STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	1901 N MERIDIAN ST INDIANAPOLIS, IN 46202

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K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 05/10/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 07/05/12 Facility Number: 005408 Provider Number: 15C0001027 AIM Number: 100103070A Surveyor: Mark Caraher, Life Safety Code Specialist At this PSR survey, Surgery Center of Eye Specialists of Indiana 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 located on the first and second floor of a two story building with a basement was determined to be of Type II (111) construction and was not sprinklered. The facility has a fire alarm system with smoke detection in corridors.	K0000		

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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	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/09/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0021	416.44(b)(1) LIFE SAFETY CODE STANDARD Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3 Based on observation and interview, the facility failed to ensure 1 of 4 stairwell exit doors was one hour fire rated and latched into the door frame. LSC 21.2.2.1 says the means of egress shall be limited to the types described in 39.2.2. LSC 39.2.2.2.1 says doors complying with 7.2.1 shall be provided and 7.2.1.1.1 says a door assembly shall conform to the general requirements of Section 7.1. LSC 7.1.3.2.1 states an exit required to be separated from other parts of the building shall be separated with not less than one hour fire resistance rating where the exit connects three stories or less and 7.1.3.2.1(c) requires openings in the separation shall be protected by fire door assemblies. NFPA 80, Standard for Fire Doors and Fire Windows, at 2-1.4 requires all swinging doors to be closed and latched at the time of fire and 2-1.4.1 requires the door to close and latch each time it is opened. This deficient practice affects any patient or staff exiting the	K0021	**K 021** 1. The practice will attempt to have the door rated by an appropriate service. If it is not possible to determine the fire rating of the door, then a new door will be purchased and installed between the stairwell and the pre/post operative area. 2. This will prevent future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Contacted Indianapolis Fire Chief Fred Pervine to try and locate a company to rate the door in question. Awaiting his response. If a company cannot be found to rate the door, a new door will be purchased and installed by 9/5/2012.	08/05/2012

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	second floor from the PreOp/Post Op waiting area. Findings include: Based on observation with the Administrator during a tour of the facility from 9:50 a.m. to 10:00 a.m. on 07/05/12, the stairwell exit door from the PreOp/Post Op waiting area has no fire resistance rating on the door and the door is not equipped with a positive latching device. Based on interview at the time of observation, the Administrator acknowledged the stairwell exit door from the PreOp/Post Op waiting area has no fire resistance rating and the door is not equipped with a positive latching device. This deficiency was cited on 05/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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K0064	416.44(b)(1) LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2 Based on observation and interview, the facility failed to inspect 3 of 3 portable fire extinguishers each month. LSC 21.3.5.2 requires portable fire extinguishers be provided in ambulatory health care facilities in accordance with 9.7.4.1. LSC 9.7.4.1 says where required by the provisions of another section of this Code, fire extinguishers shall be installed, inspected and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all patients, staff and visitors. Findings include:	K0064	**K 064** 1. In the future, all fire extinguishers will be "quick checked" on a monthly basis to ensure proper operation. 2. A practice employee will "quick check" all 3 fire extinguishers on a monthly basis. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date corrected 7/17/2012.	07/17/2012

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	Based on observations with the Front Desk Supervisor during a tour of the facility from 9:10 a.m. to 9:25 a.m. on 07/05/12, the inspection tags attached to three facility portable fire extinguishers indicated the monthly inspection for June 2012 was not documented. The locations of the portable fire extinguishers are: a) on the first floor by the back exit, b) on the second floor by the Big OR, and c) in the Attic hallway. Based on interview at the time of the observations, the Front Desk Supervisor acknowledged it had been more than one month since the most recent monthly inspection was performed for each of the aforementioned fire extinguishers. This deficiency was cited on 05/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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K0144	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 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 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. 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: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum 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. NFPA 110,	K0144	**K 144** 1. Future documentation in the generator/emergency lighting testing logs will include appropriate information. Koorsen Fire &Security will inspect and test the emergency lighting by the generator as appropriate. This will be documented and retained in the facility. We will obtain confirmation from our gas provider that the supply comes from a reliable source. 2. These steps will prevent future deficiencies. 3. Nick Hunter (Administration) responsible. 4. New generator/emergency lighting logs created and implemented. These forms were approved by Mark Caraher, ISDH Life Safety Code inspector, and we were assured that these would correct this deficiency. Statement of reliability obtained from Citizens Gas. Deficiencies corrected on 7/18/2012.	07/18/2012

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	6-3.4 requires a written record of inspections, tests, exercising and repairs shall be regularly maintained on the premises. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Generator Testing Log" documentation with the Administrator during record review from 10:00 a.m. to 10:40 a.m. on 07/05/12, monthly load testing documentation for the period of July 1, 2011 through June 25, 2012 show the emergency generator ran for at least thirty minutes each month for the twelve month period but the operating temperature, percentage of load capacity or minimum exhaust gas temperature was not recorded when each monthly load test was conducted. Based on interview at the time of record review, the Administrator stated no load bank testing is performed on the generator and acknowledged the operating temperature, the percentage of load capacity or minimum exhaust gas temperature was not recorded for monthly generator load testing for the period of July 1, 2011 through June 25, 2012 This deficiency was cited on 05/10/12. The facility failed to implement a systemic plan of correction to prevent			

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	recurrence. 2. Based on record review and interview, the facility failed to document monthly and annual testing for 1 of 1 emergency task lights in and around the generator set. LSC Section 21.5.1 requires utilities shall comply with the provisions of Section 9.1. Section 9.1.3 requires emergency generators to be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5.3.1 states the emergency power system location shall be provided with battery powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. LSC Section 21.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.3 requires a functional test shall be conducted on every required lighting system at thirty day intervals for not less than thirty seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than one and a half hours. Equipment shall be fully operational for the duration of the test. Written records or visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This			

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	deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Generator Testing Log" documentation with the Administrator during record review from 10:00 a.m. to 10:40 a.m. on 07/05/12, the facility is equipped with one emergency task light having battery backup power at the emergency generator in the basement. Based on interview at the time of record review, the Administrator stated the facility does not test the battery backup task light at the generator and acknowledged no documentation of monthly and annual testing was available for review. This deficiency was cited on 05/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3. Based on record review and interview, the facility failed to ensure the off site fuel source for the emergency generator was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use			

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	for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) require a letter of reliability from the natural gas vendor regarding the fuel supply that must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery 2. A brief description that supports the statement regarding the reliability 3. A statement that there is a low probability of interruption of the natural gas 4. A brief description that supports the statement regarding the low probability of interruption			

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	5. The signature of technical personnel from the natural gas vendor. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Generator Testing Log" documentation with the Administrator during record review from 10:00 a.m. to 10:40 a.m. on 07/05/12, the off site fuel source for the emergency generator is natural gas. Based on interview at the time of record review, the Administrator acknowledged the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. This deficiency was cited on 05/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.			