STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/08/16 Facility Number: 003633 Provider Number: 15C0001133 AIM Number: 200503030A At this Life Safety Code Survey, Sullivan Surgicenter 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 20, New Ambulatory Health Care Occupancies. This three story facility was determined to be of Type I (332) construction and partially sprinklered. The facility has a fire alarm system with smoke detection in corridors and hazardous areas. Sprinklers were located in the laundry, maintenance shop, and rooms 101 and 309. Quality Review completed on 02/11/16 -	K 0000		

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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	DA			
K 0048 Bldg. 01	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 1. Based on record review and interview, the facility failed to provide a written policy for the protection of all patients 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, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: Based on review of the Disaster Preparedness Plan Manual on 02/08/16 at	K 0048	1 Located Fire Alarm System Outage or Impaired Sprinkler System Policy 900.41 2 Keep a copy of the policy in the Fire Safety Manual along with our other Policy & Procedure Manuals 3 Theresa Gilbert, Director of Nursing 4 Policy is dated 4/30/2010 and was revised on 2/27/13	03/04/2016

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	10:15 a.m. with the Director of Nursing (D.O.N.) present, a written plan in the event the fire alarm system is out of service for 4 hours or more in a 24 hour was not available for review. Based on interview at the time of record review, the D.O.N. acknowledged a written plan in the event the fire alarm system is out of service for 4 hours or more in a 24 hour was not available for review. 2. Based on record review and interview, the facility failed to provide a 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			

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	tenant, management firm, or managing individual, the tenant, management firm, 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. Findings include: Based on review of the Disaster Preparedness Plan Manual on 02/08/16 at 10:15 a.m. with the Director of Nursing (D.O.N.) present, a written plan in the event the automatic sprinkler system is out of service for 4 hours or more in a 24 hour was not available for review. Based on interview at the time of record review, the D.O.N. acknowledged a written plan in the event the automatic sprinkler system is out of service for 4 hours or more in a 24 hour was not available for review.			
K 0050 Bldg. 01	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			

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	of established routine. 20.7.1.2, 21.7.1.2 1. Based on record review and interview, the facility failed to ensure fire drills were performed on each shift for 1 of 4 quarters. This deficient practice could affect all occupants in the facility. Findings include: Based on review of fire drill documentation on 02/08/16 at 11:00 a.m. with the Director of Nursing (D.O.N.) present, the facility lacked written documentation or other evidence a fire drill was conducted during the second quarter (April, May, and June) of 2015. During an interview at the time of record review the D.O.N. acknowledged there was no fire drill documentation available for the second quarter of 2015. 2. Based on record review and interview, the facility failed to ensure 3 of 3 fire drills conducted, included activating the fire alarm and included the transmission of a fire alarm signal to the monitoring company or fire department. LSC 21.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. This deficient practice could affect all occupants in the facility. Findings include:	K 0050	1 Fire drills will be performed on each of the four quarters of every year Koorsen will be notified to put our alarm system on test mode, we will document who we spoke to. We will then sound alarm, and document drill in the Fire Safety Manual, Fire Drill section 2 We will regularly check documentation in Fire Safety Manual to ensure a drill was performed in each of the quarters as follows: March, June, September and December 3 Theresa Gilbert, Director of Nursing 4 3/04/2016	03/04/2016

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	Based on review of fire drill documentation on 02/08/16 at 11:00 a.m. with the Director of Nursing (D.O.N.) present, when fire drills were conducted on 03/10/15, 08/18/15, and 11/10/15, the fire drill reports did not include information for the activation of the alarm or transmission of a fire alarm signal to the monitoring company or fire department. Based on interview at the time of record review, the D.O.N. said the fire alarm system was not activated during any of the three documented fire drills.			
K 0064 Bldg. 01	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 ensure monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 21 of 21 portable fire extinguishers. NFPA 101, 21.3.5.2 refers to 9.7.4. NFPA 101, 9.7.4.1 requires portable fire extinguishers to be installed, inspected and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, 4-3.1 requires that extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check that an	K 0064	1 Fire Extinguisher inspections will done monthly and will be initialed and dated on all fire extinguishers within facility 2 Tags will be inspected regularly to ensure monthly checks are being performed 3 Reno Lim, Maintenance Department 4 3/04/2016	03/04/2016

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	extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all occupants in the facility. Findings include: Based on observations of fire extinguisher inspection/maintenance tags on 02/08/16 between 12:00 p.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was no documentation on the inspection tags which indicated the twenty one portable fire extinguishers had been inspected during the following months: April through December of 2015. The yearly inspections were performed in March of 2015 according to the inspection tags on all of the portable fire extinguishers. The Maintenance Supervisor indicated there was no other evidence the twenty one portable fire extinguishers were inspected between April through December of 2015.			
K 0130 Bldg. 01	416.44(b)(1) MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review and interview, the facility failed to ensure sprinkler	K 0130	1 We have contacted the State Fire Safety Inspector, Chip Dudley concerning removal	03/04/2016

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	waterflow alarm devices were tested quarterly for 3 of 4 quarters. LSC 4.5.7 states whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. LSC 4.6.12 requires maintenance and testing of the automatic sprinkler system are made at specified intervals in accordance with applicable NFPA standards. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires that waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires that the priming level shall be tested quarterly. NFPA 25, 9-7.1 requires that the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires that records shall indicate the procedure performed (inspection, test, or maintenance), the organization that performed the work, the results and the date. Finally, NFPA 25, 1-8 requires that		of the sprinkler system and were given the information necessary to begin this process We have also contacted Koorsen Fire & Safety to check the sprinkler system and provide us with estimates to repair, remove, or replace the system which ever may be necessary Quarterly tests shall be performed by Koorsen on the system until removed 2 We will notify Koorsen Fire and Security that quarterly checks need to be performed until the system is approved for removal 3 Custodio Lim, MD-administrator 4 This is an ongoing process We have initiated contact with the appropriate divisions and hope to have this process completed within 6 months by September 4, 2016	

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	records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Koorsen sprinkler system inspection reports on 02/08/16 at 11:20 a.m. with the Director of Nursing (D.O.N.) present, the only sprinkler system inspection report available during the past twelve months was dated 08/28/15 for the third quarter (July, August, and September) of 2015. During an interview at the time of record review, the D.O.N. said the sprinkler system was inspected only once per year, furthermore, the D.O.N. confirmed there were no quarterly inspection reports for the sprinkler system performed during the first quarter (January, February, and March), second quarter (April, May, and June), and fourth quarter (October, November, and December) of 2015. 2. Based on observation and interview, the facility failed to ensure 1 of 1			

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	automatic sprinkler system was continuously maintained in reliable operating condition. This deficient practice could affect all occupants in the facility. Findings include: Based on review of the facility's Koorsen annual sprinkler system inspection on 02/08/16 at 11:25 a.m. with the Director of Nursing (D.O.N.) present, the 08/28/15 inspection report stated "Sprinklers are dated 1958 and should be replaced due to being over 50 years. No smooth bore on inspectors outlet. Customer does not want quote, stated he would take care of deficiencies on his own.". There was no supporting documentation to show these items have been corrected. This was acknowledged by the D.O.N. at the time of record review. 3. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions			

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	where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all occupants in the facility. Findings include: Based on review of sprinkler system inspection reports on 02/08/16 at 11:45 a.m. with the Director of Nursing (D.O.N.) present, there was no documentation to show the sprinkler system has had an internal pipe inspection. Based on an interview at the time of record review, the D.O.N. acknowledged the sprinkler system has not had an internal pipe inspection. This was confirmed with the sprinkler system vendor via phone interview at the time of record review.			
K 0144 Bldg. 01	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per			

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	month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 7.9.2.3 requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all occupants in the facility. Findings include: Based on review of the facility's Emergency Generator Log Book on 02/08/16 at 11:55 a.m. with the Director of Nursing (D.O.N.) and Maintenance Supervisor present, the generator log form documented the generator was tested weekly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a	K 0144	1 Five minute time delay shall be provided for unloaded running of the EPS Generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30% of the EPS nameplate rating at least monthly for a minimum of 30 minutes Testing shall be performed and documented accordingly in the Emergency Generator Log Book 2 Maintenance Supervisor will perform all testing and ensure all documentation needed is completed 3 Reno Lim, Maintenance Supervisor 4 3/07/16	03/07/2016

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	cool down time following its load test. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include documentation of a cool down time being recorded. 2. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. 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 occupants in the facility. Findings include:			

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	Based on review of the facility's Emergency Generator Log Book on 02/08/16 at 11:55 a.m. with the Director of Nursing (D.O.N.) and Maintenance Supervisor present, the generator log form documented the generator was tested monthly under load, however, the documentation did not show the generator was exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months. This was acknowledged by the Maintenance Supervisor at the time of record review, furthermore, the Maintenance Supervisor stated the emergency generator was a diesel generator and there was no load bank test documentation available.			