

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2013
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NAME OF PROVIDER OR SUPPLIER SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY INDIANAPOLIS, IN 46256
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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
K0000	<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: 01/28/13</p> <p>Facility Number: 005392 Provider Number: 15C0001011 AIM Number: 100274160A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Surgical Care Center Inc. 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 with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p>	K0000	Please see our response to citations listed	

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>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/04/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0029	<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 mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons are located in a room protected as a hazardous area when not attended. This deficient practice could all patients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Director during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, two 20 gallon receptacles for soiled linen were observed stored next to one another in the recovery room in an area not protected as a hazardous area. Based on interview at the time of observation, the Director acknowledged two, 20 gallon receptacles for soiled linen were observed stored next to one another in the recovery room.</p>	K0029	One 20 gallon receptacle has been removed. This was the responsibility of the director. All staff has been educated and this will prevent the citation from happening again.	01/28/2013			

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K0051	<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</p> <p>1. Based on record review, observation and interview; the facility failed to document annual functional testing for 2 of 2 duct detectors in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 refers to LSC 9.6 and LSC 9.6.1.4 refers to NFPA 72, the National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices to be tested at least annually. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, two duct detectors were observed installed in the HVAC system in the basement. Based on review of Koorsen Fire &</p>	K0051	<p>1. Functional testing for 2 of 2 duct detectors in the HVAC systems in the basement was performed on February 5, 2013 by Koorsen. This testing will be done annually by Koorsen and monitored by VEI. This is the responsibility of VEI. VEI will be monitoring Koorsen to be sure this does not happen in the future.2. 5 of 20 smoke detectors could not be assured the facility was maintaining and inspecting per manufacture's guidelines. The measured sensitivity for two smoke detectors located in the first floor mechanical room. This sensitivity testing was done February 5, 2013 by Koorsen and documented. The smoke detector in the basement power room was replaced on February 5, 2013 by Koorsen. The two duct detectors located in the HVAC system in the basement, sensitivity testing was done on February 5, 2013 by Koorsen. Detector sensitivity will be done every alternate year. The sensitivity testing passed. VEI is responsible for this and will be monitoring it in the future to make sure it is done as indicated.3. 8</p>	02/25/2013			

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	<p>Security "Report of Inspection" documentation dated 11/17/12 with the Director and the VEI Building Maintenance Manager during record review from 9:45 a.m. to 11:50 a.m. on 01/28/13, documentation of annual functional testing for two duct detectors located in the HVAC system in the basement was not available for review. Based on interview at the time of record review and of the observations, the Director and the VEI Building Maintenance Manager acknowledged documentation of annual functional testing for two duct detectors located in the HVAC system in the basement was not available for review.</p> <p>2. Based on observation, record review and interview; it could not be assured the facility was maintaining and inspecting 5 of 20 smoke detectors per the manufacturer's recommendations. LSC Section 21.3.4.1 requires ambulatory health care facilities to be in accordance with LSC Section 9.6. LSC Section 9.6.1.4 requires a fire alarm system to be maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3 requires smoke detector testing to be in accordance Section 7-3, Inspection and Testing Frequencies. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every</p>		<p>of 20 smoke detectors in the facility were not installed where air flow would adversely affect its operation. The eight smoke detectors in the facility found to be within three feet of an air diffuser: 1) in the main entry of the Surgical Care Center; 2) in the corridor outside the main entry of the Surgical Care Center; 3) receptionist area; 4) prep room; 5) two smoke detectors in the recovery room; 6) two smoke detectors in the corridor outside operating rooms. These eight smoke detectors will be moved prior to 2/25/2013. It will be done by and is the responsibility of VEI.</p>				

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	<p>alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p>			

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	<p>NOTE: The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Report of Inspection/Test" documentation dated 10/01/11 with the Director and the VEI Building Maintenance Manager during record review from 9:45 a.m. to 11:50 a.m. on 01/28/13, the following was noted:</p> <p>a) the measured sensitivity for two smoke detectors located in the first floor mechanical room was not documented.</p> <p>b) results of sensitivity testing of the smoke detector located in the basement power room was recorded as "Device Failed. Needs Replaced".</p> <p>c) sensitivity testing of two duct detectors located in the HVAC system in the basement was not available for review.</p> <p>Based on observations with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, two duct detectors were observed installed in the HVAC system in the basement.</p> <p>Based on interview at the time of record review, the Director and the VEI Building</p>			
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	<p>Maintenance Manager stated no other sensitivity testing documentation was available for review, the basement power room smoke detector has not been repaired or replaced and acknowledged it has been more than two years since smoke detector sensitivity testing was performed for the aforementioned smoke detector locations.</p> <p>3. Based on record review, observation and interview; the facility failed to ensure 8 of 20 smoke detectors in the facility were not installed where air flow would adversely affect its operation. LSC Section 21.3.4.1 requires ambulatory health care facilities to be in accordance with LSC Section 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 "Work Order" documentation dated 01/10/12 with the Director and the VEI Building Maintenance Manager during record review from 9:45 a.m. to</p>			

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	<p>11:50 a.m. on 01/28/13, eight smoke detectors in the facility were found to be within three feet of an air diffuser. Based on interview at the time of record review, the VEI Building Maintenance Manager stated the aforementioned smoke detectors have not been repositioned to more than three feet from an air diffuser. Based on observations with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, each of the following eight smoke detector locations referenced in the aforementioned documentation 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 Main Entry of the surgical care center. b) in the corridor outside the Main Entry for the surgical care center. c) in the Receptionist area. d) in the Prep room. e) two smoke detectors in the Recovery room. e) two smoke detectors in the corridor outside the operating rooms. <p>Based on interview at the time of the observations, the Director and the VEI Building Maintenance Manager acknowledged the aforementioned smoke detectors were each installed on the ceiling less than three feet from a supply or return vent.</p>			

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K0067	<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 100 % of fire dampers 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 basement.</p> <p>Findings include:</p> <p>Based on observation with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, one fire damper was observed in the south wall of the elevator machine room located</p>	K0067	One fire damper in the south wall of the elevator machine room located in the basement lacked documentation of fire damper testing within the last four years. This will be done on Wednesday, 2/25/2013. It is the responsibility of VEI. They will add this to their preventive maintenance software and a work order will be submitted when it is time for inspection in the future.	02/25/2013			

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	in the basement. Based on interview at the time of observation, the VEI Building Maintenance Manager acknowledged documentation of fire damper testing of the aforementioned fire damper within the last four years was not available for review.			

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K0075	<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/ft² (20.4L/m²). A capacity of 32 gal (121L) shall not be exceeded with any 64 ft² (5.9m²) 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 mobile soiled linen or trash collection receptacles was not exceeded within any 64 square foot area for 1 of 1 recovery rooms. LSC 21.7.5.5 states a capacity of 32 gal shall not be exceeded within any 64 square foot area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons are located in a room protected as a hazardous area when not attended. This deficient practice could affect all patients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Director during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, two 20 gallon receptacles for soiled linen were observed stored next to one another</p>	K0075	One 20 gallon receptacle has been removed from our recovery area. This standard will be followed so a capacity of 32 gal shall not be exceeded within a 64 square foot area. This is the responsibility of the director. All staff has been educated and this will prevent this citation from happening again.	01/28/2013			

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	within a 64 square foot area in the Recovery Room. Based on interview at the time of observation, the Director acknowledged two, 20 gallon receptacles for soiled linen were observed stored next to one another within a 64 square foot area in the Recovery Room.			

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K0076	<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 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 all patients.</p> <p>Findings include:</p> <p>Based on observation with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, the entry door to the piped in medical gas systems room for oxygen storage had a twenty minute fire resistance rating label</p>	K0076	<p>1. Oxygen storage locations greater than 3000 cu feet must be enclosed by a one hour separation. The new one hour fire door has been ordered and will be installed by BAF Corporation and is the responsibility of VEI. We will be requesting a waiver for this citation, pending the door being delivered2. Locations for supply systems of greater than 3000 cu feet must be vented to the outside. Air deflectors have been ordered and will be installed by BAF Corporation. VEI is responsible for this. This will be completed by 2/26/2013.</p>	03/29/2013			

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	<p>affixed to the door. Based on interview at the time of observation, the Director and the VEI Building Maintenance Manager acknowledged the entry door to the oxygen storage room for the piped in medical gas systems did not provide one hour fire resistive construction.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of less 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(c) states, where the supply system door opens onto an exit access corridor, the location of nonflammable gas supply systems of less than 3000 cubic feet shall comply with the dedicated mechanical ventilation system requirements of Section 4-3.1.1.2(b)4. This deficient practice could affect all patients.</p> <p>Findings include:</p> <p>Based on observation with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, the piped in medical gas systems storage and supply room was not vented to the outside. The entry door to the piped in</p>			

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	medical gas systems storage and supply room opens onto an exit access corridor in the basement. Based on interview at the time of observation, the Director and the VEI Building Maintenance Manager stated oxygen storage and supply is less than 3000 cubic feet and acknowledged the piped in medical gas systems room for oxygen storage was not vented to the outside.			

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K0077	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99.</p> <p>Based on record review and interview, the facility failed to maintain system integrity for 1 of 1 piped gas systems in accordance NFPA 99, Standard for Health Care Facilities, 1999 Edition. NFPA 99 at Chapter 4-3.4.1.1 states inspection and testing shall be performed on all repaired piped gas systems to ensure system integrity has been achieved or maintained. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Beacon Medaes "Manifold Planned Maintenance Checklist" documentation dated 10/22/12 with the Director and the VEI Building Maintenance Manager during record review from 9:45 a.m. to 11:50 a.m. on 01/28/13, testing results listed under "Section Comments and Recommendations" for an oxygen leak test and repair stated "Found minor leaks on pipeline which require shutdown for repair." Based on interview at the time of record review, the Director stated the piped gas system pipeline oxygen leak has not been located or repaired at the time of this survey, documentation for the repair of the pipeline oxygen leak was not</p>	K0077	Oxygen leak - a second company has been out to investigate where this leak is coming from. They have not been able to find this leak either. They are sending out other people from their company to try and locate this leak. We will request a waiver for this citation. The repair will be completed immediately upon identifying the source of the leak. The director is responsible. We will monitory oxygen daily for leaks so this won't happen in the future.	03/29/2013			

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	available for review and acknowledged an oxygen leak condition exists in the piped gas system for the facility.			

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K0130	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 exit discharges was in accordance with LSC Section 21.2.7. LSC Section 21.2.7 states the discharge from exits shall be in accordance with LSC 39.2.7. 39.2.7 states exit discharge shall comply with Section 7.7. LSC Section 7.7.1 states exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open space, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. This deficient practice could affect all patients and staff using the exit by the soiled linen room if the facility were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Director during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, the exit discharge from the facility by the soiled linen room led to a grass covered lawn outside the building and not to a public way. Based on interview at the time of observation, the Director acknowledged the exit discharge from the facility by the soiled linen room led to a grass covered</p>	K0130	<p>1. The exit discharge from the facility by the soiled linen room, VEI has received a quote on the sidewalk to be installed by that exit. We will be requesting a waiver for this project as it will most likely not be completed prior to 2/27/2013. This will be completed as soon as weather permits.2. The pressure gauge on the sprinkler system was outdated and was replaced on 2/5/2013. The pressure gauge will be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Guages not accurate to within 3 percent of the full scale shall be recalibrated or replaced. VEI is responsible and will be monitoring this to prevent it from happening in the future.3. The facility will keep a supply of spare sprinkler heads which include at least two of each type of sprinkler head used in the facility. These are located in the spare sprinkler head cabinet located in the basement next to the sprinkler system riser. Spare sprinkler heads were replaced on 2/12/2013 by Koorsen. VEI is responsible for this and will be monitoring it to make sure it does not happen in the future.4. The sprinkler pipe in the basement hallway near the stairwell by the elevator had two data cables attached to the sprinkler pipe.</p>	03/29/2013			

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	<p>lawn outside the building and not to a public way.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. LSC 21.7.6, Maintenance and Testing, refers to 4.6.12. LSC 4.6.12.2 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.5 states all automatic sprinkler systems shall be maintained in accordance with NFPA 25, the Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, the</p>		The cable that was wrapped around the sprinkler was moved on 1/29/2013. This is the responsibility of VEI				

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	<p>pressure gauge on the sprinkler system was outdated. The manufacture date listed on the pressure gauge was 2007 and no recalibration date was provided for the pressure gauge. Based on interview at the time of observation, the Director and the VEI Building Maintenance Manager acknowledged the sprinkler system pressure gauge was more than five years old.</p> <p>3. Based on observation and interview, the facility failed to keep a supply of spare sprinkler heads which included at least two of each type of head used in the facility. LSC 21.7.6, Maintenance and Testing, refers to 4.6.12. LSC 4.6.12.2 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.5 states all automatic sprinkler systems shall be maintained in accordance with NFPA 25, the Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, in Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet for replacement purposes with the stock of spare sprinklers being proportionally representative of the types and temperature ratings of the system sprinklers including a minimum of two</p>			

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	<p>sprinklers of each type and temperature rating installed. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, quick response sprinkler heads were observed installed on the ceiling in the recovery room and RASCO 212 degree sprinkler heads were observed installed in the sprinkler system throughout the basement mechanical room. One spare RASCO 212 degree sprinkler head and no spare quick response sprinkler heads were observed in the spare sprinkler head cabinet located in the basement next to the sprinkler system riser. Based on interview at the time of the observations, the Director and the VEI Building Maintenance Manager acknowledged a minimum of two spare sprinkler heads of each type and temperature rating were not provided in the spare sprinkler cabinet.</p> <p>4. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 21.7.6, Maintenance and</p>						

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	<p>Testing, refers to 4.6.12. LSC 4.6.12.2 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice affects one staff in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, a twenty foot section of a two inch sprinkler pipe in the basement hallway near the stairwell by the elevator had two data cables attached to the the sprinkler pipe. Based on interview at the time of observation, the Director and the VEI Building Maintenance Manager acknowledged a twenty foot section of a two inch sprinkler pipe in the basement hallway near the stairwell by the elevator had two data cables attached to the the sprinkler pipe.</p>			

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K0144	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2</p> <p>Based on observation and interview, the facility failed to provide an alarm annunciator for 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 21.2.9.2 requires where general anesthesia or life support equipment is used, each ambulatory health care facility shall be provided with an essential electrical system in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an</p>	K0144	The facility failed to provide an alarm annunciator for 1 of 1 generator set. The annunciator for the generator is in the process of being installed. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source. The wires have been run. The remainder of the work will be completed on 2/26/2013. This is the responsibility of the Surgical Care Center and once this is completed, it won't happen again.	02/26/2013

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	<p>engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director and the VEI Building Maintenance Manager during a tour of the facility from 11:50 a.m. to 1:30 p.m. on 01/28/13, the facility utilizes a 100 kW diesel fired emergency generator and has a generator operation panel with indicator lights for "generator standby", "generator running" and "generator failure" located in the Main Entrance lobby of the surgical care center. A remote annunciator panel for engine generator alarm conditions was not located in the facility. Based on interview at the time of the observations, the Director and the VEI Building Maintenance Manager acknowledged the facility did not have a remote annunciator for the generator.</p>			

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