

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001142	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2012
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4715 STATESMEN DR STE A INDIANAPOLIS, IN 46250
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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: 11/08/12</p> <p>Facility Number: 004157 Provider Number: 15C0001142 AIM Number: 200805390A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sycamore Springs 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 20, New Ambulatory Health Care Occupancies.</p> <p>This facility located in a one story building determined to be of Type II (000) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in all areas open to the corridor and in all patient rooms.</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.

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K010048	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/13/12.</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 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. In addition, LSC Section A.9.6.1.8 states a fire watch should at least involve some special action beyond normal staffing, such as assigning an individual specially trained in the particular fire safety situation to walk the areas affected. This deficient practice could affect all patients, staff,</p>	K010048	<p>We are in the process of revising our fire policies to include a fire watch if our sprinkler system is out of service for greater than 4 hours, staff involved and notification of the ISDH of the fire watch. This policy will be complete by 12-15-12 then approved by the Board by 12-31-12. The administrator is responsible for completing this task so as not to be cited in the future.</p>	12/31/2012

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on review of "Life Safety Management Plan: Failure of Fire Alarm System" documentation with the Administrator during record review from 9:20 a.m. to 10:55 a.m. on 11/08/12, the facility's written policy in the event the fire alarm system has to be placed out of service did not include:</p> <ol style="list-style-type: none"> a. a statement of the building being evacuated or a fire watch be conducted in the event the fire alarm system is out of service for four hours or more in a twenty four hour period. b. a statement identifying an individual to conduct the fire watch and who will have no other duties during the fire watch. c. notification of the Indiana State Department of Health which is the authority having jurisdiction. <p>Based on interview at the time of record review, the Administrator acknowledged the written fire watch policy did not include the aforementioned statements.</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</p>			

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	<p>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 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 occupants of the facility including patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "Life Safety Management Plan: Failure and Repair of</p>			

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K010050	<p>the Automatic Sprinkler System" documentation with the Administrator during record review from 9:20 a.m. to 10:55 a.m. on 11/08/12, the facility's written policy in the event the automatic sprinkler system has to be placed out of service did not include:</p> <p>a. a statement of the building being evacuated or a fire watch would be conducted in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period.</p> <p>b. a statement identifying an individual to conduct the fire watch and who will have no other duties during the fire watch.</p> <p>c. notification of the Indiana State Department of Health which is the authority having jurisdiction and notification of the local fire department, the insurance carrier, alarm company and building owner or manager.</p> <p>Based on interview at the time of record review, the Administrator acknowledged the written fire watch policy did not include the aforementioned statements.</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</p>			

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	<p>of established routine. 20.7.1.2, 21.7.1.2 Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 4 of 4 quarterly fire drills. LSC 20.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" documentation with the Administrator during record review from 9:20 a.m. to 10:55 a.m. on 11/08/12, all four quarterly fire drills conducted on the first shift on 11/20/11, 02/10/12, 06/27/12 and 08/23/12 did not include documentation of the transmission of the fire alarm signal. Based on interview at the time of record review, the Administrator acknowledged documentation for first shift fire drills did not include the transmission of the fire alarm signal.</p>	K010050	Our fire drill form that is used to review the drill now includes a check box and space for time the alarm was transmitted to our monitoring company. This was completed 11-9-12. The administrator is responsible for this form.	11/09/2012			

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K010105	<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 2 of 2 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:</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>	K010105	Battery operated back-up lighting has been installed in both of our operating rooms as per the citation. They were installed 11-14-12. The administrator was responsible for getting this completed.	11/14/2012

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K010144	<p>repeated automatic operation without manual intervention. This deficient practice could affect two patients and staff in the two operating rooms.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator from 10:55 a.m. to 11:50 a.m. on 11/08/12, battery operated emergency lighting to provide continuous illumination was not provided in each of the two operating rooms in the facility. Based on interview at the time of the observations, the Administrator stated patients in each operating room can be completely sedated and rendered immobile using general anesthesia. Based on interview at the time of observation, the Administrator acknowledged an emergency generator is utilized to provide emergency lighting in each of the two operating rooms but there is no battery operated back up emergency lighting system to provide continuous illumination in each operating room.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p>			

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	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110</p> <p>1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing of 2 of 12 months. NFPA 99, the Standard for Health Care Facilities, Chapter 3-4.4.1.1 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator 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 Buckeye Power Sales "Service Report" documentation with the Administrator during record review from 9:20 a.m. to 10:55 a.m. on 11/08/12,</p>	K010144	<p>Our generator has a kill switch but it is within the outer shell. There will be an our kill switch installed by 12-14-12. The administrator is responsible for this. We have been in communications with our generator service provider in order to ensure we will in the future receive the more detailed reports instead of just the service write up, from them each and every time they service our unit showing the transfer times. This was completed 11-30-12. Our administrator is responsible for this. We have also made sure for our QA program monitoring and regulations that when we have to reschedule generator testing due to patient care that they are rescheduled within the month so as to meet the required monthly service. We are developing a procedure for this, for our front office staff. It will be complete by 12-14-12. Our administrator is responsible for this.</p>	12/14/2012

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	<p>monthly load test documentation for February 2012 and August 2012 was not available for review. Based on interview at the time of record review, the Administrator stated Buckeye Power Sales performs monthly load testing on the facility's behalf and acknowledged monthly load test documentation for February 2012 and August 2012 was not available for review.</p> <p>2. 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 11 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 Buckeye Power Sales</p>			

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	<p>"Service Report" documentation with the Administrator during record review from 9:20 a.m. to 10:55 a.m. on 11/08/12, monthly load test documentation of emergency power transfer time for the period of October 2011 through October 2012 was not available for review for 11 of 12 months. Based on interview at the time of record review, the Administrator stated Buckeye Power Sales performs monthly load testing on the facility's behalf and acknowledged monthly load test documentation of emergency power transfer time was not available for review for eleven months of the aforementioned twelve month period.</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 I 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 residents, staff and visitors.</p>			

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator from 10:55 a.m. to 11:50 a.m. on 11/08/12, a remote shut off device was not found for the 150 kW diesel fired emergency generator. Based on interview at the time of observation, the Administrator stated the emergency generator was installed after 2003 and acknowledged there is no remote emergency shut off device for the emergency generator.</p>			