

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001114	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2015
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NAME OF PROVIDER OR SUPPLIER SOUTH CENTRAL SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5002 E SR 44 FRANKLIN, IN 46131
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 04/28/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 08/14/15</p> <p>Facility Number: 003073 Provider Number: 15C0001114 AIM Number: 200377120A</p> <p>At this PSR survey, South Central Surgery Center LLC 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.</p> <p>This facility located in a one story building was determined to be of Type V (111) construction and was fully sprinklered except for two exterior combustible canopies. The facility has a fire alarm system with smoke detection at corridor smoke barrier door sets and in ventilation ducts.</p>	K 0000		
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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 0115 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance rating. Doors in smoke barriers are equipped with positive latcher. Doors are constructed of not less than 1¾ inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per panel. 20.3.7.1, 20.3.7.2, 20.3.7.3, 21.3.7.1, 21.3.7.2, 21.3.7.3</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 3 smoke barriers was protected to maintain the one hour fire resistance rating of the smoke barrier. LSC 8.2.3.2.1 states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, 1999 edition, section 2-3.1.7 states the clearance between the meeting edges of doors swinging in pairs on the pull side shall not exceed 1/8 inch for wood doors. This deficient practice could affect all patients and staff if smoke from a fire was to infiltrate the protective barrier.</p> <p>Findings include: Based on review of facility blueprint</p>	K 0115	I have gotten two estimates on service calls to repair the doors. The first was from Automated Door for \$155.00 for the first hour plus parts. The other was from Record for \$70.00 for the first 2 hours. \$55.00 for truck trip plus parts. Both of these quotes were given to the Governing board on August 25,2015. The quotes are still under consideration.The Governing board is trying to understand why we need the positive door latch. The have inquired with other fire inspectors and they cannot explain either. I will have to give you another update in 30 days. There will be a quality assessment sheet developed to monitor the latches and closing of these doors. It will be maintained by the Director of Nursing. The results will be sent to the Quality Assessment committee and they will give the results to the Governing Board.	10/04/2015			

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	<p>documentation with the Director of Nursing (DON) during record review at 9:15 a.m. on 08/14/15, the facility measures 13,125 square feet and South Central Surgery Center LLC occupies the entire building. A one hour fire rated smoke barrier wall separates the facility into at least two smoke compartments. Based on observations with the DON during a tour of the facility at 9:00 a.m. on 08/14/15, the following was noted:</p> <p>a. the set of smoke barrier doors in the one hour fire rated smoke barrier wall separating the patient recovery area from the operating rooms smoke compartment was not equipped with a positive latching device.</p> <p>b. the set of smoke barrier doors in the one hour fire rated smoke barrier wall separating the office area corridor from the patient recovery room was not equipped with a positive latching device.</p> <p>c. the smoke barrier door in the one hour fire rated smoke barrier wall next to the Pathology Lab was equipped with a self closing device and a positive latching device but failed to self close because carpet stopped the bottom of the door from swinging and failed to latch because the door was stopped from fully closing by hitting the frame on the latching side of the door.</p> <p>Based on interview at the time of the observations, the DON acknowledged 2</p>			

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K 0130 Bldg. 01	<p>of 3 smoke barriers was not protected to maintain the one hour fire resistance rating of the smoke barrier at the aforementioned smoke barrier door locations.</p> <p>This deficiency was cited on 04/28/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 21.7.6, Maintenance and Testing, refers to 4.6.12. LSC 4.6.12.2 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 5-1.1 states the requirements for spacing, location and position of sprinklers shall be based on the following principles or met an Exception:</p>	K 0130	The Governing board requested a second estimate on the sprinkler system. Hydrox was the first estimate for \$5700.00. The second estimate was from Koorsen and they have not returned my estimate at this time. I contacted them and they said it was not ready. They also wanted me to know that they would not install the sprinklers until the fall because it is too hot in the attic where they would have to work. All this information has been sent each person on the governing board. The Director of Nursing will develop a Quality Assessment quarterly to make sure these are inspected quarterly. The results will be sent to the Quality Assessment Committee and they will sent the results to the Governing board.	10/04/2015

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	<p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>NFPA 13, 5-13.8 states sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width.</p> <p>Exception: Sprinklers are permitted to be omitted where the canopy or roof is noncombustible or limited combustible construction.</p> <p>This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility blueprint documentation with the Director of Nursing (DON) during record review at 9:15 a.m. on 08/14/15, the exterior canopy at the main entrance and the exterior canopy at the patient discharge exit each extended at least 30 feet from the building and were of combustible construction. In addition, the review of Hydro Fire Protection documentation dated 06/23/15 provided exterior canopy sprinkler installation pricing quote estimates with installation yet to be performed. Based on observations with</p>			

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	<p>the DON during a tour of the facility at 9:00 a.m. on 08/14/15, the exterior canopy at the main entrance and the exterior canopy at the patient discharge exit each extended at least 30 feet from the building and were not provided with sprinklers. Based on interview at the time of record review and of the observations, the DON stated canopy sprinkler installation has not yet been approved by the facility's Board of Governors and acknowledged the aforementioned exterior canopies were not provided with sprinklers.</p> <p>This deficiency was cited on 04/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				