

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/19/2015
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NAME OF PROVIDER OR SUPPLIER  SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
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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: 10/19/15</p> <p>Facility Number: 009971 Provider Number: 15C0001069 AIM Number: 200145120A</p> <p>At this Life Safety Code survey, Surgicare 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>This facility, located on the first floor of a split level two story building, was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p> <p>Quality Review completed on 10/23/15 - DA</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>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>1. Based on record review, observation and interview; the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 2 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices including but not limited to, mechanical water motor gongs, vane-type waterflow devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all patients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Tri-State Fire Protection "Fire Sprinkler Inspection Report" documentation dated 12/11/14 and 06/24/15 with the Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, quarterly sprinkler waterflow device inspection documentation for the first quarter (January, February, March) and third quarter (July, August,</p>	K 0012	<p>K 012 416.44 (b) (1) 1. 1) Tri-State Fire Protection notified to begin quarterly inspections Nov 2015, Feb. 2016, May 2016, August 2016, and each calendar quarter thereafter. 2) Schedule for quarterly inspections will be scheduled and maintained with Tri-State. 3) Administrator responsible to schedule date of quarterly inspections. 4) Date of quarterly inspections began Nov. 10, 2015 2. 1) Policy "Fire Watch during System Impairment" devised to determine what is to be done if sprinkler/alarm system is out of service for 4 hours or more in a 24 hour period. Persons to be notified including name and contact phone number. "Fire Watch Log" devised for monitoring. 2) Sprinkler alarm system monitored by Tri-State Fire Protection with Administrator's name, office phone number, and cell phone number in case of sprinkler/alarm impairment. Alarm system/panel monitored in west mechanical room weekly. 3) Administrator will monitor and assign "fire watch" person should an impairment occur. 4) Date of</p>	11/10/2015

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	<p>September) 2015 was not available for review. Based on interview at the time of record review, the Administrator acknowledged quarterly sprinkler waterflow device inspection documentation for the first quarter and third quarter 2015 was not available for review. Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the hanging tag affixed to the sprinkler system riser in the Mechanical Room by Tri-State Fire Protection indicated 06/24/15 as the only documented quarterly sprinkler waterflow alarm device inspection within the most recent twelve month period.</p> <p>2. 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 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</p>		quarterly inspections began Nov. 10, 2015 and will be completed each quarter.				

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K 0020  Bldg. 01	<p>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 Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, 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 Administrator acknowledged 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.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Vertical openings such as stairways, elevator shaftways, escalators, and building service shaftways are enclosed in accordance with section 8.2.5. 8.2.5.2, 38.3.1, 39.3.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical</p>	K 0020	K 020 416.44 (b) (1) 1) Progressive Construction and Development (PCD) notified by	11/19/2015

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	<p>opening stairwell doors were provided with self-closing devices. LSC 8.2.5.4 refers to 7.1.3.2 for enclosure of exits. 7.1.3.2.1 requires the separating construction shall meet the requirements of Section 8.2 and the following: (a) the separation shall have not less than a 1-hour fire resistance rating where the exit connects three stories or less. (c) Openings in the separation shall be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. LSC 7.2.1.8 states a door normally required to be kept closed shall not be secured in the open position at any time and shall be self closing or automatic closing in accordance with 7.2.1.8.2. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the northeast stairwell door on the lower level was not equipped with a latching mechanism to allow the door to self close and latch the door into the door frame. Based on interview at the time of observation, the Administrator acknowledged the northeast stairwell door on the lower level was not equipped with a latching mechanism to allow the</p>		<p>administrator northeast stairwell door did not contain latching mechanism. 2) PCD has ordered materials to install latching device to northeast stairwell door. 3) Administrator will monitor progress of completion of installation by contractor, Robert Stancombe. 4) Installation to be completed 11/19/2015</p>	

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K 0021  Bldg. 01	<p>door to self close and latch the door into the door frame.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 stairwell exit doors latched into the door frame. LSC 21.2.2.1 says the means of egress shall be limited to the types described in 39.2.2. LSC 39.2.2.2.1 says doors complying with 7.2.1 shall be provided and 7.2.1.1.1 says a door assembly shall conform to the general requirements of Section 7.1. LSC 7.1.3.2.1 states an exit required to be separated from other parts of the building shall be separated with not less than one hour fire resistance rating where the exit connects three stories or less and 7.1.3.2.1(c) requires openings in the separation shall be protected by fire door assemblies. NFPA 80, Standard for Fire Doors and Fire Windows, at 2-1.4 requires all swinging doors to be closed and latched at the time of fire and 2-1.4.1 requires the door to</p>	K 0021	<p>K 021 416.44 (b) (1) 1) PCD notified by administrator 2) PCD has ordered materials for installation of latching panic device to northeast stairwell door. 3) Administrator will monitor until completion of installation by contractor is completed 4) Installation scheduled to be completed 11/19/2015</p>	11/19/2015

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K 0029 Bldg. 01	<p>close and latch each time it is opened. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the northeast stairwell door on the lower level was not equipped with a latching mechanism to allow the door to self close and latch the door into the door frame. Based on interview at the time of observation, the Administrator acknowledged the northeast stairwell door on the lower level was not equipped with a latching mechanism to allow the door to self close and latch the door into the door frame.</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 2 hazardous areas corridor doors latched into the door frame. LSC 38.3.2.1 states hazardous areas such as general storage areas shall</p>	K 0029	K 029 416.44 (b) (1) 1) PCD notified by administrator door to dirty utility room was not equipped with latching mechanism. 2) PCD has ordered materials to install full mortise lockset	11/19/2015	

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K 0046  Bldg. 01	<p>be protected in accordance with Section 8.4. Section 8.4.1.2 states the area shall be enclosed with smoke resistant partitions in 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 all patients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the Dirty Utility Room corridor door was equipped with a self closing device but was not equipped with a latching mechanism to latch the door into the door frame. The aforementioned storage room contained two red bag hazardous waste bins and one trash bag filled with trash. Based on interview at the time of observation, the Administrator acknowledged the corridor door to the aforementioned hazardous area failed to latch into the door frame.</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>passage function for the latching mechanism on door frame of dirty utility room to corridor. 3) Administrator will monitor progress of completion by contractor. 4) Installation of full mortise lockset passage function on door is scheduled to be completed 11/19/2015.</p>	

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	<p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 4 of 4 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 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. 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 and staff.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, documentation of 30 second functional testing conducted at 30 day intervals and annual 90 minute testing for battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on</p>	K 0046	<p>K 046 416.44 (b) (1) 1) Battery operated Emergency Light Test Log has been devised to be included in scheduled monthly preventative maintenance, 30 second function test will be conducted monthly and 90 minute function test will be conducted annually. Unit location OR 1, OR 2, Procedure Room 1, Procedure 2, and unit outside Mechanical Room. 2) Testing on emergency lights will be conducted on monthly basis for 30 seconds. Annual testing will be done in December of each year. Emergency lighting system in Procedure room 1 scheduled to be replaced by Progressive Construction &amp; Development 11/24/2015. 3) Administrator will be responsible for quarterly and annual testing. 4) Monthly inspections began 11/2/2015, annual inspection will begin December upon completion of installation of new emergency light system 11/24/2015.</p>	11/24/2015

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K 0048 Bldg. 01	<p>10/19/15, Operating Room 1 (OR1), OR2 and each of the two Procedure Rooms are provided with battery operated emergency lighting to provide continuous illumination. Each of the four room's battery operated emergency lighting systems functioned when their respective test button was pushed five separate times except for the lighting system in Procedure Room 1 which failed to illuminate. Based on interview at the time of the observations, the Administrator acknowledged documentation of 30 second functional testing conducted at 30 day intervals and annual 90 minute testing for battery powered emergency lights in the facility for the most recent twelve month period was not available for review.</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 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</p>	K 0048	<p>K 048 416.44 (b) (1) 1. (1) Vanguard Alarm Systems and Tri-State Fire Protection notified to begin quarterly inspections to commence November 2015, and each calendar quarter thereafter. (2) "Fire Watch during System Impairment should sprinkler/alarm be impaired for 4 hours or more in a 24 hour period. Fire Watch Log will be initiated to begin continuous tours</p>	11/10/2015

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	<p>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 Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, 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 Administrator acknowledged 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.</p> <p>2. Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 21.7.2.2.</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area</p>		<p>at 30 minute intervals at start of "fire watch" and every 30 minutes until system is back on line. Nurse will be assigned watch duty and report any problems found to administrator. Vanguard Alarm System, Tri-State FireProtection, Central Security Communications, Robert Stancombe, and Bloomington Fire Department will be notified of watch. (3) Administrator developed fire watch protocol and will monitor systems should an impairment occur. (4) Policy devised for Fire Watch and Log 11/04/2015. 2. (1). "SurgiCare Fire and Evacuation Policy" and "Response:Fire-Code Red have been revised. Development of plan establishes primary responsibilities of each staff member in event of fire. Sequence of events to be followed per policy; Smoke barriers are identified behind each corridor wall. Progressive Construction &amp; Development will provide floor plan denoting smoke and one hour barrier walls which will be included in policy for reference. a) Rescue people in immediate danger b)Activate fire pull, alert staff, call 9-911 c) Confine fire to minimize danger by makingsure all doors are closed d) Extinguish with use of fire extinguisher, evacuate each area and move to "safety zone" located in parking area left of facilities main door southeast of building. (2)Administrator will</p>		

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K 0050	<p>(6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all patients, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Surgicare: Fire &amp; Evacuation" documentation with the Administrator during record review from 9:50 a.m. to 12:00 p.m. on 10/19/15, the written health care occupancy fire safety plan for the facility did not identify the set of smoke barriers in the facility for evacuation of a smoke compartment in the event of an emergency. The "Evacuation" section of the aforementioned plan stated "transfer the patients to a designated area that is beyond the first set of smoke barriers" but did not identify the location of smoke barriers for smoke compartment evacuation purposes in the facility.</p> <p>Based on interview at the time of record review, the Administrator acknowledged smoke barriers are not identified in the written fire safety plan for the facility for evacuation purposes in the event of an emergency.</p>				<p>designate person in charge to carry out said duties in event of fire. Policy will be reviewed on annual basis, present to Board for approval. (3)Administrator will be responsible. (4) Policies revised and will seek approval at Board of Managers meeting 11/10/2015.</p>		
	416.44(b)(1)						

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Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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 document fire drills on the first shift for 4 of 4 quarters. This deficient practice affects all patients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, documentation of a fire drill conducted on the first shift (8:00 a.m. to 5:00 p.m.) for the fourth quarter of 2014 (October, November, December), the first quarter (January, February, March), the second quarter (April, May, June) and the third quarter (July, August, September) of 2015 was not available for review. Based on interview at the time of record review, the Administrator stated the facility operates one shift per day and acknowledged documentation of fire drills conducted on the first shift for the aforementioned calendar quarters was not available for review.</p>	K 0050	<p>K 050 416.44 (b) (1) 1. Fire Drill was conducted 11/02/2015. Sandra Luman activated fire alarm in OR corridor at 1332. Central Security Communications and Tri-State fire Protection notified of drill by Laura Corron. 2. Fire drills will be conducted on quarterly basis with all staff members participating. Drill will be evaluated and critiqued using "Fire Drill Evaluation Tool" and findings will be discussed at staff meeting. 3. Administrator and Sandra Luman will be responsible for conduction of fire drills. 4. Fire Drills will be conducted in February, May, August, and November with mandatory fire control and evacuation procedures reviewed with demonstrations by Scott Smith, FirePrevention Safety Officer in April 2016.</p>	11/02/2015			
K 0051 Bldg. 01	<p>416.44(b)(1) <b>LIFE SAFETY CODE STANDARD</b> A manual fire alarm system, not a pre-signal type, is provided to automatically warn the</p>						

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 main fire alarm control panels, located in an area that was not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all patients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the main fire alarm control panel located in the enclosed Mechanical Room was not provided with automatic smoke detection. Based on interview at the time of observation, the Administrator acknowledged the main fire alarm control panel location was not</p>	K 0051	K 051 416.44 (b) (1) 1. Progressive Construction & Development notified by administrator Mechanical Room was not equipped with automatic smoke detection. 2. Automatic smoke detector will be placed in west Mechanical Room where main fire alarm control panel is located. 3. Administrator will monitor completion of installation by contractor. 4. Installation in progress, to be completed 11/13/2015.	11/13/2015

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K 0114 Bldg. 01	<p>provided with automatic smoke detection.</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 maintain 1 of 1 one hour fire barriers separating it from an adjoining tenant. LSC Section 21.3.7.1 requires ambulatory health care facilities to provide fire barriers with one hour fire resistance rating for tenant separation. LSC 21.3.7.3 requires any smoke barrier to be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one hour. LSC Section 8.3.6.1 states annular spaces caused by penetrations in fire barriers from pipes and conduits shall be filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier.</p>	K 0114	<p>K 114 416.44 (b) (1) 1. 1). Progressive Construction &amp;Development (PCD) notified tenant separation fire barrier was not adequately sealed to maintain fire resistant barrier. Fire caulking/spray will be used to seal annular spaces and PVC pipes in tenant separation wall located above ceiling in Administrator/Business Office located near exit door to foyer of Summit Urology Imaging. 2). PCD will install fire caulking/spray to areas in tenant separation fire wall above the suspended ceiling. 3). Administrator will monitor progress of completion of installation. 4). Installation ofcaulking/spray to be completed 11/24/2015. 2. 1) PCD notified by administrator tenant separation door between Business Office and foyer of Summit Urology Imaging was not equipped with self-closing door. 2) Materials ordered by PCD to install regular</p>	11/24/2015

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	<p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the following openings were noted in the tenant separation fire wall:</p> <p>a. the four inch annular space surrounding one three inch in diameter PVC pipe and the two inch annular space surrounding three one inch in diameter conduits which penetrated the tenant separation fire wall above the suspended ceiling near the exit door to the foyer for Summit Imaging. In addition, a four inch in diameter hole was also noted next to the penetrations.</p> <p>b. a ten inch by six inch hole for the passage of a six inch in diameter PVC pipe and an eight inch in diameter hole for the passage of a six inch in diameter PVC pipe were noted in the tenant separation fire wall above the suspended ceiling in the Administrators Office. Based on interview at the time of the observations, the Administrator acknowledged the aforementioned openings in the tenant separation fire barrier were not filled with a material to maintain the fire resistance of the fire barrier.</p> <p>2. Based on observation and interview,</p>		<p>mount closer. 3) Administrator will monitor progress of completion of installation. 4) Installation to be completed 11/19/2015.</p>	

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K 0144 Bldg. 01	<p>the facility failed to ensure 1 of 1 doors in the tenant separation fire barrier wall was self closing. LSC Section 21.3.7.1 states doors in tenant separation fire barriers shall be constructed of not less than 1 3/4 inch solid bonded wood core or the equivalent and shall be equipped with positive latches. These doors shall be self closing and shall be kept in the closed position except when in use. 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 12:00 p.m. to 1:20 p.m. on 10/19/15, the exit door in the tenant separation fire barrier in the Office area which leads into the foyer for Summit Imaging was not equipped with a self closing device. Based on interview at the time of observation, the Administrator acknowledged the exit door in the tenant separation fire barrier in the Office area which leads into the foyer for Summit Imaging was not equipped with a self closing device.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and</p>			

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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.</p> <p>NFPA 110, 6-4.2.2 states diesel powered</p>	K 0144	<p>K 144 416.44 (b) (1) 1. Buckeye Power contacted and visited facility. Provided administrator instruction for Kohler generator, model # K 168341-0225. Demonstration given by Danny Volner: 1)battery voltage 2) lubricating system/ oil level 3) cooling system/ coolant level 4) fuel system/natural gas 5) exhaust system 6)engine/air filter 7)electrical system/ generator 8) automatic transfer system 9) operational readings-emergency system operation without load transfer, shut down function,emergency stop, oil pressure, and voltage. "Cold start" test performed to simulate power failure. Monthly load testing performed and formula demonstrated to obtain proper readings, operating temperature, and percentage of load capacity and exhaust gas temperature.</p> <p>2. "Emergency Generator Weekly Inspection Checklist" has been devised to monitor: A.general condition of generator B.condition of belts and hoses C.engine oil level D.cooling system E.battery system F.exhaust system G.fuel system Monthly generator log will be revised to include operating temperature and percentage of load capacity. Generator scheduled to run on emergency power on Tuesdays for 30</p>	11/20/2015

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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 Checks" documentation with the Administrator during record review from 9:50 a.m. to 12:00 p.m. on 10/19/15, monthly load testing documentation for the emergency generator for the twelve month period of November 2014 through October 2015 did 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 Administrator stated the emergency generator is load tested on a monthly basis but 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>minutes and will be monitored for recordkeeping. Buckeye Power will be notified if problems occur.</p> <p>3. Administrator will perform, monitor, and document weekly and monthly generator checks.</p> <p>4. Implementation of weekly/monthly inspection will commence 11/09/2015. 3. 1) Vectren Energy notified 10/29/2015 to request letter of reliability from natural gas vendor to include: a) statement of reliability of natural gas delivery b) brief description to support statement c) low probability of interruption statement d) brief description to support statement e) signature of technical personnel from Vectren Energy</p> <p>2) Follow up phone call requesting letter of reliability 11/05/2015 3) Administrator will continue to contact Vectren Energy for completion of letter 4) Letter of reliability to be received no later than 11/18/2015. 4. 1) Progressive Construction &amp; Development (PCD) notified of requirement of emergency lighting system to be located outside of mechanical room door near generator should problems occur after facility operating hours. 2) PCD has ordered emergency exterior lighting system for installation. 3) Administrator will monitor progress of installation of lighting system. 4) Installation to be completed by contractor 11/20/2015.</p>		

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	<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 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 Checks" documentation with the Administrator during record review from 9:50 a.m. to 12:00 p.m. on 10/19/15, documentation of emergency power transfer time to the emergency generator for monthly load testing documentation for the twelve month period of November 2014 through October 2015 was not available for review. Based on interview at the time of record review, the Administrator acknowledged emergency</p>						

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	<p>power transfer time for monthly load testing documentation for the aforementioned twelve month period was not available for review.</p> <p>3. Based on record review, observation and interview; the facility failed to ensure the offsite fuel source for the emergency generator was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source.</p>			

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	<p>CMS (Centers for Medicare/Medicaid Services) require a letter of reliability from the natural gas vendor regarding the fuel supply that must contain all of the following:</p> <ol style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery</li> <li>2. A brief description that supports the statement regarding the reliability</li> <li>3. A statement that there is a low probability of interruption of the natural gas</li> <li>4. A brief description that supports the statement regarding the low probability of interruption</li> <li>5. The signature of technical personnel from the natural gas vendor.</li> </ol> <p>This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 9:50 a.m. to 12:00 p.m. on 10/19/15, documentation of the reliability of the offsite fuel source for the emergency generator was not available for review. Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the offsite fuel source for the emergency generator is natural gas. Based on interview at the time of record review and of observation, the</p>						

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	<p>Administrator acknowledged the facility did not have documentation from their natural gas provider indicating the natural gas was from a reliable source.</p> <p>4. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with LSC Section 7.9.2.3. 7.9.2.3 requires that emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 12:00 p.m. to 1:20 p.m. on 10/19/15, the emergency generator was located outside the building within a four foot high enclosure with a gate and lacked battery powered emergency lighting. Based on interview at the time of observation, the Administrator</p>			

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	acknowledged the emergency generator location was not provided with battery powered emergency lighting.				