

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001114	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/05/2016
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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 PSR conducted on 10/07/15 to the PSR conducted on 08/14/15 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: 01/05/16</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</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>corridor smoke barrier door sets and in ventilation ducts.</p> <p>Quality Review completed on 01/06/16 -DA</p> <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 were to</p>	K 0115	<p>The positive latches were placed on the door by the oscopy room. These are functional and will be tested during fire drills which is quarterly. The QA committee has developed a QA for checking on the latches. It will be maintained by the Director of Nursing. The QA committee will receive a report quarterly which they will submit to the governing body. The door near the pathology came in but was the incorrect size it was reordered and will be here in 4 weeks. I have included a letter from Elite Bio Medical which is installing the door for us.</p>	01/22/2016

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	<p>infiltrate the protective barrier.</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 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 facility DON during a tour of the facility from 9:40 a.m. to 9:50 a.m. on 01/05/15, 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</p>			

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K 0130 Bldg. 01	<p>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 stated quotes have been obtained from contractors to make the necessary repairs to the aforementioned smoke barrier doors but acknowledged the repairs have not been made and 2 of 3 smoke barriers were not protected to maintain the one hour fire resistance rating of the smoke barrier at the three smoke barrier door locations.</p> <p>This deficiency was cited on 04/28/14, 08/14/15 and 10/07/15. 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</p>	K 0130	The sprinklers were completed on Feb.8, 2016 under the south and west awnings. These will be checked quarterly by Certified Fire Systems. A QA has been completed by the QA committee it will be maintained by the Director of Nursing. The QA committee will receive a report quarterly which they will submit to the governing body.	02/08/2016

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	<p>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> <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. 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</p>			

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	<p>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 the facility DON during a tour of the facility from 9:40 a.m. to 9:50 a.m. on 01/05/15, 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 the observations, the DON stated quotes had been obtained from a contractor for canopy sprinkler installation, canopy sprinkler installation has not yet been performed and acknowledged the aforementioned exterior canopies were not provided with sprinklers.</p> <p>This deficiency was cited on 04/28/14, 08/14/15 and 10/07/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				