

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001172	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2015
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NAME OF PROVIDER OR SUPPLIER  ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 INDIANAPOLIS, IN 46202
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K 0000  Bldg. 01	<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: 05/26/15</p> <p>Facility Number: 012397 Provider Number: 15C0001172 AIM Number: NA</p> <p>At this Life Safety Code survey, ROC Surgery Center LLC was found not in compliance with Requirements for Participation in Medicare, 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 facility, located on the lower level of a four story building, was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p>	K 0000		
K 0048  Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the</p>			

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>event of an emergency. 20.7.1.1, 21.7.1.1</p> <p>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. LSC, Section 9.6.1.8 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. LSC Section A.9.6.1.8 states a fire watch should at least involve some special action beyond normal staffing and they should understand the particular fire safety situation. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures", "Facilities &amp; Environment - Fire Prevention &amp; Safety", "Emergency Operations Plan" and "Fire Response Plan" documentation with the Administrator during record review from 9:30 a.m. to 12:45 p.m. on 05/26/15, the facility's written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period did not include what procedures would be performed should a fire watch be instituted for fire alarm system</p>	K 0048	<p>The Clinical Operations Managers are responsible for ensuring that the required additions to the written policy have occurred. The Interim Life Safety Measure Policy has been revised to include the information required to meet the standard . The revised policy will be reviewed with the staff during the June staff meeting. See Attachment#1.</p>	06/02/2015

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	<p>impairment. Based on interview at the time of record review, the Administrator acknowledged the written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period did not include what procedures would be performed should a fire watch be instituted for fire alarm system impairment.</p> <p>2. Based on record review and interview, the facility failed to provide a complete written plan 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 states the building owner shall assign an impairment coordinator to comply with the requirements of Chapter 11. In the absence of a specific designee, the owner shall be considered the impairment coordinator. Exception: Where the lease, written use agreement, or management contract specifically grants the authority for inspection, testing, and maintenance of the fire protection system(s) to the tenant, management firm, or managing individual, the tenant, management firm,</p>			

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	<p>or managing individual shall assign a person as impairment coordinator. 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 or manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures", "Facilities &amp; Environment - Fire Prevention &amp; Safety", "Emergency Operations Plan" and "Fire Response Plan" documentation with the Administrator during record review from 9:30 a.m. to 12:45 p.m. on 05/26/15, the facility's written plan in the event the automatic sprinkler system is out of service for 4 hours or more in a 24 hour did not include notification of the insurance carrier, alarm company, building owner or manager. In addition, the facility's written fire watch plan did not include what procedures would be performed should a fire watch be instituted for sprinkler impairment. Based on interview at the time of record review, the Administrator acknowledged the facility's written plan in the event the automatic sprinkler system is out of</p>			

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K 0050 Bldg. 01	<p>service for 4 hours or more in a 24 hour period did not include notification of the insurance carrier, alarm company, building owner or manager and did not state what procedures would be performed should a fire watch be instituted for sprinkler impairment.</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 transmission of the fire alarm signal for 1 of 4 quarterly fire drills. LSC 20.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:  Based on review of "Code Red Drill</p>	K 0050	The Clinical Managers are responsible to ensure that there is documentation of transmission time of alarm signal from a pull station in the department to the monitoring office during quarterly fire drills. The Fire Drill Evaluation Checklist has been updated to include this documentation. See attachment Number 2	06/03/2015

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K 0114 Bldg. 01	<p>Evaluation Report", "I.U. Pulse Page" printout and "Fire Video and Extinguishing" documentation with the Administrator during record review from 9:30 a.m. to 12:45 p.m. on 05/26/15, the fire drill conducted on 12/17/14 did not include activation of the fire alarm system and transmission of the fire alarm signal. In addition, the fire drill conducted on 12/17/14 did not include the time of day the fire drill was conducted. Based on interview at the time of record review, the Administrator stated the facility operates one shift per day (6:00 a.m. to 7:00 p.m.), the fire drill documented for the fourth quarter 2014 on 12/17/14 documented on "Fire Video and Extinguishing" is for annual staff training in the event of a facility fire. The Administrator acknowledged the facility failed to document activation of the fire alarm system and transmission of the fire alarm signal for the fourth quarter of 2014.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1¾ inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors are fixed fire window assemblies in</p>			

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	<p>accordance with 8.2.3.2.2</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 ceiling fire barriers separating it from an adjoining tenant. LSC Section 20.3.7.1 requires ambulatory health care facilities to provide fire barriers with one hour fire resistance rating for tenant separation. LSC 20.3.7.3 requires any smoke barrier to be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one hour. LSC Section 8.3.6.1 states annular spaces caused by penetrations in fire barriers from pipes and conduits shall be filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Supervisor of Facilities Maintenance, the Administrator and the Clinical Operations Manager during a tour of the facility from 1:15 p.m. to 2:50 p.m. on 05/26/15, numerous holes surrounding conduits which penetrated the ceiling of Room 0206A above 11 electrical panels were not filled with a material capable of maintaining the fire resistance of the fire</p>	K 0114	This deficiency was corrected on June 8. The Clinical Managers contacted the facilities maintenance department and fire caulking was used to fill the spaces in the ceiling of electrical room R0206A. See attachment 3.	06/08/2015

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	barrier or by an approved device designed for the specific purpose. The ceiling of Room 0206A consisted of two layers of five eighths inch thick drywall. Based on interview at the time of the observations, the Supervisor of Facilities Maintenance acknowledged the aforementioned holes in the ceiling of Room 0206A were not filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose.				