STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICAL CENTER OF NEW ALBANY	2201 GREEN VALLEY RD NEW ALBANY, IN 47150

(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: 01/26/16 Facility Number: 005386 Provider Number: 15C0001005 AIM Number: 100274040A At this Life Safety Code survey, Surgical Center of New Albany 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. This facility was a one story fully sprinklered building determined to be of Type V (000) construction. The facility has a fire alarm system with smoke detection in corridors and some common areas. Quality Review completed on 02/03/16 - DA	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.

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K 0046 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1 Based on record review and interview, the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 7 of 7 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all patients and staff. Findings include: Based on review of the "Safety" book and "Contracts Vendor Audits Book 2" on 01/26/16 between 10:45 a.m. and 12:45 p.m. with the Administrator present, there was no documentation available to show a monthly 30 second functional test	K 0046	A list of emergency battery powered lights will be initiated along with a spreadsheet for testing documentation. The spreadsheet will include the location, a 30 second monthly test column check and an annual 90 minute test. The safety officer will be responsible for performing the monthly and annual checks. The documentation will be filed in the safety binder and the administrator will monitor for compliance.	03/03/2016

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	and an annual 90 minute test for all seven battery operated emergency light sets. During a tour of the facility with the Administrator between 12:45 p.m. and 1:45 p.m. battery operated emergency light sets were observed in the Sterilizer Room, Mechanical Room, Sterile Supply room, two Prep rooms, and two Operating Rooms. Based on interview at the time of record review and observations, the Administrator acknowledged there was no documentation to show a 30 second monthly test and an annual 90 minute test for the seven battery operated emergency light sets during the most recent twelve month period.			
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 policy for the protection of all patients 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. LSC 9.7.6.2 requires sprinkler	K 0048	The phone numbers of the local fire department and the ISDH has been added to the fire watch policy. The administrator will oversee the fire watch policy and the need for the implementation of that policy.	03/03/2016

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	impairment procedures comply with NFPA 25, Standard for 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/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: Based on review of the Fire Watch policy with the Administrator present on 01/26/16 at 11:10 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy and procedure did not include the phone number for the local fire department, and there was no mention of contacting the Indiana State Department of Health with phone number included. Also, under "Procedures" at 2.(d) it was stated "The person conducting the Fire Watch will go on a specific/consistent path throughout the Center making sure all areas are covered at least hourly", instead of every 15 minutes. The lack of this documentation was acknowledge by the Administrator at the time of record			

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	review. 2. Based on record review and interview, the facility failed to provide a complete written policy for the protection of all patients containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all patients, as well as staff, and visitors in the facility. Findings include: Based on review of the Fire Watch policy with the Administrator present on 01/26/16 at 11:10 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch policy and procedure did not include the phone number for the local fire department, and there was no mention of contacting the Indiana State Department of Health with phone number included. Also, under "Procedures" at 2.(d) it was stated "The person conducting the Fire Watch will go on a specific/consistent path throughout the Center making sure all areas are covered at least hourly", instead of every 15 minutes. The lack of this documentation was acknowledge by the			

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	Administrator at the time of record review.			
K 0050 Bldg. 01	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 ensure documentation that actual fire drills were performed during 4 of 4 quarters. Furthermore, the facility failed to provide documentation that the audible fire alarm system was activated during 4 of 4 quarters. This deficient practice could affect all occupants in the facility. Findings include: Based on review of fire drill documentation on 01/26/16 at 12:00 p.m. with the Administrator present, the facility lacked written documentation or other evidence that actual fire drills were conducted during the past four quarters. The following was noted when reviewing the Safety book: 1. A report dated 03/18/15 indicated there was a meeting with staff only. There was no time of day included. There was no documentation of an alarm	K 0050	A fire drill with actual pull alarm activation was performed by staff on February 9, 2016. The local fire marshal was present. All was documented in the safety binder. Fire drills will be completed quarterly. The administrator will be responsible for the running the drills, documenting, and monitoring for compliance.	02/09/2016

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	activated. 2. A report dated 06/17/15 indicated it was "Fire Education" with signatures of staff in attendance only. There was no time of day included. There was no documentation of an alarm activated. 3. A report dated 08/15 was a "Safety Survey 2015" report. At #12 it said "Annually, at least one fire drill has included a check of communication with the monitoring service. The date of this drill Aug. 2015". There was no actual fire drill included with date, time of day, alarm activation, or any other pertinent fire drill information. 4. A report dated 11/20/15 indicated it was an "Education Attendance Record for fire safety" and "Fire Extinguisher Drill". This report had staff attendance only. There was no fire drill information included. The lack of fire drill information was acknowledged by the Administrator at the time of record review.			
K 0051 Bldg. 01	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 Based on record review and interview, the facility failed to ensure	K 0051	The administrator notified the alarm inspection and testing	03/07/2016

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	documentation for the testing of 1 of 1 fire alarm system's components and devices such as smoke detectors and fire alarm pull boxes was complete. LSC Section 21.3.4.1 requires Ambulatory health care facilities to be in accordance with LSC Section 9.6. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors and fire alarm boxes be tested annually. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire alarm system inspection reports in the "Contracts Vendor Audits Book 2" on 01/26/16 at 11:35 a.m. with the Administrator present, the four most recent quarterly fire alarm system inspection reports were the equivalent of a cover page with only the number of devices installed and the number of devices tested with no itemized list indicating the location of each smoke detector and pull station. Furthermore, the following was noted about each quarter fire alarm inspection: 1. Report dated 02/09/15 indicated 12 smoke detectors installed and 12 tested 2. Report dated 05/04/15 indicated 15		vendor regarding the lack of documentation on his reports. The vendor made an on site visit on March 7, 2016 and numbered the smoke detectors for a total of 14. The administrator and vendor agreed that the vendor will itemize the smoke detectors, numbers of devices, their location, and which of them are tested on each visit. Manual pull stations will also be documented as to the number, location, and testing of each for every quarter that it is inspected. The administrator will oversee the vendor's documentation for compliance. Vendor is returning for another inspection on May 16, 2016 and will commence with the new documentation at that time.	

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	smoke detectors installed and 15 tested 3. Report dated 08/10/15 indicated 14 smoke detectors installed and 7 tested 4. Report dated 11/02/15 indicated 13 smoke detectors installed and 4 tested 5. Sensitivity test report dated 08/04/14 indicated 14 smoke detectors were tested During an interview at the time of record review, the Administrator acknowledged there was no itemized documentation available to show the locations of smoke detectors and manual pull stations on the quarterly fire alarm system inspection reports, furthermore, the Administrator acknowledged the quarterly fire alarm system reports were not consistent with the number of smoke detectors installed and the number of smoke detectors tested.			
K 0076 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 101. (a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation. (b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside. 4.3.1.1.2, 20.3.2.4, 21.3.2.4 Based on observation and interview, the	K 0076	The administrator will obtain consultations and estimates for	03/14/2016

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	facility failed to ensure oxygen and nitrogen H sized cylinders stored in 1 of 1 storage locations with a capacity of non-flammable gases greater than 3000 cubic feet, were stored in a protected area. NFPA 99, 4-3.1.1.2(a)(6) requires cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. Additionally at 4-3.1.1.2 (a)(10)(a) requires supply systems for medical gases or mixtures of these gases shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes. This deficient practice could affect mostly staff, visitors and delivery personnel outside the back of the building. Findings include: Based on observation on 01/26/16 at 1:15 p.m. during a tour of the facility with the Administrator, there was a concrete block building outside the back of the facility within four feet of the main building which was storing eleven H size Nitrogen tanks and twelve H size Oxygen tanks that were part of the facility's piped in med gas system, furthermore, there were thirteen E size oxygen cylinders within		moving the manifolds and tanks inside versus building an enclosed separation between the tanks and generator. The estimates and reports will be completed by March 31, 2016. Once the estimates and consults are obtained, they will be addressed by the Governing Board on April 29, 2016. When the governing board votes on which action to take, the work to move or build will be scheduled. The scheduling of the service will be completed by May 31, 2016, and the work completed by August 31, 2016. Consultations and estimate was obtained on March 4, 2016. Corporate and GB was notified to expedite the decision and process. Contractor/consultant made site visit on Monday March 7, 2016. New Manifolds were delivered on March 8, 2016. Installation of manifolds moving to different location will begin on March 10, 2016 and installation and move will be completed, certified, and ready for use on Monday March 14, 2016. The administrator will oversee the medical gas storage for compliance.	

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	the block building. The facility's generator was also stored in the concrete block building within three feet of the oxygen and nitrogen cylinders. This was acknowledged by the Administrator at the time of observation.			
K 0130 Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all patients, as well as staff, visitors in the facility. Findings include: Based on observation with the Administrator on 01/26/16 at 1:00 p.m., the sprinkler system located in the sprinkler riser room had two pressure gauges with a date indicating the gauges were manufactured in 1983. Based on	K 0130	The administrator contacted the sprinkler system inspection vendor who confirmed that the internal pipe inspection had not been completed. It is scheduled for March 29, 2016. The gauges will be replaced at that time. The administrator will monitor to assure completion of the task.	03/29/2016

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	interview at the time of observation, the Director of Nursing acknowledged the date on the gauge was 1983 and indicated she was not sure if the gauge had been recalibrated within the past five years. 2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: Based on review of sprinkler system inspection reports on 01/26/16 at 11:50 a.m. with the Administrator present, there was no documentation to show the sprinkler system has had an internal pipe			

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	inspection. Based on an interview at the time of record review, the Administrator acknowledged the sprinkler system has not had an internal pipe inspection. This was confirmed with the sprinkler system vendor via phone interview at the time of record review.			
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 in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2 Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load.	K 0144	On January 27, 2016, the administrator spoke with the Cummins rep who informed her that the generator which was installed in 1983 did not have a requirement for an annunciator at that time. Cummins rep met with the surgical center's contract bio-medical engineer on March 22, 2016. It was determined at that time that a simple annunciator could be installed to alarm at the nurses station. This will be accomplished by March 31, 2016. Our policy states that once the center has converted to generator power, then surgery that is in process will be completed as quickly as possible and no new cases will be started. During the time the center is running on generator, the administrator or person in charge will check the generator every 15 minutes to assure it is functioning properly. The administrator will	03/31/2016

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	2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 01/26/16 between 12:45 p.m. and 1:45 p.m. during a tour of the facility with the Administrator, a remote alarm annunciator for the generator was not provided in a location readily observed		be responsible to oversee for compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICAL CENTER OF NEW ALBANY	2201 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	by operating personnel at a regular work station such as a nurses' station. During an interview on 01/26/16 at 1:20 p.m., the Administrator indicated there was no remote alarm annunciator for the generator in a location readily observed by operating personnel at a regular work station such as a nurses' station or any other area of the facility.			