

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001147	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2012
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NAME OF PROVIDER OR SUPPLIER  INVERNESS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8004 CARNEGIE BOULEVARD FORT WAYNE, IN 46804
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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: 02/10/12</p> <p>Facility Number: 004581 Provider Number: 15C0001147 AIM Number: 200814740A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Inverness 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 20, New Ambulatory Health Care Occupancies.</p> <p>This one story facility was determined to be of Type II (000) construction and is sprinklered.</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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	<p>The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridor.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0048	<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</p> <p>Based on record review and interview, the facility failed to protect all occupants by providing a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(e) requires the authority having jurisdiction be notified. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director and the Quality &amp;</p>	K0048	<p>Life Safety Code Survey Plan of Correction Tag: K048 / 416.44(b)(1)</p> <p>While the Center had a written fire plan, it was not specific enough to meet the standards. This deficiency was corrected by revising and / creating the following documents.</p> <p>Policy # Policy / Document Name Change Addition Purpose for the change / addition EC 44 Fire Watch Alert</p> <p>X The policy previously that a Fire Watch would be implemented in the event of a failure of the fire alarm system. We have added that it be implemented in the event of a fire alarm system and/or sprinkler system, in part or in whole.</p> <p>X Where the policy stated the time frame of 9 hours in a 24 hour period, the policy has been changed to "4 hours in a 24 hour period". We also added that if this occurs, a fire watch will be</p>	02/28/2012	

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	<p>Accreditation Specialist on 02/10/12 at 1:50 p.m., the facility did not have a written policy and procedure for an impaired sprinkler system. This was acknowledged by the Director at the time of record review.</p> <p>2. Based on interview and record review, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect all occupants in accordance with LSC, Section 9.6.1.8 which requires the authority having jurisdiction shall be notified and the building shall be evacuated or an approved fire watch shall be provided. This deficient practice affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director and the Quality &amp; Accreditation Specialist on 02/10/12 at 1:50 p.m., the facility did have a written policy and procedure for an impaired fire</p>		<p>implemented or the facility will be evacuated.</p> <p>X The policy now includes contacting the ISDH in the event that a situation warrants implementation of a Fire Watch.</p> <p>X The policy has added wording describing the duties of a Fire Watch Coordinator. This person(s) only responsibility is making Fire Watch rounds and documenting the findings and times. EC 44A Fire Watch Alert Assignment</p> <p>X The Center adopted this form to document who assigned the job of Fire Watch Coordinator and that the only responsibilities of this person is Fire Watch duties. It is signed by the person who made the assignment as well as the person accepting the assignment. EC 44B Fire Watch Log Form</p> <p>X The Center adopted this form to thoroughly document Fire Watch rounds, times, and findings. EC 44c</p>		

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	alarm system but the policy did not include: contacting the Indiana State Department of Health, person assigned shall have not other duties or responsibilities, and it stated the fire watch is to began after nine hours in a twenty four hour period. This was acknowledged by the Director at the time of record review.		Fire Watch Alert Sign  X Also added to the policy EC 44 was the usage of signage as a means of communicating the Fire Watch status. These policy changes were presented to the Safety Committee on 2/16/2012, the QI Committee on 2/17/12, the Medical Executive Committee on 2/27/12, and the Governing Body on 2/27/12. The changes were approved by all on the day of presentation. Staff was informed of the changes during the above committee meetings and by posting of the new policies on the educational board and implementation began on February 28, 2012.		

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K0050	<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</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters during the past year. This deficient practice affects all patients in the facility.</p> <p>Findings include:</p> <p>Based on review of the fire drill form titled Fire Drill Evaluation with the Director and the Quality &amp; Accreditation Specialist on 02/10/12 at 1:59 p.m., only one fire drill took place in the fourth quarter 2011. According to the Quality &amp; Accreditation Specialist the facility has overnight patients for twenty three hours and the staff work two shifts. Based on an interview with the Director at the time of record review, no other documentation was available for review.</p>	K0050	<p>Life Safety Code Survey Plan of Correction Tag: K050 / 416.44(b)(1)</p> <p>While the Center had a written Mock Fire Drill policy, it was not adequate to meet the standards. This deficiency was corrected by revising and / creating the following documents. Policy # Policy / Document Name Change Addition Purpose for the change / addition</p> <p>X The Center did not have documentation of a fire drill for one quarter out of the 4 quarters. The Director of the Center has developed a calendar of required events to insure compliance with mandatory items such as fire drills. The Director will work with the Safety Officer to insure that fire drills are conducted at a minimum frequency of one per quarter per shift. EC 14 Mock Fire Drill X</p>	02/28/2012			

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			<p>The Mock Fire Drill policy has been changed to include the wording that fire drills must be performed at a minimum frequency of one per quarter per shift. This is reported to the Safety Committee to ensure that the drills occur. EC 14A Fire Drill Evaluation X</p> <p>This form has been revised to include required documentation per the standards.</p> <p>These policy changes were presented to the Safety Committee on 2/16/12, the QI Committee on 2/17/12, the Medical Executive Committee on 2/27/12, and the Governing Body on 2/27/12. The changes were approved by all on the day of presentation. Staff was informed of the changes during the above committee meetings and by posting of the new policies on the educational board and implementation began on February 28, 2012.</p>		

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K0051	<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>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the clean supply room was installed where air flow would not adversely affect its operation. LSC Section 21.3.4.1 requires facilities to be in accordance with LSC Section 9.6. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect any patient near the clean supply room.</p> <p>Findings include:</p> <p>Based on an observation with the Director and the Quality &amp; Accreditation Specialist on 02/10/12 at 12:35 p.m., the</p>	K0051	<p>Life Safety Code Survey Plan of Correction Tag: K051 / 416.44(b) (1) The Director of the Center contacted Parkview facilities regarding the need to move the smoke detector in the clean supply room across from the Pre/Post nurse's station as it was too close to an air/heat duct. On February 17, 2012, WS Mechanical Inc. moved the smoke detector so that it is now greater than 3 feet between the smoke detector and air/heat duct to be in compliance with the regulations. The Center observed the rest of the facility and found no other instances of this problem in the building, therefore no further action will need to take place. This finding and correction was presented to the Safety Committee on 2/27/12, the QI Committee on 2/27/12, the Medical Executive Committee on 2/27/12 and the Governing Body on 2/27/12. No further actions recommended by any Committee.</p>	02/28/2012	

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	<p>smoke detector in the clean supply room was located within three feet of a air supply duct. This was acknowledged by the Director at the time of observation.</p> <p>3.1-19(b)</p>			

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K0147	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code 9.1.2, 20.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical receptacles in the Private Recovery room # 3 restroom were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, 517-20 requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects any patient who would use the Private Recovery room # 3 restroom.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Quality &amp; Accreditation Specialist on 02/10/12 at 12:30 p.m., the Private Recovery room # 3 restroom had two electrical receptacles on the wall within three feet of a sink without GFCI</p>	K0147	<p>Life Safety Code Survey Plan of Correction Tag: K147 / 416.44(b) (1) The Director of the Center contacted Parkview Facilities regarding the need to replace the current non-protected electrical outlet receptacles with GFCI protected electrical outlet receptacles in Private Recovery Room #3 as required due to the close proximity of a sink. On February 17, 2012, WS Mechanical Inc. made the change as noted above. The Center observed the rest of the facility and found no other instances of this problem in the building, therefore no further action will need to take place. This finding and correction was presented to the Safety Committee on 2/27/12, the QI Committee on 2/27/12, the Medical Executive Committee on 2/27/12, and the Governing Body on 2/27/12. No further actions recommended by any Committee.</p>	02/28/2012			

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	protection. When the receptacles were tested with a GFCI testing device, power was not interrupted indicating there was not GFCI protection at the breaker. This was confirmed by the Administrator at the time of observation.			