

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001017	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304
---	--

(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
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: 06/19/14</p> <p>Facility Number: 005398 Provider Number: 15C0001017 AIM Number: 100274250A</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Muncie Eye Specialists Surgery Center 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 first floor of a two story building of Type II (000) construction with a basement was fully sprinklered. The facility has a fire alarm system with smoke detectors in the corridors and in common areas.</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001017		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2014	
NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304			
(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			
K010046	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/26/14.</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 observations and interview, the facility failed to provide emergency lighting in 2 of 2 operating rooms. 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:</p> <p>(1) Interruption of normal lighting such as any failure of a public utility or other 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.</p> <p>LSC Section 7.9.2.5 requires the emergency lighting system to either be in continuous operation or be capable of</p>	K010046	The emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. The facility is installing battery operated emergency lights in each operating room. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001017	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304
---	--

(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
	<p>repeated automatic operation without manual intervention. This deficient practice could any patient or staff in the operating room.</p> <p>Findings include:</p> <p>Based on observations on 06/19/14 from 12:45 p.m. to 12:59 p.m. with the Office Manager, there was no battery operated emergency lighting to provide continuous illumination in the two operating rooms in the facility. Based on interview on 06/19/14 concurrent with the observations, the Office Manager acknowledged an emergency generator is utilized to provide emergency lighting in the operating room but there is no battery operated back up emergency lighting system to provide continuous illumination in the operating room during the time it takes for the generator to resume electrical service.</p>			