

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001021	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2012
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NAME OF PROVIDER OR SUPPLIER SCP INDIANAPOLIS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7430 N SHADELAND AVE STE 100 INDIANAPOLIS, IN 46250
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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: 10/10/12</p> <p>Facility Number: 005402 Provider Number: 15C0001021 AIM Number: 100274310A</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, Surgery Center Plus 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>This facility located on the first floor of a two story building was determined to be of Type II (111) construction and was nonsprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p> <p>Quality Review by Robert Booher, Life Safety</p>	K010000	Supporting documents for each plan of correction are attached.	

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>Code Specialist-Medical Surveyor on 10/15/12.</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:</p> <p>Based on review of "Policy & Procedures 16.12 Emergency Preparedness: Fire Safety" documentation with the General</p>	K010048	<p>1. A Fire Watch Log was created to be utilized in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24-hour period. The Center's Fire Safety section of the Policy and Procedure manual has been updated to reflect procedures that will be followed and how the log will be completed. The Fire Watch policy (Attachment A Fire Watch Policy2) and the Fire Watch log (Attachment B Fire_Watch_Log) are attached.</p> <p>2. After notification that the fire alarm system is out of service, the Director of Nursing will time the outage. Once the 4 hour limit has been reached, the Director of Nursing will follow the established procedures and ensure the completion of the Fire Watch Log.</p> <p>3. The Director of Nursing will be responsible for ensuring that a Fire Watch is implemented and</p>	11/16/2012

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K010050	<p>Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, the facility did not have 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. Based on interview at the time of record review, the General Manager acknowledged there is no written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period.</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 Based on record review and interview, the facility failed to document quarterly fire drills on the first shift for 3 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 Check List" documentation with the General</p>	K010050	<p>the Fire Watch Log is completed. 4. The Fire Watch Log and Policy and Procedure updates were implemented on 11/9/12 and the Fire Watch Policy was updated per ISDH request on 11/16/12.</p> <p>1. A fire drill was not conducted in the 4 th quarter of 2011 or the 3 rd quarter of 2012. There was; however, a fire drill conducted in the 2 nd quarter of 2012. The documents and critique for the 2 nd quarter 2012 fire drill are attached (Attachment C & D.) On 11/5/12 an unannounced fire drill was conducted at our Center. This fire drill included staff and patients present during our only shift, 7:00am – 4:30pm. The</p>	11/05/2012

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K010051	<p>Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, documentation was not available for review of a fire drill conducted on the first shift (7:00 a.m. to 4:30 p.m.) for the fourth quarter of 2011 or for the second and third quarter of 2012. Based on interview at the time of record review, the General Manager acknowledged documentation was not available for review of a fire drill conducted on the first shift (7:00 a.m. to 4:30 p.m.) for the fourth quarter of 2011 and for the second and third quarter of 2012.</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> <p>1. Based on record review and interview, the facility failed to ensure one of one 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</p>	K010051	<p>documentation and critique of that fire drill are attached (Attachment E.).</p> <p>2. To ensure all future quarterly fire drills are conducted on time, the future dates for 2013 drills are already scheduled in the General Manager and Director of Nursing's Outlook calendars.</p> <p>3. The Director of Nursing will be responsible for conducting and documenting all fire drills.</p> <p>4. This deficiency was corrected on 11/5/12.</p> <p>1. Koorsen Fire & Security inspected our system on 10/12/12. The report from that inspection is attached. (Attachment F) In addition, a check of our detector sensitivity was conducted by Koorsen Fire & Security on 11/5/12. A copy of</p>	11/30/2012

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	<p>9.6.2.10 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. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection" documentation dated 05/03/11 with the General Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, it has been more than one year since the most recent documented fire alarm inspection was performed. Based on interview at the time of record review, the General Manager acknowledged it has been more than one year since the fire alarm system inspection was performed.</p> <p>2. Based on record review and interview, it could not be assured the facility was maintaining and inspecting 10 of 10 smoke detectors. LSC Section 21.3.4.1 requires ambulatory health care facilities</p>		<p>that report is also attached. (Attachment G) 2. Koorsen was back in on 11/21/12 to repair the duct detectors so they would shut down the air handlers. (Attachment I). Koorsen came in again on 11/26/12 and performed smoke sensitivity testing on the duct detectors. (Attachment J) The General Manager has already pre-scheduled the next annual inspection for September 2013 and a reminder is also in our Center's calendar. 3. The General Manager is responsible for ensuring that the inspection of our fire and security system is conducted annually. 4. The initial inspections were completed on 10/12/12 & 11/5/12. The duct detectors were completed on 11/26/12..</p>				

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	<p>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 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 			

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	<p>arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.</p> <p>(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, visitors and patients.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection" documentation dated 04/17/10 with the General Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, 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 General Manager acknowledged it has been more than two years since smoke detector sensitivity testing was</p>			

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K010105	<p>performed.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an emergency power system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2</p> <p>Based on observation and interview, the facility failed to provide emergency lighting in 1 of 4 operating rooms and 1 of 1 procedure 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 LSC Section 7.9. LSC Section 7.9.2.2 states an emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following:</p> <p>(1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply (2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities.</p> <p>LSC Section 7.9.2.5 requires the emergency lighting system to either be in</p>	K010105	<ol style="list-style-type: none"> 1. An electrician was contracted to provide an estimate for installing emergency battery lighting to provide continuous illumination in Operating Room #1 and also in the Procedure Room. The emergency lights will be installed by 11/07/12. 2. To prevent this deficiency in the future, emergency battery lighting will be installed in any other ORs or Procedure Rooms where general anesthesia or life support equipment is used. 3. The General Manager is responsible for ensuring that emergency battery lighting is installed and tested. 4. This deficiency will be corrected with emergency battery lighting installed by 11/07/12. 	11/07/2012

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	<p>continuous operation or be capable of repeated automatic operation without manual intervention. This deficient practice could affect two patients and staff in Operating Room # 1 and in the Procedure Room.</p> <p>Findings include:</p> <p>Based on observations with the General Manager and the Director of Nursing during a tour of the facility from 12:00 p.m. to 12:45 p.m. on 10/10/12, there is no battery operated emergency lighting to provide continuous illumination in Operating Room # 1 and in the Procedure Room. Based on interview at the time of the observations, the General Manager stated patients in Operating Room # 1 and in the Procedure Room can be completely sedated and rendered immobile while undergoing procedures in each of the rooms. In addition, the General Manager stated an emergency generator is utilized to provide emergency lighting in each of the rooms but acknowledged there is no battery operated back up emergency lighting system to provide continuous illumination in Operating Room # 1 and in the Procedure Room.</p>			

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K010144	<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 the load for the monthly load test for the generator was at least 30% of the nameplate rating for 10 of 12 months. 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. In addition, NFPA 99, the Standard for Health Care Facilities, Chapter 3-4.4.1.1 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 6-4.2. 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 (Emergency Power Supply) nameplate rating.</p> <p>b. Loading that maintains the minimum</p>	K010144	<p>1. Indiana Power conducted a load bank test on our generator on 11/5/12. This test had our generator running and drawing full power for 4 hours. The test provided our maximum load rating. Our new monthly test log has been updated so that we can now document the % of the maximum load which is required to be at 30%. Our new testing log has also been updated so that we can document the number of seconds it takes to transfer from normal electrical power to the emergency generator. A copy of the load bank test and the new testing log is attached. (Attachment H & I) 2. To prevent this deficiency in the future, a monthly check of the generator testing log will be conducted by the General Manager. 3. The General Manager is responsible for ensuring that the testing of the generator is conducted and that the generator testing log is properly completed. 4. These deficiencies were corrected on 11/5/12.</p>	11/05/2012

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	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Weekly System Check" documentation with the General Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, monthly load testing documentation for the period of January 3, 2012 through October 1, 2012 show the emergency generator ran for at least thirty minutes each month for the ten month period but neither the percentage of load capacity or minimum exhaust gas temperature was recorded when each monthly load test was conducted. Based on interview at the time of record review, the General Manager stated no load bank testing is performed on the generator and acknowledged neither the percentage of load capacity nor minimum exhaust gas temperature was recorded for monthly generator load testing for the period of January 3, 2012 through October 1, 2012.</p> <p>2. Based on record review and interview,</p>			

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	<p>the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 10 of 12 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 "Weekly System Check" documentation with the General Manager and the Director of Nursing during record review from 9:15 a.m. to 12:00 p.m. on 10/10/12, monthly load testing records of emergency power transfer time for the period of January 3, 2012 through October 1, 2012 did not document the transfer time from normal electrical power to the emergency generator. Based on interview at the time of record review, the General Manager acknowledged emergency power transfer</p>			

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	time for monthly load testing for the period of January 3, 2012 through October 1, 2012 was not available for review.				