the aforementioned hole above the suspended ceiling failed to maintain the one hour fire resistance rating of the tenant separation smoke barrier.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0130 Bldg. 01	416.44(b)(1) MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review, observation and interview; the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. LSC Section 21.7.6 refers to LSC Section 4.6.12. LSC Section 4.6.12.3 requires equipment requiring periodic testing of operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at Section 2-3.3 requires waterflow alarm devices including but not limited to, mechanical water motor gongs, vane-type waterflow devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all patients, staff and visitors. Findings include: Based on review of Koorsen Fire & Security "Inspection & Test Report" documentation dated 01/05/15 and 05/30/15 with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, it had been 144 days in between documented sprinkler	K 0130	*It is the responsibility of the clinical manager for ensuring correction of, and then compliance with the deficiency K130. Testing with documentation of fire sprinkler inspections will be done every 120 days. Sprinkler will be added to the elevator room in accordance with NFPA 13, 5-136.2. These will be in place by April 2, 2016*	04/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inspections in the first and second quarter of 2015. Based on interview at the time of record review, the Clinical Manager stated additional quarterly sprinkler inspection documentation for the first and second quarter of 2015 was not available for review and acknowledged it had been greater than 120 days since first and second quarter 2015 sprinkler inspections had been performed. Based on observation with the Clinical Manager and the Property Manager during a tour of the facility from 12:10 p.m. to 1:40 p.m. on 02/23/16, Koorsen Fire & Security had affixed a hanging tag indicating it had been greater than 120 days in between sprinkler inspections documented as being performed on 01/05/15 and 05/30/15. 2. Based on observation and interview, the facility failed to ensure 1 of 1 basement elevator equipment rooms were provided with sprinkler coverage. LSC 4.5.6 says any fire protection system, building service equipment, feature of protection, or safeguard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect 5 staff. Findings include: Based on observation with the Clinical Manager and the Property Manager during a tour of the facility from 12:10 p.m. to 1:40 p.m. on 02/23/16, the elevator machine room in the basement was not provided with sprinkler coverage. Based on interview at the time of the observation, the Clinical Manager and the Property Manager acknowledged the elevator machine room in the basement was not provided with sprinkler coverage.			
K 0144 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure emergency	K 0144	*It is the responsibility of the clinical manager for ensuring*	04/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	15C0001019		02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	power would be transferred to the emergency generator within 10 seconds of building power loss for the most recent 12 month period. 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. Findings include: Based on review of "Emergency Generator - Monthly Test Log" documentation with the Clinical Manager and the Property Manager during record review from 9:30 a.m. to 12:10 p.m. on 02/23/16, monthly load test documentation of emergency power transfer time for the twelve month period of 03/16/15 through 02/22/16 was not available for review. Based on interview at the time of record review, the Property Manager stated facility emergency power is transferred to the emergency generator		*correction of, and then compliance with the deficiency K144. Monthly load documentation for the emergency power generator will include the exact transfer time. This will be in place by April 2, 2016.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within ten seconds during monthly load testing but acknowledged monthly load test documentation of the emergency power transfer time for the most recent twelve month period was not available for review.			