

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001157	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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NAME OF PROVIDER OR SUPPLIER SENATE STREET SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD 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: 04/27/15</p> <p>Facility Number: 006622 Provider Number: 15C0001157 AIM Number: NA</p> <p>At this Life Safety Code survey, Senate Street Surgery Center 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 first floor of a two story building was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p> <p>IDR Committee met on 06/09/2015: No changes for K105 and K144-DAustill</p>	K 0000	Agreed	
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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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K 0012 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings two or more stories in height and of Type II (000), III (200), or V (000) construction are equipped throughout with a supervised approved automatic sprinkler system in accordance with section 9.7. 20.1.6.3, 21.1.6.3</p> <p>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 which 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. In addition, sprinkler impairment procedures shall comply with NFPA 25, Standard for the 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 or manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients,</p>	K 0012	<p>The policy titled, "Interim Life Safety Measures", LSC 8.00, was corrected on 04/29/2015 and now includes the Indiana State Department of Health will also be notified in the event the automatic sprinkler system is out of service for 4 or more hours in a 24 hour period. Employee education of the correction to the said policy was completed on 05/14/2015. The Clinical Managers of the Center are responsible for the ensurance of compliance with this policy. To prevent noncompliance, the Clinical Managers will reinforce the policy requirements during the annual fire safety in-service to the staff.</p>	05/14/2015

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K 0020	<p>staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures" with the Clinical Director during record review from 9:10 a.m. to 11:35 a.m. on 04/27/15, the facility's written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period did not include notification of the Indiana State Department of Health which is the authority having jurisdiction. In addition, the aforementioned written policy did not include notification of the insurance carrier and the alarm monitoring entity. Based on interview at the time of record review, the Clinical Director acknowledged the facility's written fire watch policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period did not include notification of the Indiana State Department of Health, the insurance carrier and the alarm monitoring entity.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p>						

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Bldg. 01	<p>Vertical openings such as stairways, elevator shaftways, escalators, and building service shaftways are enclosed in accordance with section 8.2.5. 8.2.5.1, 38.3.1, 39.3.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of vertical openings adjoining the electrical room by the break room was enclosed with construction having at least a one hour fire resistance. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.5.4(2) requires a one hour rated fire barrier in vertical openings. This deficient practice could affect ten staff in the break room.</p> <p>Findings include:</p> <p>Based on observation with the Clinical Manager during a tour of the facility from 1:15 p.m. to 2:15 p.m. on 04/27/15, a two foot by two foot hole was cut in the electrical room smoke barrier wall for access to an HVAC system fire damper inside the vertical opening for HVAC equipment which adjoined the electrical room by the break room. Based on interview at the time of observation, the Clinical Manager acknowledged the aforementioned hole in the electrical room smoke barrier wall did not enclose</p>	K 0020	Harmon construction has been contracted to correct this breach in LSC on Monday, May 18, 2015, after facility hours. The Director is responsible for ensuring the contractor completes the work and LSC is met. The Clinical Managers are responsible to maintain open communication with the facility maintenance staff to ensure LSC breaches do not reoccur in different areas of the Center.	05/18/2015

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K 0048 Bldg. 01	<p>the adjoining vertical opening for HVAC equipment with a fire resistance rating of at least one hour.</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 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 in accordance with LSC, Section 9.6.1.8 which 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. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interim Life Safety Measures" with the Clinical Director during record review from 9:10 a.m. to 11:35 a.m. on 04/27/15, 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 notification of the Indiana State Department of Health which is the</p>	K 0048	The policy titled, "Interim Life Safety Measures", LSC 8.00, was corrected on 04/29/2015 and now includes the Indiana State Department of Health will also be notified in the event the fire alarm system is out of service for 4 or more hours in a 24 hour period. Employee education of the correction to the said policy was completed on 05/14/2015. The Clinical Managers of the Center are responsible for the ensurance of compliance with this policy. To prevent noncompliance, the Clinical Managers will reinforce the policy requirements during the annual fire safety in-service to the staff.	05/14/2015

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K 0051 Bldg. 01	<p>authority having jurisdiction. Based on interview at the time of record review, the Clinical Director acknowledged 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 notification of the Indiana State Department of Health.</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 observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the facility waiting area were installed where air flow would not adversely affect its operation. LSC 20.3.4.1 requires ambulatory health care facilities have a fire alarm system in accordance with 9.6. LSC 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 all patients, staff and visitors.</p> <p>Findings include:</p>	K 0051	Harmon construction has been contracted to move the smoke detector for meet LSC requirements on May 18, 2015 after surgery center hours. The Director of the facility is responsible for ensuring the work is completed as scheduled. The Clinical Managers are responsible to communicate to the facility maintenance staff the change in location of the smoke detector.	05/18/2015

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K 0105 Bldg. 01	<p>Based on observation with the Clinical Manager during a tour of the facility from 1:15 p.m. to 2:15 p.m. on 04/27/15, the smoke detector in the patient waiting area was installed on the ceiling one foot from an air supply vent. Based on interview at the time of observation, the Clinical Director acknowledged the patient waiting area smoke detector was installed on the ceiling less than three feet from an air supply vent.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an emergency power system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2</p> <p>Based on observation and interview, the facility failed to provide emergency lighting in 7 of 8 operating rooms where general anesthesia or life support equipment is used. LSC Section 20.2.9.2 requires ambulatory health care facilities to provide emergency lighting where general anesthesia or life support equipment is used to be in accordance with LSC Section 7.9. LSC Section 7.9.2.2 states an emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following:</p>	K 0105	The emergency lighting is present in each of the OR suites in the Center. I have uploaded the past 12 months of the monthly checks ensuring the lights function properly. The OR Clinical Manager is responsible for communication with the maintenance personnel of the Center that the monthly tests are completed. The monthly log was received by maintenance personnel on June 11, 2015. The OR Clinical Manager is responsible to educate the OR staff regarding the existence of the emergency lights, where to	06/11/2015

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	<p>(1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply</p> <p>(2) Opening of a circuit breaker or fuse</p> <p>(3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities.</p> <p>LSC Section 7.9.2.5 requires the emergency lighting system to either be in continuous operation or be capable of repeated automatic operation without manual intervention. This deficient practice could affect seven patients and staff in any of seven operating rooms where general anesthesia or life support equipment is used.</p> <p>Findings include:</p> <p>Based on observations with the Clinical Manager during a tour of the facility from 1:15 p.m. to 2:15 p.m. on 04/27/15, Operating Room 2 (OR2), OR3, OR4, OR5, OR6, OR7 and OR8 were each not provided with battery operated emergency lighting to provide continuous illumination in seven of eight operating rooms where general anesthesia or life support equipment is used. OR1 was being utilized as an equipment storage room. Based on interview at the time of the observations, the Clinical Manager stated patients in each of the aforementioned seven operating rooms</p>		locate the monthly checks, and who to notify for any concerns with the lighting.				

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K 0114 Bldg. 01	<p>can be completely sedated and rendered immobile using general anesthesia. In addition, the Clinical Manager stated OR1 is being utilized as an equipment storage room. The Clinical Manager also stated an emergency generator is utilized to provide emergency lighting in each of the aforementioned operating rooms but acknowledged there is no battery operated back up emergency lighting system to provide continuous illumination in each of the seven operating rooms.</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 accordance with 8.2.3.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 smoke barriers separating the facility from other occupancies were protected to maintain the one hour fire resistance rating of the smoke barrier. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier.</p>	K 0114	Harmon Construction will complete the work on the Senate Street Surgery Center fire wall as noted in citation K 0114. The work will be completed no later than 06/29/2015. Upon completion of the work, the Center will be in compliance with the cited LSC. The Clinical Director is responsible for ensuring the appropriate work is completed by the date stated.	06/29/2015

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K 0144 Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Clinical Manager during a tour of the facility from 1:15 p.m. to 2:15 p.m. on 04/27/15, a five foot long by eight foot high section of the smoke barrier wall was missing in the one hour fire rated tenant separation smoke barrier wall above the ceiling in the patient waiting area north of the main entrance doors. Based on interview at the time of observation, the Clinical Manager acknowledged a five foot long by eight foot high section of the smoke barrier wall was missing in the one hour fire rated tenant separation smoke barrier wall above the ceiling in the patient waiting area north of the main entrance doors.</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</p> <p>1. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 2 of 12 months for each of three emergency generators.</p>	K 0144	#1, documentation of the emergency power transfer for the Center will be 10 seconds or less. Attached you will find the work proposal to include the ability to measure the Senate Street Surgery Center's transfer	06/17/2015

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	<p>NFPA 99, 3-4.1.1.8 states 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. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Power Supply System (EPSS) Monthly Test" documentation dated 12/17/14 with the Clinical Director during record review from 9:10 a.m. to 11:35 a.m. on 04/27/15, monthly load test documentation of emergency power transfer time for each of three facility generators was documented as "12.9 seconds." Based on interview at the time of record review, the Clinical Director stated the facility contracts emergency generator inspection and testing requirements with Methodist Hospital staff on site but acknowledged 12/17/14 monthly load test documentation stated emergency power transfer time for each</p>		<p>of power time, separate from the rest of the hospital. This work is proposed to be completed by June 17, 2015. The Clinical Director is responsible for ensuring the work is completed as scheduled and monthly documentation is started when IU Hospital facilities personnel does the load testing. The Clinical Managers are responsible for reporting any incidences of the transfer of power timing exceeding 10 seconds. #2. The Clinical Director met with the IU Health Senior Facilities Engineer regarding the LSC requirement for a remote shut of for the generator. I have uploaded the email correspondence from the engineer which shows of his plan to install the emergency shutoff. The Clinical Director is responsible for ensuring the work stated is completed by June 17, 2015 as proposed. The Clinical Director is responsible for educating the Clinical Managers of the Center regarding the regulation and the location of the emergency shutoff. This corrective action will be monitored and maintained by the IU Health Facilities personnel.</p>	

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	<p>of three facility generators exceeded 10 seconds. In addition, review of 04/15/15 "Emergency Power Supply System (EPSS) Monthly Test" monthly load test documentation with the Fire Technician for Methodist Hospital at 2:00 p.m. indicated emergency power transfer time for each of three facility generators was documented as "11.9 seconds." Based on interview at the time of review of the 04/15/15 monthly load test documentation, the Fire Technician for Methodist Hospital acknowledged 04/15/15 load test documentation for each of three facility generators exceeded 10 seconds.</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 3 emergency generators were equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level 1 installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all patients, staff and visitors.</p>			

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	<p>Findings include:</p> <p>Based on observation with the Fire Technician for Methodist Hospital at 2:10 p.m. on 04/27/15, a remote shut off device was not found for the three 750 kW diesel fired emergency generators located inside the North Generating Station. Based on interview at the time of observation, the Fire Technician for Methodist Hospital stated Methodist Hospital by contract with Senate Street Surgery Center performs testing and preventive maintenance for emergency generators supplying emergency power to the Senate Street Surgery Center and acknowledged there is no remote emergency shut off device for the three 750 kW diesel fired emergency generators located inside the North Generating Station.</p>				