

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2011	
NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN46237			
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K0000	<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: 11/14/11</p> <p>Facility Number: 008858 Provider Number: 15C0001058 AIM Number: 200064740A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Endoscopy Center at St. Francis 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 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 on the first floor of a four story building was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p>	K0000					

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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K0050	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/18/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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</p> <p>Based on record review and interview, the facility failed to document quarterly fire drills under varying conditions for 2 of 4 quarters. This deficient practice affects all occupants in the facility including patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Drill-Code Red" documentation with the Clinical Director from 10:10 a.m. to 10:50 a.m. on 11/14/11, a time of day was not documented for the fire drills conducted on 01/31/11 and 04/12/11.</p> <p>Based upon interview at the time of record review, the Clinical Director acknowledged documentation for fire drills conducted on 01/31/11 and 04/12/11 did not include the time of day each drill</p>	K0050	<p>Laura Allen RN, Clinical Director, conducted fire drills on a quarterly basis but neglected to insure that the time that the drill was conducted was entered for the drill. Laura Allen RN, Clinical Director mistakenly thought that this was not required as there is only one shift operating in the ASC. Laura Allen RN, Clinical Director, corrected the Fire Drill Report Form to include the time of day that the drill is conducted. The staff committee responsible for conducting the drills for the ASC were instructed to document time of day that drill is performed on the new Fire Drill Report Form. Laura Allen RN, Clinical Director and/or Dianna Faulkner RN, Asst. Clinical Director are responsible to ensure that the time is documented for each fire drill. Copy of new Fire Drill</p>	11/30/2011

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K0051	<p>was conducted.</p> <p>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> <p>1. Based on record review and interview, the facility failed to ensure 11 of 11 smoke detectors were tested and maintained. 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</p>	K0051	<p>Report Form is attached.</p> <p>Laura Allen RN, Clinical Director, contacted Ken Pendleton, Chief Engineer for Lillibridge Health Services (owners of the building from which the ASC leases from) to have Functional Testing of Smoke Detectors (11 of 11) and Sensitivity Testing of Smoke Detectors (11 of 11) tested in the ASC. Koorsen Fire and Security Company is scheduled to conduct the testing of the 11 of 11 smoke detectors for functionality and sensitivity within the ASC on December 7, 2011 at 6pm. Laura Allen RN, Clinical Director and/or Dianna Faulkner, RN, Asst. Clinical Director are responsible for ensuring that the smoke detector sensitivity and functionality testing is completed in a timely manner and in the time frame required.</p>	12/07/2011	

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	<p>maximum of 5 years. If the frequency is extended, records of detector caused nuisance 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> <p>(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> <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 occupants in the facility including staff,</p>			

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	<p>visitors and patients.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection/Test" documentation dated 08/15/09 with the Clinical Director from 10:10 a.m. to 10:50 a.m. on 11/14/11, the most recent sensitivity testing documentation available for review for the 11 smoke detectors in the facility is more than two years old. Based on interview at the time of record review, the Clinical Director acknowledged smoke detector sensitivity testing documentation is more than two years old.</p> <p>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, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually.</p>						

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	<p>This deficient practice affects all occupants in the facility including patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection/Test" documentation dated 10/09/10 and 07/30/11 with the Clinical Director during record from 10:10 a.m. to 10:50 a.m. on 11/14/11, the most recent passing functional tests for all 11 smoke detectors in the facility occurred on 10/09/10 which is more than one year old. Smoke detector testing documentation on the 07/30/11 "Report of Inspection/Test" stated "Did Not Report" for each of the 11 smoke detectors in the facility. Based on a telephone interview at 4:00 p.m. on 11/15/11 with the Chief Engineer for Lillibridge Health Care Services, who is the building manager for the facility, flooring in the facility was being replaced at the time of the 07/30/11 fire alarm system testing and the smoke detectors could not be tested at that time. In addition, the Chief Engineer stated no subsequent smoke detector testing documentation was available for review and acknowledged it has been more than one year since passing functional tests for smoke detectors in the facility has occurred.</p>				

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K0144	<p>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>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 II 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. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower or more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K0144	<p>Laura Allen RN, Clinical Director, contacted MacAllister Engine and Generators to equip the 1 of 1 generator for the ASC with a remote manual stop. The remote shut off device is to be installed between 12/5/2011 - 12/14/2011 by MacAllister engine. Laura Allen RN, Clinical Director has contracted with MacAllister Engine and Generators to maintain the remote shut off device in working order and maintain condition during their biannual preventative maintenance checks on the 1 of 1 generator. Laura Allen RN, Clinical Director is responsible to ensure the installation of the remote shut off device is installed and maintained.</p>	12/14/2011

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	Based on observation with the Clinical Director during a tour of the facility from 9:30 a.m. to 10:10 a.m. on 11/14/11, a remote shut off device was not found for the 100 kW diesel fired emergency generator. Based on interview at the time of observation, the Clinical Director stated the emergency generator was installed prior to 2003 and acknowledged there is no remote emergency shut off device for the emergency generator.				