

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001026	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  04/10/2014
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW SURGERYONE	STREET ADDRESS, CITY, STATE, ZIP CODE 11420 PARKVIEW CIRCLE FORT WAYNE, IN 46845
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K020000	<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: 04/10/14</p> <p>Facility Number: 005407 Provider Number: 15C0001026 AIM Number: 100274410A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Parkview Surgeryone 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 Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This is a one story facility of Type I (332) construction with a basement was fully sprinklered. The facility has a fire alarm system with smoke detectors in the corridors and in areas open to the corridors.</p>	K020000		
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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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K020047	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/15/14.</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 Exits and ways of travel thereto are marked in accordance with section 7.10. 20.2.10, 21.2.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 paths in the means of egress from the main lobby was identified. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director of Operations and the Facilities Maintenance Manager on 04/10/14 at 2:55 p.m., the lobby had only one illuminated exit sign which was located above the main entrance door. Based on an interview with the Director of Operations and the Facilities Maintenance Manager at the time of observation, the secondary exit from the</p>	K020047	<p>Action: On 4-10-14, the secondary exit from the lobby is identified as the double doors to the Special Procedures Unit. The vendor was contacted and the appropriate illuminated Exit Sign was ordered. In addition, evacuation signage will be revised to indicate both emergency exits from the lobby. The Quality Improvement/Safety Committee was informed on 4-17 and the Board of Managers was informed on 5-7. Prevention: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that the facility has 2 paths for egress from the main lobby. Federal and state codes will be reviewed on an</p>	05/10/2014

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K020048	<p>lobby is through the double doors leading to the Special Procedures Care unit, but an illuminated exit sign was not provided above these double doors.</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 1. Based on record review and interview, the facility failed to protect all occupants by providing a complete written policy 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 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(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 and 11-5(f) requires notification of supervisors in the area in addition to</p>	K020048	<p>annual basis to ensure compliance. Responsible Party: Board of Managers, Chief Operating Officer, Director of Operations, Facilities Maintenance Manager. Date of Correction: May 10, 2014.</p> <p>Action: The Fire Watch Policy was reviewed on 4-10-14. Appropriate revisions were made to the policy to indicate that the ISDH will be notified, in addition to the other entities already listed in the policy, whenever the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period and whenever the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. The revised Fire Watch Policy was approved by the Quality Improvement/Safety Committee on 4-17 and the Board of Managers was informed on 5-7.</p> <p>Prevention: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that the Fire Watch Policy is appropriately implemented.</p> <p>Responsible Party: Board of Managers, Chief Operating Officer, Director of Operations, Facilities Maintenance Manager.</p>	05/07/2014			

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	<p>those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Operations and the Facilities Maintenance Manager on 04/10/14 at 12:58 p.m., the facility did have a written policy and procedure for an impaired sprinkler system but the policy did not include contacting the Indiana State Department of Health. This was confirmed by the Director of Operations 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>		Date of Correction: May 7, 2014.		

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K020051	<p>Based on record review with the Director of Operations and Facilities Maintenance on 04/10/14 at 12:58 p.m., the facility did have a written policy and procedure for an impaired fire alarm system but the policy did not include contacting the Indiana State Department of Health. This was confirmed by the Director of Operations at the time of record review.</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 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 20.3.4.1 requires fire alarm systems to be in accordance with 9.6. LSC 9.6.1.4 requires fire alarm systems be installed, tested and maintained in accordance with NFPA 72, 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</p>	K020051	<p>Action: The vendor for Fire Alarm Testing and Inspection was contacted on 4-10-14 and appropriate documentation of sensitivity testing was requested. Vendor stated that they will provide clear and appropriate documentation of the sensitivity test for all smoke detectors in the facility. Met with vendor on 4-24-14 to review documentation needs and assured that proper documentation would be available on or before -10-14.</p> <p>Prevention: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that the appropriate sensitivity</p>	05/10/2014	

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K020144	<p>Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Operations and the Facilities Maintenance Manager on 04/08/14 at 12:36 p.m., the "Fire Alarm Inspection and Testing Form" by TCSI Service Organization dated 09/07/13 listed 76 total smoke detectors in the building with only 70 smoke detectors receiving a sensitivity test. A sensitivity test from TCSI Service Organization date 09/07/12 stated 147 smoke detectors received a sensitivity test. Based on an interview with the Facilities Maintenance Manager at the time of record review, he was unable to confirm the actual number of smoke detectors in the building nor could he confirm all devices received an annual inspection.</p> <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 Based on record review and interview,</p>			K020144	<p>testing for the all smoke detectors occurs on a regular schedule and is documented accurately. If the vendor should not supply the appropriate documentation, a new vendor will be contracted. The Quality Improvement/Safety Committee was informed on 4-17 and the Board of Managers was informed on 5-7.</p> <p>Responsible Party: Board of Managers, Chief Operating Officer, Director of Operations, Facilities Maintenance Manager.</p> <p>Date of Correction: May 10, 2014.</p> <p>Action: The vendor for the monthly generator testing was contacted on</p>		04/21/2014

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	<p>the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the 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. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the emergency generator operating log titled "Generator System Log" with the Director of Operations and the Facilities Maintenance Manager on 04/10/14 at 1:30 p.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator. Based on an interview with the Facilities Maintenance Manager at the time of record review, he will ensure the generator log includes the time it takes to transfer power every month since the documentation was completed by a campus maintenance person.</p>		<p>4-10-14. The generator was exercised under full load for 30 minutes on 4-21-14. The Generator System Log was revised to include the time that it takes to transfer power from the main source to the generator. The Quality Improvement/Safety Committee was informed on 4-17 and the Board of Managers was informed on 5-7.</p> <p>Prevention: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that the monthly testing of the generator includes documentation of the time for the transfer of power.</p> <p>Responsible Party: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that the monthly testing of the generator includes documentation of the time for the transfer of power.</p> <p>Date of Correction: April 21, 2014.</p>				

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K020147	<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 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 20.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Operations and the Facilities Maintenance Manager on 04/10/14 at 2:12 p.m., a regular heavy weight extension cord was plugged in and providing power for the card reader system computer in the IT room. This was acknowledged by the Facilities Maintenance Manager at the time of observation.</p>	K020147	<p>Action: On 4-10-14, the Director of Information Technology was contacted regarding the use of an extension cord in the IT Bunker. The cord was removed and replaced with fixed wiring on 4-11-14. IT staff was educated on the LSC 9.1.2. at this same time. The Quality Improvement/Safety Committee was informed on 4-17 and the Board of Managers was informed on 5-7. Prevention: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that extension cords are not utilized in the facility. Observation of appropriate wiring practices is already part of the facility wide safety walk. The Facilities Maintenance Manager will pay special attention to extension cords on these safety walks.</p> <p>Responsible Party: The Board of Managers delegated ongoing responsibility to the Director of Operations and the Facilities Maintenance Manager to ensure that extension cords are not utilized in the facility. Date of Correction: 4-11-14.</p>	04/11/2014