

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
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K010000	<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: 01/23/14</p> <p>Facility Number: 010525 Provider Number: 15C0001079 AIM Number: 200186370A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Naab Road 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>The facility located in a one 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.</p>	K010000		
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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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K010046	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/14.</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 Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1</p> <p>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 operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Written records of visual inspections and tests shall be kept by the owner for inspection</p>	K010046	Label all exit lights and all emergency lighting to reference blue print address location of each device. Implement monthly 30 second test and record test results in state book spread sheet. The Executive and Clinical Director will be responsible for making this is completed.	02/08/2014

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	<p>by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Fire Extinguisher Work Order" documentation dated 10/20/13 and "Emergency Lighting Affidavit" documentation signed by building maintenance on 01/03/13 with the Clinical Director during record review from 9:30 a.m. to 11:30 a.m. on 01/23/14, annual testing for each of six battery operated emergency lights in the facility were not itemized by location for tests conducted during the most recent twelve month period. The "Exit/Emergency Lights" section of Koorsen's "Fire Extinguisher Work Order" documentation listed the total number of devices tested for 90 minutes but did not itemize which device was an exit sign, which device was a battery operated emergency light and the result of the test. In addition, documentation of functional testing of battery operated lights at 30 day intervals for the most recent twelve month period was not available for review. The "Emergency Lighting Affidavit" documentation did not state the number of battery operated emergency lights tested for 90 minutes</p>						

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K010048	<p>and the location of the device tested. As a result, the total number of battery operated emergency lights in the facility which were tested and the individual device location could not be determined from the aforementioned documentation. Based on observations with the Clinical Director during a tour of the facility from 11:30 a.m. to 1:55 p.m. on 01/23/14, a battery operated emergency light was observed in each of six operating rooms and each light functioned when their respective test button was pushed. Based on interview at the time of record review, the Clinical Director acknowledged documentation of functional testing at 30 day intervals for each of six battery operated lights for the most recent twelve month period was not available for review and annual testing for each of six battery operated emergency lights in the facility was not itemized by location for tests conducted during the most recent twelve month period.</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</p>	K010048	Add 5 categories for notification to the ASC's current fire watch	02/04/2014

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	<p>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 review of "Cornerstone Companies, Inc. Life Safety Code NFPA 101 Fire Watch Policies" documentation with the Clinical Director during record review from 9:30 a.m. to 11:30 a.m. on 01/23/14, the facility's written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period did not include notification of the Indiana State Department of Health which is the authority having jurisdiction. Based on interview at the time of record review, the Clinical Director stated Cornerstone Companies is the building manager and acknowledged the written fire watch policy did not include notification of the Indiana State Department of Health in</p>		<p>policy. The Executive and Clinical Director will be responsible for monitoring this.</p>		

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	<p>the event the fire alarm system is out of service for four hours or more in a twenty four hour period.</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 review of "Cornerstone Companies, Inc. Life Safety Code NFPA</p>			

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	101 Fire Watch Policies" documentation with the Clinical Director during record review from 9:30 a.m. to 11:30 a.m. on 01/23/14, the facility's written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period did not include notification of the Indiana State Department of Health which is the authority having jurisdiction. In addition, the aforementioned fire watch policy for sprinkler impairment did not include notification of the insurance carrier, alarm company and building owner. Based on interview at the time of record review, the Clinical Director stated Cornerstone Companies is the building manager and acknowledged the written fire watch policy did not include notification of the Indiana State Department of Health, insurance carrier, alarm company and building owner in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period.				

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K010051	<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, observation and interview; the facility failed to ensure 6 of 43 smoke detectors in the facility were installed where air flow would not adversely affect its operation. LSC 21.3.4.1 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:</p> <p>Based on review of Koorsen Fire & Security "Inspection Test Report" documentation dated 05/11/13, a total of 43 smoke detectors are installed in the building. Based on observations with the Clinical Director during a tour of the facility from 11:30 a.m. to 1:55 p.m. on</p>	K010051	NRSC will move 6 smoke detectors or HVAC diffusers to create a 3 foot distance between a return or supply air diffuser per Koorsen's report and Life Safety Inspectors violations report. The Executive and Clinical director will be responsible for making sure this is completed.	03/14/2014			

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K010067	<p>01/23/14, each of the following six smoke detector locations was installed on the ceiling less than three feet from a supply or return vent:</p> <ul style="list-style-type: none"> a. in the east side of the patient waiting area and on the west side of the patient waiting area. b. in the lobby leading to the patient waiting area. c. in the corridor by the Minor Procedure Room. d. in the corridor in the surgical suite outside the Male Dressing Area. e. in the corridor in the surgical suite outside Operating Room 1. <p>Based on interview at the time of the observations, the Clinical Director acknowledged the aforementioned smoke detectors were each installed on the ceiling less than three feet from a supply or return vent.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Heating, ventilating, and air-conditioning comply with the manufacturer's specifications and section 9.2. 20.5.2.1, 21.5.2.1</p>			

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	<p>Based on record review, observation and interview; the facility failed to ensure 2 of 2 of fire dampers observed in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects one staff in the Main Mechanical Room.</p> <p>Findings include:</p> <p>Based on record review with the Clinical Director from 9:30 a.m. to 11:30 a.m. on 01/23/14, documentation of facility fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observations with the Clinical Director during a tour of the facility from 11:30 a.m. to 1:55 p.m. on</p>	K010067	NRSC ensure that landlord will contract to test and service all smoke/fire dampers and all fire dampers. Record test results in state book on provided spread sheet every 4 years. Mark location address on ceiling grid for easy identification below ceiling. Start testing immediately for year of 2014 LS compliance. The Executive and Clinical Director will ensure this is completed and monitored going forward.	03/14/2014			

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K010076	<p>01/23/14, two fire dampers were observed in ductwork in the Main Mechanical Room. Based on interview at the time of record review and of the observations, the Clinical Director acknowledged documentation of fire damper inspection and maintenance within the last four years was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities, and NFPA 101.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside.</p> <p>4.3.1.1.2, 20.3.2.4, 21.3.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 1 piped gas system supply areas was enclosed with a separation of 1 hour fire resistive construction. NFPA 99, Standard for Health Care Facilities, Section</p>	K010076	NRSC will ensure that landlord address areas in the Med Gas room to ensure One Hour fire rating. The Executive and Clinical Directors will be in charge of ensuring this is completed.	03/14/2014

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	<p>4-3.1.1.2(a)2 states nonflammable gas storage and supply areas for piped gas systems, in storage, connected or both, shall be in an enclosure with a fire resistive rating of at least one hour. This deficient practice could affect six patients.</p> <p>Findings include:</p> <p>Based on observations with the Clinical Director during a tour of the facility from 11:30 a.m. to 1:55 p.m. on 01/23/14, the ceiling of the piped gas supply area consisted of one layer of 5/8th inch drywall which exposed the underside of the roof deck above and did not enclose the supply area with a separation of 1 hour fire resistive construction. In addition, the three inch annular space surrounding each of two, one inch in diameter pipes penetrating the ceiling was not firestopped. The one inch annular space surrounding each of seven pipes measuring one half inch in diameter penetrated the ceiling and were also not firestopped. Based on interview at the time of the observations, the Clinical Director acknowledged the ceiling and the aforementioned openings in the ceiling of the piped gas supply area did not provide one hour fire resistive construction.</p>						

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was vented to the outside. NFPA 99, Standard for Health Care Facilities, Section 4-3.1.1.2(a)10 c. requires adequate ventilation for piped gas supply systems and storage areas. Section 4.3.1.1.2(b)4 states locations for supply systems of more than 3000 cubic feet total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent or openings shall be a minimum of 72 square inches in total free area. This deficient practice could affect all patients.</p> <p>Findings include:</p> <p>Based on observation with the Clinical Director during a tour of the facility from 11:30 a.m. to 1:55 p.m. on 01/23/14, the louvered entry door from the outside of the building into the piped in medical gas systems storage and supply room provided the only natural or mechanical vent to the outside. The entry door to the piped in medical gas systems storage and supply room did not open onto an exit access corridor for the facility. The louvered portion of the entry door was completely covered with</p>			
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	cardboard to prevent cold air from entering the room. Based on interview at the time of observation, the Clinical Director acknowledged the louvered entry door from the outside of the building into the piped in medical gas systems storage and supply room provided the only natural or mechanical vent to the outside and was completely covered with cardboard to prevent cold air from entering the room. Based on a telephone interview at 10:30 a.m. on 01/24/14, the Clinical Director stated the piped in medical gas systems storage and supply room total storage capacity (connected and in storage) was in excess of 3000 cubic feet but less than 20,000 cubic feet, the louvered portion of the entry door measured 102 square inches and was entirely covered with cardboard which prevented natural venting of the aforementioned medical gas systems storage and supply room.				

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K010078	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities and NFPA 101.</p> <p>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.</p> <p>(b) Relative humidity is maintained equal to or greater than 35%.</p> <p>NFPA 99, 4.3.1.2.3(n) and 5.4.1.1, 20.3.2.2, 21.3.3.2 Based on record review and interview, the facility failed to ensure relative humidity was maintained equal to or greater than 35 % in 6 of 6 operating rooms. This deficient practice could affect six patients and staff.</p> <p>Findings include:</p> <p>Based on record review with the Clinical Director from 9:30 a.m. to 11:30 a.m. on 01/23/14, the relative humidity is not monitored and documented for each of six anesthetizing locations in the facility. Based on interview at the time of record review, the Clinical Director stated patients in each of the six operating rooms can be completely sedated using an intravenous injection of propofol and acknowledged relative humidity is not monitored and documented to ensure</p>	K010078	NRSC will have digital hygrometers installed in each of the ORS to monitor humidity. The Clinical Director will be responsible for tracking the humidity in each of the ORS.	02/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2014
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	relative humidity was maintained equal to or greater than 35 % in 6 of 6 procedure rooms.			