

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
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K 000 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: 01/07/15</p> <p>Facility Number: 004746 Provider Number: 15C0001146 AIM Number: 200268580B</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Surgery Center of Carmel 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.</p> <p>The facility, located on the first floor of a three 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 and ductwork.</p>	K 000		
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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 029 Bldg. 01	<p>The facility has elected to utilize the Categorical Waiver pertaining to relative humidity levels in anesthetizing locations.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/12/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>IDR Committee met on 01-29-15, no changes made. JLee</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems. 38.3.2, 39.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 hazardous areas self closing corridor doors were not secured in the open position. LSC 38.3.2.1 states hazardous areas such as general storage areas shall be protected in accordance with Section 8.4. Section 8.4.1.2 states the area shall be enclosed with smoke resistant partitions in</p>	K 029	<p>1/07/15 1. All door stoppers from PACU soiled utility room were removed from the facility. PACU manager was in- serviced on LSC 38.3.2.1 on 1/12/15. Safety RN and committee met to confirm understanding of the code and to monitor the use of door stoppers.</p> <p>2. Safety RN or an appointed person will monitor on a regular basis through inspections with</p>	01/12/2015

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K 046 Bldg. 01	<p>accordance with 8.2.4. 8.2.4.3.5 states doors shall be self-closing or automatic closing in accordance with 7.2.1.8. 7.2.1.8 states a door normally required to be kept closed shall not be secured in the open position. This deficient practice could affect four patients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 2:10 p.m. to 3:30 p.m. on 01/07/15, the corridor door to the soiled utility room in the Post Anesthesia Care Unit (PACU) area was propped in the fully open position with a wedge. Based on interview at the time of observation, the Administrator acknowledged the corridor door to this hazardous area was propped in the fully open position with a wedge.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1 Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 6 of 6 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be</p>	K 046	<p>safety checks to make sure door stoppers are not used. 3. Safety RN and Managers will be responsible to monitor deficiency, life safety code 38.3.2.1 and report to Administrator if rules are not followed. 4. Complete on 1/12/15</p> <p>1. Monthly Life Safety form has been updated to itemize each battery and mark the 90 minute testing for each battery from Jan to June. Every battery will be tested for 30 sec each month and initialed on the safety checklist. 90 minutes checks will be checked on the designated month and initialed. 2. Administrator</p>	01/12/2015

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	<p>conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration.</p> <p>Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner 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 Safety Checklist" documentation for January 2014 through December 2014, with the Administrator during record review from 10:15 a.m. to 2:10 p.m. on 01/07/15, functional testing conducted at 30 day intervals and annual 90 minute testing conducted on 03/31/14 for battery powered emergency lights in the facility were not itemized by location for tests conducted during the most recent twelve month period. Based on interview at the time of record review, the Administrator acknowledged monthly and annual battery powered emergency light testing results were not itemized by location.</p> <p>Based on observations with the Administrator during a tour of the facility from 2:10 p.m. to 3:30 p.m. on 01/07/15,</p>		<p>updated the Life Safety checklist on 1-8-15. On 1-12-15 Administrator trained the Safety RN and safety Committee members on LSC 38.3.2.1 . Safety RN or an appointed designee will test the batteries for 90 minutes on their appointed month per the safety checklist.(see attachment A) Person testing the battery will initial the form and notify administrator or Safety RN with any problems with the lights.</p> <p>3. Safety RN will be responsible to make sure that all batteries are test and working order. She will report to Administrator if battery is not functioning. 4. 1/12/15</p>	

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K 048 Bldg. 01	wall mounted battery powered emergency lights were observed installed in each of four operating rooms, the Procedure Room and the electrical room where the transfer switches were located. Each battery powered emergency light tested operated when its respective test button was depressed except for the light located in the Procedure Room which failed to operate when its test button was pushed ten times. 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 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	K 048	1. Administrator revised the Disaster Preparedness Plan to mention the facilities plan if the automatic sprinkler system is down for 4 hours or more than 24 hours . (see attachment B) Administrator stated the centers plan which will be presented to the Quality Assurance, Safety Committee, and Medical Advisory Committee on 1-27-15. Governing Board will approve on 2/09/15. 2. Disaster Preparedness plan has been revised to include sprinkler impairment by the safety Committee, Administrator, and HCREIT(Building owners). The plan was revised on 1/19/15. 3. Safety RN and Administrator	02/09/2015

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	<p>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 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.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" documentation with the Administrator during record review from 10:15 a.m. to 2:10 p.m. on 01/07/15, 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 Administrator 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</p>		<p>are responsible for revising and making sure the Disaster Preparedness plan is up to date. 4. 2/09/15 Approval by the Governing Board</p>	

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K 050 Bldg. 01	<p>available for review.</p> <p>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 of established routine. 20.7.1.2, 21.7.1.2 Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions on the first and second shift for 3 of 4 quarters. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Observer Evaluation" and "Fire Drill Evaluation Form" documentation with the Administrator during record review from 10:15 a.m. to 2:10 p.m. on 01/07/15, the following was noted:</p> <p>a. fire drills conducted on the first shift (6:00 a.m. to 5:00 p.m.) on 02/13/14, 06/27/14 and 08/08/14 were conducted at, respectively, 1:30 p.m., 1:30 p.m. and 1:45 p.m.</p> <p>b. fire drills conducted on the second shift (5:00 p.m. to 5:00 a.m.) on 03/03/14, 04/30/14 and 12/22/14 were conducted at, respectively, 5:00 p.m., 5:15 p.m. and 6:00 p.m.</p>	K 050	<p>1. The facility performs two Fire Drills each Qtr unannounced on evenings and day shifts. The facility shifts are 5AM-5PM days and 5PM to 5AM Evenings. Even though the times are similar due to the shifts the drill are always unannounced with different scenarios. The Administrator will attempt to perform drills at different times during the day to satisfy the LSC guidelines. 2. The Administrator and Safety RN will make an effort to randomly change the fire drill times so that they are not so common. The Fire drills will continue to be unannounced but Center will improve our random times . 3. Administrator and Safety RN will be responsible for Fire drills at unannounced times through-out the day. 4. 1/8/2015</p>	01/08/2015

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K 051 Bldg. 01	<p>Based on interview at the time of record review, the Administrator acknowledged the aforementioned fire drills were not conducted at unexpected times under varying conditions on the first and second shift.</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 3 of over 18 smoke detectors in the facility were not installed where air flow would 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: Based on observations with the Administrator during a tour of the facility</p>	K 051	<ol style="list-style-type: none"> Administrator contacted Koorsen Fire and safety to replace smoke detectors in 3 of the 18 locations so that they are at least 3 feet from airflow vents per LSC 20.3.4.1. Koorsen scheduled replacing of smoke detectors on 2/5/15 after cases are complete in the OR corridors. Administrator notified Koorsen and also scheduled a walk thru with Koorsen to make sure no other smoke detectors were in violation with code. Walk through is scheduled on 2/5/15, the earliest appointment available. Administrator. 2/5/15 	02/05/2015

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K 105 Bldg. 01	<p>from 2:10 p.m. to 3:30 p.m. on 01/07/15, the smoke detector installed on the ceiling in the waiting area, at the entrance to the sterile corridor and in the corridor outside Operating Room 1 were each installed eight inches from an air supply vent. Based on interview at the time of the observations, the Administrator acknowledged the aforementioned three smoke detectors were each 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 1 of 5 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: (1) Interruption of normal lighting such as any failure of a public utility or other</p>	K 105	<p>1. Monthly Life Safety form has been updated to itemize each battery and mark the 90 minute testing for each battery from Jan to June. Every battery will be tested for 30 sec each month and initialed on the safety checklist. Freije Electrical has been notified to replace OR 5 battery light due to button is stuck. 2. Administrator updated the Life Safety checklist on 1-8-15. On 1-12-15 Administrator trained the Safety RN and safety Committee members on LSC 38.3.2.1 . Safety RN or an appointed person will test the batteries for 90 minutes on their appointed month per the safety checklist.(see attachment A) Person testing</p>	01/28/2015

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	<p>outside electrical power supply (2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities. 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 one patient and staff in the Procedure Room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 2:10 p.m. to 3:30 p.m. on 01/07/15, it could not be assured the battery operated emergency lighting system installed in the Procedure Room where general anesthesia can be used is functional. The test button on the lighting system would not depress. The lighting system failed to illuminate when the test button was pushed ten times. Based on interview at the time of observation, the Administrator stated patients in the Procedure Room can be completely sedated and rendered immobile using general anesthesia and an emergency generator is utilized to provide emergency lighting for the facility but acknowledged the battery</p>		<p>the battery will initial the form and notify administrator or Safety RN with any problems with the lights. Freije Electrical will replace OR 5 light on 1-28-15. 3. Safety RN will be responsible to make sure that all batteries are tested and in working order. She will report to Administrator. 4. 1/28/15</p>				

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K 114 Bldg. 01	<p>operated back up emergency lighting system installed in the Procedure Room to provide continuous illumination failed to operate when tested ten times.</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>1. Based on observation and interview, the facility failed to ensure doors in 1 of 1 fire barriers separating the facility from other tenants and occupancies were 1 3/4 inch thick, solid-bonded, wood core or equivalent and were equipped with a positive latching device. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 2:10 p.m. to 3:30 p.m. on 01/07/15, the main entrance door to the patient waiting room from the main lobby was a nonrated glass door and was not equipped</p>	K 114	<p>1. The entrance door from the main lobby of the building is a glass door that remains unlocked when employees, patients and families are in the building. The main glass entrance door has dual hinges to swing open and close either way. The entrance door remains closed at all times during the day. Per conversation with Daniel Kloc (Architect) and Dan Austill with ISDH he will take the atrium exception as long as the gasket/seal is taken care with the 1/4 inch gaps on both sides of the door. Plan of Correction: 1-28-15 Administrator repaired the 4 x 4 inch hole in the fire rated wall. 2-9-15 Brown Sprinkler was notified to look at adding Sprinklers to the lobby corridor to meet the exception of the nonrated glass. The original</p>	04/24/2015

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	<p>with a positive latching device. Based on interview at the time of observation, the Administrator acknowledged the aforementioned tenant separation door was not rated and was not equipped with a positive latching device.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 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> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 2:10 p.m. to 3:30 p.m. on 01/07/15, the following was noted:</p> <p>a. a four inch by four inch hole was noted in the one hour fire rated smoke barrier wall above the suspended ceiling in the waiting area.</p> <p>b. the tenant separation smoke barrier wall at the main entrance to the patient waiting room from the main lobby consisted of six nonrated glass panes which each measured ten feet tall by four feet wide and also consisted of a nonrated glass entrance door. A one half inch gap</p>		<p>installation and plan with cost will be submitted on 2/17/15. 2-17-15 spoke with AGM Architect he will submit a plan to add seal to the 6 panels that has 1/4in openings from ceiling to floor. 2-24-15 HCREIT, Brown Sprinkler, Vision drywall and painting and Center will meet to schedule a time for installation of the project. 2. The Administrator notified the building owners to discuss the entrance to our facility. HCREIT stated that the responsibility is with the tenant for repairs. Center Administrator is meeting with HCREIT and the contractors to schedule completion date to meet the LSC guidelines. Date TBD 3. Administrator 4. Pending : Meeting with contractors and HCREIT approx. date of completion 4/24/15.</p>		

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K 115 Bldg. 01	<p>was noted between each glass pane running ten feet from the floor to the suspended ceiling. In addition a one inch gap was noted on each side of the glass door on the handle side and on the hinge side of the door. Neither the glass wall, door or gaps maintained the one hour fire resistance rating of the smoke barrier wall. Based on interview at the time of the observations, the Administrator acknowledged the glass wall and door were not fire rated and the aforementioned gaps in the glass panes and the glass door failed to maintain the one hour fire resistance rating of the smoke barrier.</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 a positive latch. 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, 21.3.7.2</p> <p>Based on record review, observation and interview; the facility failed to ensure the suite was divided into at least two smoke compartments with smoke barriers having at least a 1 hour fire resistance rating or met an Exception. LSC 20.3.7.2 states an ambulatory health care facility</p>	K 115	<p>1(a). Administrator notified the Building tenant and the Center maintenance person to repair the 4 x4 inch hole in the 1 hour fire wall. Terry Christman will repair the hole on 1-28-15 once the patients have left the facility.</p> <p>2(a). Administrator and Matt</p>	04/24/2015

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	<p>shall be divided into not less than two smoke compartments.</p> <p>Exception No. 3: An area in an adjoining occupancy shall be permitted to serve as a smoke compartment for the ambulatory health care facility if the following criteria are met:</p> <p>(a) The separating wall and both compartments meet the requirements of 20.3.7.</p> <p>(b) The ambulatory health care facility is less than 22,500 square feet.</p> <p>(c) Access from the ambulatory health care facility to the other occupancy is unrestricted.</p> <p>This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on review of the facility's floor plan during record review with the Administrator from 10:15 a.m. to 2:10 p.m. on 01/07/15, the suite measures a total of 12,000 square feet in size. The only division of the suite into two smoke compartments with a one hour smoke barrier is in the tenant separation smoke barrier which separates the facility from other occupancies. Based on observations with the Administrator during a tour of the facility from 2:10</p>		<p>Tabler, Lauth Building manager will do a full inspection of the fire rated wall to make sure we have no other holes. Matt will review yearly to make sure no other holes develop. 3(a) Administrator will be in charge of scheduling the inspections. 4(a) Completion date 1-28-15 1(b) The entrance door from the main lobby of the building is a glass door that remains unlocked when employees, patients and families are in the building. The main glass entrance door has dual hinges to swing open and close either way. The entrance door remains closed at all times during the day. Per conversation with Daniel Kloc (Architect) and Dan Austill with ISDH he will take the atrium exception as long as the gasket/seal is taken care with the 1/4 inch gaps on both sides of the door. Plan of Correction: 1-28-15 Administrator repaired the 4 x 4 inch hole in the fire rated wall. 2-9-15 Brown Sprinkler was notified to look at adding Sprinklers to the lobby corridor to meet the exception of the nonrated glass. The original installation and plan with cost will be submitted on 2/17/15. 2-17-15 spoke with AGM Architect he will submit a plan to add seal to the 6 panels that has 1/4in openings from ceiling to floor. 2-24-15 HCREIT, Brown Sprinkler, Vision drywall and painting and Center will meet to schedule a time for installation of the project. 2(b)</p>				

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K 144 Bldg. 01	<p>p.m. to 3:30 p.m. on 01/07/15, the following was noted:</p> <p>a. a four inch by four inch hole was noted in the one hour fire rated smoke barrier wall above the suspended ceiling in the waiting area.</p> <p>b. the tenant separation smoke barrier wall at the main entrance to the patient waiting room from the main lobby consisted of six nonrated glass panes which each measured ten feet tall by four feet wide and also consisted of a nonrated glass entrance door. A one half inch gap was noted between each glass pane running ten feet from the floor to the suspended ceiling. In addition a one inch gap was noted on each side of the glass door on the handle side and on the hinge side of the door. Neither the glass wall, door or gaps maintained the one hour fire resistance rating of the smoke barrier wall. Based on interview at the time of the observations, the Administrator acknowledged the glass wall and door were not fire rated and the aforementioned gaps in the glass panes and the glass door failed to maintain the one hour fire resistance rating of the smoke barrier.</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.</p>		Administrator contacted the waiting room entrance glass door installer to review the glass rating and latch door lock. John/Ryan (1-317-472-7450) scheduled an appointment on 1-30-15 to review options to fix the door locking device. 3(b). Administrator 4(b) Pending : Meeting with contractors and HCREIT approx. date of completion 4/24/15.	

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	<p>3.4.4.1, NFPA 110</p> <p>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 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 Load Transfer Test" and "Generator Inspection 1.2" documentation with the Administrator during record review from 10:15 a.m. to 2:10 p.m. on 01/07/15, monthly load test documentation of emergency power transfer time for the twelve month period of January 2014 through December 2014 was not available for review. Based on interview at the time of record review, the</p>	K 144	<p>1. Administrator and Matt Tabler (Lauth Building Management) reviewed the monthly transfer log form and added a line that marks the "time" the transfer occurs when the generator is activated. McCallister Manufacturers were out and tested the transfer switch and as well as completed a PM1 on 1-20-15. Matt will perform a test on 1-23-15 to make sure the generator transfers over within 10 seconds.</p> <p>2. New form was approved by the Administrator for monthly testing. Administrator also changed the weekly generator form to the recommended ISDH form. Safety Committee will approve on 2-3-15 and Governing Board will review on 2/9/15. Administrator will review forms weekly and monthly to make sure that all parties are completing properly.</p> <p>3 Administrator and Nimroy Cannon will be responsible to make sure the testing is complete.</p> <p>4. 1-23-15</p>	01/23/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Administrator acknowledged monthly load test documentation of emergency power transfer time was not available for review for the aforementioned twelve month period.				