

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001013	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER AT THE INDIANA EYE CLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 30 N EMERSON AVE GREENWOOD, IN 46143
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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: 03/03/15</p> <p>Facility Number: 005394 Provider Number: 15C0001013 AIM Number: 100274240A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Ambulatory Surgery Center at the Indiana Eye Clinic 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 on the 1st floor of a two story multiple occupancy building, was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors.</p>	K 0000		

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>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/05/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. LSC 9.7.5 states all required automatic sprinkler and standpipe systems shall be inspected, tested, and maintained in accordance with NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, 1998 Edition. NFPA 25 at 10.2.3 states if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by</p>	K 0012	<p>The ASC contacted Simplex Grinnell on 3/16/15 to investigate options for either flushing the system or replacement. The following is a time line of events: 3/23/15 IEC owners met with Simplex Grinnell to discuss options. 3/31/15 Proposal for Main piping replacement with addition of Nitrogen generator. 4/2/15 Met with Simplex Grinnell to work on scheduling replacement of the system. 4/13/15 Replacement work to begin in the ASC. 4/17/15 Estimated date of completion. An in-service was held on 3/24/2015 for the ASC staff to educate them of Fire watch policy # 14.141. This policy will be implemented during the sprinkler replacement and a Fire Watch</p>	04/17/2015

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	<p>qualified personnel. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Simplex/Grinnell's "Obstruction Investigation Report" documentation dated 02/07/14 during record review with the ASC Director from 9:30 a.m. to 12:15 p.m. on 03/03/15, an internal pipe inspection conducted on 02/07/14 for the facility's automatic sprinkler system stated, "The sprinkler systems are in need of internal cleaning. Some of the pipes were found to be partially full of foreign materials". Also stated was "percentage of internal diameter blocked" as "50%". Based on observation with the ASC Director during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 03/03/15, the hanging tag affixed to the sprinkler system riser indicated the results of the internal pipe inspection on 02/07/14 as "Fail". No other documentation was affixed to the sprinkler system riser indicating the automatic sprinkler system had been flushed on or after 02/07/14. Based on interview at the time of record review and of the observation, the ASC Director acknowledged flushing of the facility's automatic sprinkler system has not been scheduled or performed</p>		<p>Log will be maintained.</p> <p>In-services have also been held on fire evacuation routes, fire extinguishers locations and use, and safety for staff, visitors and patients. The ASC Director will be responsible for this compliance. Quarterly inspections of the sprinkler system will be conducted by Simplex Grinnell and results monitored by the ASC Director. A letter from Simplex Grinnell stating completion of pipe replacement will be submitted to ISDH.</p>	

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K 0048 Bldg. 01	<p>following Simplex/Grinnell's 02/07/14 internal pipe inspection which revealed blockage.</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 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 record review with the ASC Director from 9:30 a.m. to 12:15 p.m. on 03/03/15, a written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the ASC Director acknowledged a written policy in the event the fire</p>	K 0048	<p>Fire Watch Policy# 14.141 was written for procedures to be followed in the event the fire alarmsystem/automatic sprinkler system has to be placed out of service for 4 or morehours in a 24 hr period to protect patients, visitors and staff. An in-servicewas held on 3/24/2015 for the ASC staff to inform them of Policy #14.141 andthe Fire Watch protocol was discussed. It will be the responsibility of the ASC Director to review this policyupon employment during the orientation period and yearly in-servicesthereafter. This has been listed on an Excel spreadsheet titled "TimeRequirements" to assist with compliance. The "Time Requirements" is a quick reference tool that will be monitoredby ASC Director on a monthly basis. This Policy was sent to the Governing Body 3/26/15 forapproval.</p>	03/26/2015

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	<p>alarm system is out of service for four hours or more in a twenty four hour period was not available for review.</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 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, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the ASC Director from 9:30 a.m. to 12:15 p.m. on</p>			

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K 0051 Bldg. 01	<p>03/03/15, a written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the ASC Director acknowledged a 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 was not available for review.</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 record review and interview, it could not be assured the facility was maintaining and inspecting all smoke detectors per the manufacturer's recommendations. LSC Section 21.3.4.1 requires ambulatory health care facilities to be in accordance with LSC Section 9.6. LSC Section 9.6.1.4 requires a fire alarm system to be maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3 requires smoke detector testing to be in accordance Section 7-3, Inspection and Testing Frequencies. NFPA 72, 7-3.2.1 states detector sensitivity shall be</p>	K 0051	The Smoke Detector Sensitivity testing was performed by Simplex Grinnell on 3/5/15 and their report showed no deficiencies during the inspection. An addendum was added to the facility contract with Simplex Grinnell to perform Smoke Detector Sensitivity every 2 years. This has been listed on an Excel spreadsheet titled "Time Requirements" to assist with compliance. The "Time Requirements" is a quick reference tool that will be monitored monthly by ASC Director. The Practice Manager will also monitor this time requirement.	03/05/2015

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	<p>checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity</p>			

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K 0114 Bldg. 01	<p>range shall be cleaned and recalibrated, or replaced.</p> <p>NOTE: The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the ASC Director from 9:30 a.m. to 12:15 p.m. on 03/03/15, documentation of fire alarm system smoke detector sensitivity testing performed within the most recent two year period was not available for review. Based on interview at the time of record review, the ASC Director stated the facility contractor for fire alarm system testing, Simplex/Grinnell, stated it was not in their contract to perform sensitivity testing. As a result, the ASC Director acknowledged smoke detector sensitivity testing performed within the most recent two year period was not available for review.</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</p>				

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K 0144 Bldg. 01	<p>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 the ambulatory health care facility waiting area was separated from other tenants by fire barriers with at least a one hour fire resistance rating in accordance with LSC 21.3.7.1. This deficient practice could affect all patients, staff and visitors in the waiting area.</p> <p>Findings include:</p> <p>Based on observation with the ASC Director during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 03/03/15, the waiting area for the ambulatory surgery center was open to the Indiana Eye Clinic lobby and was not separated from other tenants by fire barriers with at least a one hour fire resistance rating. Based on interview at the time of observation, the ASC Director acknowledged the waiting area for the ambulatory surgery center was open to the Indiana Eye Clinic lobby and was not separated from other tenants by fire barriers with at least a one hour fire resistance rating.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and</p>	K 0114	<p>3/23/15 An architect with Artekena was contacted for consultation on tenant separation for the ASC.</p> <p>3/24/15 A code specialist with RTM Consultants surveyed the building to assist in formulating a plan for compliance.</p> <p>The following are estimated dates for the plan of correction: 4/17/15 Plans for design will be completed and ready for submittal to the Life Safety Code Acute Care Division for approval. 5/18/15 Pending approval of plans from the ISDH, building remodel will be put out for contractor to bid. 6/8/15 Remodel project to begin. 6/26/15 Completion of remodel.</p> <p>The ASC Director will be responsible for completion of the tenant separation and will monitor the progress on a weekly basis and provide updates to the ISDH as necessary. At the end of the project a copy of the Greenwood Fire Dept. inspection and the Architectural Certificate of Substantial Completion will be submitted to the ISDH Life Safety Codes supervisor.</p>	06/26/2015			

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	<p>exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2</p> <p>1. Based on record review and interview, the facility failed to ensure monthly load testing for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. LSC 21.5.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.3 states emergency generators shall be tested and maintained in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 110, 6-4.2.2 states diesel powered</p>	K 0144	<p>The annual load bank test has been scheduled with Huston Electric for Friday 4/3/15 at 9:30am unless we experience extremely cold or rainy weather at which time the test will be rescheduled for the next Friday 4/10/15. This annual test has been added to a "Time Requirements" excel spreadsheet which will be checked monthly by the ASC Director to ensure compliance. Huston Electric has also added the requirement to their scheduled list to be performed on a yearly basis.</p> <p>The Monthly Generator Log was revised to include the documentation of emergency power transfer time to the emergency generator for monthly load testing. The person responsible for the documentation was in-serviced about the requirement by the ASC Director. The log will be checked monthly by the ASC Director to ensure compliance. A manual remote shut off station for the emergency generator was installed by Design and Build electrical contractors on 3/25/15. The ASC staff was in-serviced as to the location and of its function. The ASC Director will be responsible for the compliance. The shut off station is now installed and the ASC is compliant</p>	04/03/2015

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	<p>EPS installations which do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads for a total of two continuous hours. NFPA 110, 6-3.4 requires a written record of inspections, tests, exercising and repairs shall be regularly maintained on the premises. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Generator Checklist documentation with the ASC Director during record review from 9:30 a.m. to 12:15 p.m. on 03/03/15, monthly load testing documentation for the emergency generator for the twelve month period of 03/18/14 through 02/17/15 does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test conducted. Based on interview at the time of record review, the ASC Director acknowledged the aforementioned documentation does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test conducted.</p> <p>2. Based on record review and interview, the facility failed to ensure emergency</p>		with the NFPA code.				

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	<p>power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. 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 Monthly Generator Checklist documentation with the ASC Director during record review from 9:30 a.m. to 12:15 p.m. on 03/03/15, documentation of emergency power transfer time to the emergency generator for monthly load testing for the twelve month period of 03/18/14 through 02/17/15 was not available for review. Based on interview at the time of record review, the ASC Director acknowledged emergency power transfer time during monthly load testing for the aforementioned twelve month period was</p>			

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NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER AT THE INDIANA EYE CLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 30 N EMERSON AVE GREENWOOD, IN 46143			
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	<p>not available for review.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was 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 2 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> <p>Findings include:</p> <p>Based on observation with the ASC Director during a tour of the facility from 12:15 p.m. to 1:30 p.m. on 03/03/15, a remote shut off device was not found for the 20 kW diesel fired emergency generator. Based on interview at the time of observation, the ASC Director stated the emergency generator was installed after 2003 and acknowledged there is no remote emergency shut off device for the emergency generator.</p>						