

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001065	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/10/2013
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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7900 W JEFFERSON BOULEVARD, SUITE 102 FORT WAYNE, IN 46804
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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: 06/10/13</p> <p>Facility Number: 009566 Provider Number: 15C0001065 AIM Number: 200138850A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The 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 Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>The facility is located on the first floor of a three story building determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and operating rooms.</p> <p>Quality Review by Robert Booher, Life</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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	<p>Safety Code Specialist-Medical Surveyor on 06/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010029	<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>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 biohazard/trash rooms was provided with a door equipped with a self closing device that would cause the door to automatically close and latch into the door frame. This deficient practice could affect up to 2 patients in the operating room area.</p> <p>Findings include:</p> <p>Based on observation with the Director on 06/10/13 at 2:29 p.m., the biohazard/trash room corridor door failed to latch into the door frame. This was confirmed by the Director at the time of observation.</p> <p>2. Based on observation and interview, the facility failed to enclose 1 of 3 hazardous areas with smoke resistant partitions and doors. This deficient practice could affect any occupant evacuated through the back exit in the event of an emergency.</p>	K010029	<p>On the day of the survey, the fire doors that would not completely latch on automatic closing were noted to be askew at the hinges in the door frame. The Director asked that a work order be submitted to Maintenance reporting the fire doors that did not latch automatically. The work order was dated 6/17/13. These doors are being inspected and adjusted today 7/3/13 to correct the non-latching automatic closures. For future monitoring, the Director will conduct spot checks on these doors to verify the automatic latching is functioning. The Director assigned the large trash receptacle in the back exit corridor to be moved to the Soiled Utility Room. Cleaning supplies were moved to a different supply storage area to make room in the Soiled Utility Room. This was completed 6/25/13.</p>	07/03/2013

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	<p>Findings include:</p> <p>Based on observation with the Director on 06/10/13 at 1:35 p.m., there was a plastic container overflowing with trash and cardboard boxes stored in the back exit access corridor instead of in an enclosed area separate from the exit corridor. Based on an interview with the Director at the time of observation, the container measured over sixty gallons and was always stored in the corridor.</p>			

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K010046	<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 observation, record review and interview; the facility failed to ensure 6 of 6 emergency lights of at least 1½ hour duration were tested monthly in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. 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.</p> <p>Findings include:</p> <p>Based on observations with the Director and Maintenance Technician # 1 on 06/10/13 from 11:00 a.m. to 4:30 p.m., battery operated emergency lights were observed in the following locations: reception area, pre-op area, in the common area and in the surgery corridor. Based on record review at 11:45 a.m. with the Director and Maintenance Technician # 1, the "Emergency Light" monthly testing documentation lacked a monthly test for the battery operated lights for</p>	K010046	The missing monthly test from 3/19/13 was reported and on file in Maintenance. TSC Director did not have a copy in her record book. Lutheran Hospital maintenance department, TSC's contracted maintenance service, is using a system that automatically generates work orders for scheduled monthly maintenance work. These work orders are managed by the Medical Office Building maintenance manager for TSC.	07/01/2013			

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	March, 2013. Based on an interview with the Director and Maintenance Technician # 1 at the time of record review, no other documentation was available for review.			

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K010048	<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 Based on record review and interview, the facility failed to provide a written fire safety plan to include the use of the alarms, transmission of alarm to the fire department, response to alarms, isolation of fire, evacuation of immediate area, evacuation of smoke compartment, preparation of the floors and building for evacuation, and extinguishment of fire for the protection of 2 of 2 patients and for their evacuation in the event of an emergency. LSC 21.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects all patients in the facility.</p> <p>Findings include:</p> <p>Based on record review and interview</p>	K010048	<p>A new Fire Plan was written by TSC Director from the Fire Code F policy &amp; procedure. The plan includes evacuation procedures out of the building and the use of fire extinguisher identified as rated ABC. Directions for use of the extinguisher are Pull, Aim, Squeeze, and Sweep (PASS). The Director reviewed this plan with the staff during the Fire Drill on 6/28/13.</p>	06/28/2013			

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	with the Director on 06/11/13 at 12:05 p.m., the "Fire - Code F" emergency plan 1997 Edition did not include evacuation of a smoke compartment and extinguishment of fire with specific emphasis on the type of fire extinguishers available and procedure for there use. Based on an interview with the Director at 1:00 p.m., only two staff received fire extinguisher training and one of the two has left the facility.			

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K010067	<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> <p>Based on observation and interview, the facility failed to ensure 2 of 2 dampers in the ventilation system 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 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 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 all occupants.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 on 06/10/13 during a tour from 3:42 p.m. to 3:45 p.m., there were smoke dampers in the ventilation system at the smoke barrier wall. Based on an interview with Maintenance Technician # 1 at the time of observations, he was not</p>	K010067	The Lutheran Facilities Compliance & Construction Coordinator gave TSC Director the contact service for inspection of the fire dampers in the fire walls. TSC Director emailed the contact for the service Life Safety Services. The service contractor returned the Director's call, said they would be glad to inspect, but he needed the square footage of the department. TSC Director looked up the square footage from the architectural drawings and reported the figure to service contractor. The contractor will set up an inspection visit and let the Director know of the date.	07/03/2013			

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	<p>aware of the dampers and therefore the dampers have not been inspected.</p> <p>Additionally, at 3:45 p.m., Maintenance Technician # 1 observed two ventilation ducts penetrating the smoke barrier wall above the lay in ceiling in the women's locker room. Based on an interview with Maintenance Technician # 1 at the time of observation, the two ventilation ducts lacked dampers at the smoke barrier wall.</p> <p>3.1-19(b)</p>			

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K010075	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Solid linen or trash collection receptacles shall not exceed 32 gallons (121L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft<sup>2</sup> (20.4L/m<sup>2</sup>). A capacity of 32 gal (121L) shall not be exceeded with any 64 ft<sup>2</sup> (5.9m<sup>2</sup>) area.</p> <p>Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) shall be located in a room protected as a hazardous area when not attended. 20.7.5.3, 21.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 4 corridors. This deficient practice could affect any occupant evacuated through the back exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Director on 06/10/13 at 1:35 p.m., there was a large plastic container overflowing with trash and cardboard boxes stored in the back exit access corridor. Based on an interview with the Director at the time of observation, the container measured over sixty gallons and was always stored in the corridor.</p>	K010075	The Director assigned the large trash receptacle in the back exit corridor to be moved to the Soiled Utility Room. Cleaning supplies were moved to a different supply storage area to make room in the Soiled Utility Room. This was completed 6/25/13.	06/25/2013			

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K010114	<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>Based on observation and interview, the facility failed to ensure 1 of 1 fire barrier walls provided a one hour fire resistant separation from other tenants. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>a. Based on observation with the Director on 06/10/13 at 2:35 p.m., the main entrance door to the facility from the front lobby area did self close, but it failed to latch into the door frame. This was confirmed by the Director at the time of observation.</p> <p>b. Based on observation with the Director on 06/10/13 at 2:29 p.m., there was an unsealed ceiling penetration measuring one half inch in the biohazard/trash room. Measurements were provided by the Director at the time of observation.</p>	K010114	<p>On the day of the survey, the fire doors that would not completely latch on automatic closing were noted to be askew at the hinges in the door frame. The Director asked that a work order be submitted to Maintenance reporting the fire doors that did not latch automatically. The work order was dated 6/17/13. These doors are being inspected and adjusted today 7/3/13 to correct the non-latching automatic closures. For future monitoring, the Director will conduct spot checks on these doors to verify the automatic latching is functioning. In addition, the Director sent a work order for the steam pipe ceiling gaps to be closed in the OR Biohazard/Steam Room and for fire rated insulation to be added around a waste water line above the ceiling tiles in storage room #6.</p>	07/03/2013

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K010115	<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 positive latcher. Doors are constructed of not less than 1¼ 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, 21.3.7.3</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 smoke barriers was maintained to provide a one hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>a. Based on observation with Maintenance Technician # 1 on 06/10/13 at 3:40 p.m., there was an unsealed area measuring two inches by three inches around a waste line in the one hour smoke barrier wall above the lay in ceiling of storage room #6. Maintenance</p>	K010115	In addition, the Director sent a work order 7/3/13 for the steam pipe ceiling gaps to be closed in the OR Biohazard/Steam Room and for fire rated insulation to be added around a waste water line above the ceiling tiles in store room #6. The Director assigned the large trash receptacle in the back exit corridor to be moved to the Soiled Utility Room. Cleaning supplies were moved to a different supply storage area to make room in the Soiled Utility Room. This was completed 6/25/13.	07/12/2013			

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	<p>Technician # 1 confirmed this wall to be the smoke barrier wall and provided the measurements.</p> <p>b. Based on observation with Maintenance Technician # 1 at 4:00 p.m., insulation was observed stuffed into the spaces at the top of the smoke barrier wall and below the corrugated ceiling. Maintenance Technician # 1 could not confirm the insulation would provide a one hour fire resistance rating.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 4 doors in the smoke barrier wall were equipped with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Director on 06/10/13 from 2:10 p.m. to 2:25 p.m., the door entering the family waiting room from the general waiting room and the rear women's locker room door did self close but they each failed to latch into the door frame. According to the Director at the time of observations, both doors were located in the one hour smoke barrier wall.</p>						

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(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