

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001046	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2016
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NAME OF PROVIDER OR SUPPLIER  NORTH MERIDIAN SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 13225 N MERIDIAN STREET CARMEL, IN 46032
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K 0000  Bldg. 02	<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: 05/31/16</p> <p>Facility Number: 007125 Provider Number: 15C0001046 AIM Number: 100380940A</p> <p>At this Life Safety Code survey, North Meridian Surgery Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>The facility, located on the first floor of a three story building, was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p> <p>Quality Review completed on 06/06/16 - DA</p>	K 0000		
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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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K 0050 Bldg. 02	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2 Based on record review and interview, the facility failed to document transmission of the fire alarm signal for 4 of 4 quarterly fire drills. LSC 20.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Evaluation Report" documentation with the Director during record review from 9:20 a.m. to 12:00 p.m. on 05/31/16, fire drills conducted on the first shift (6:00 a.m. to 4:00 p.m.) on 06/02/15, 08/03/15, 12/04/15 and 02/29/16 did not include activation of the fire alarm system and</p>	K 0050	<p>Due to having other tenants in our building, past fire drills have utilized an audible announcement, but the fire alarm system was not activated nor a signal properly transmitted. However, the system was being tested annually. On June 17, 2016, NMSC's Fire Evaluation Report (Attachment A) was modified to include Question #5. "Was the fire alarm system activated and signal properly transmitted to the monitoring company?" We tested the alarm system on June 24, 2016 and properly transmitted a signal to the monitoring company. The Director is responsible for assuring this process is followed during all future fire drills, as well as being properly documented on the Fire Evaluation Report.</p>	06/24/2016			

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K 0064 Bldg. 02	<p>transmission of the fire alarm signal. Based on interview at the time of record review, the Director stated the facility operates one shift per day, the fire alarm system is tested once per year by a contractor and acknowledged the facility failed to document activation of the fire alarm system and transmission of the fire alarm signal for each of four fire drills conducted in the most recent twelve month period.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 6 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect five patients.</p> <p>Findings include:</p>	K 0064	The portable fire extinguisher in the medical gas storage room was inspected on June 20, 2016 by Simplex Grinnell and properly tagged (Attachment B). Going forward, this fire extinguisher will be added to our monthly inspection and recorded properly. The Director is responsible for assuring that monthly and annual inspections/ maintenance occur and are properly recorded for all of our portable fire extinguishers.	06/20/2016

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	<p>Based on observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16, the inspection tag affixed to the portable fire extinguisher in the piped in gas storage room indicated December 2014 as the date the most recent annual maintenance was performed. Based on interview at the time of observation, the Chief Engineer and Director stated no other annual fire extinguisher maintenance documentation was available for review and acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period.</p> <p>2. Based on observation and interview, the facility failed to document inspection of 1 of 6 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been</p>			

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K 0067 Bldg. 02	<p>actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect five patients.</p> <p>Findings include:</p> <p>Based on observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16, the inspection tag affixed to the portable fire extinguisher in the piped in gas storage room indicated a monthly inspection was not documented for the most recent twelve month period. Based on interview at the time of observation, the Chief Engineer acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for the most recent twelve month period.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Heating, ventilating, and air-conditioning shall comply with the manufacturer's specifications and section 9.2. 20,5.2.1, 21.5.2.1</p> <p>Based on record review, observation and interview; the facility failed to provide documentation 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</p>	K 0067	<p>Our current Fire Protection Company does not offer fire damper inspection. We have received a quote (Attachment C) for fire damper inspection and maintenance. Due to the price of this quote, our Chief Engineer will be asking other companies to bid on</p>	08/31/2016

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	<p>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 all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Chief Engineer and the Director from 9:20 a.m. to 12:00 p.m. on 05/31/16, fire damper inspection and maintenance documentation within the most recent four year period was not available for review. Based on observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16, one fire damper was observed installed in HVAC ductwork above the suspended ceiling above the patient discharge exit door by the Consultation Room. Based on interview at the time of record review and observation, the Chief Engineer</p>		<p>this service request. The fire dampers will be inspected prior to August 31, 2016, which would be 90 days from the surveyor's exit conference. The Director is responsible for assuring that this inspection is completed and properly documented. The Director will also be responsible for future compliance of fire damper testing within at least every four years.</p>	

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K 0105 Bldg. 02	<p>stated fire dampers are installed throughout the facility and acknowledged fire damper inspection and maintenance documentation within the most recent four year period was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an essential electric system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2</p> <p>Based on record review, observation and interview; the facility failed to provide emergency lighting in 3 of 3 operating rooms where general anesthesia or life support equipment is used. LSC Section 20.2.9.2 requires ambulatory health care facilities to provide emergency lighting where general anesthesia or life support equipment is used to be in accordance with NFPA 99. NFPA 99, 3-3.2.1.2(a)(5) (e) requires anesthetizing locations to be provided with battery-powered emergency lighting units. One or more battery-powered emergency lighting units shall be provided in accordance with NFPA 70, National Electrical Code, Section 700-12(e). NFPA 70, (e) Unit Equipment. Individual unit equipment for emergency illumination shall consist of the following:</p> <p>1. A rechargeable battery</p>	K 0105	<p>Our Chief Engineer was unavailable to respond to the surveyor's questions regarding emergency lighting during part of the facility tour. Each of our 3 Operating Rooms are equipped with battery-powered emergency lighting units within each bank of lights (Attachment D &amp; E). During the tour, the Director didn't realize that the test button was beneath the plastic cover (Attachment F &amp; G). Our battery-powered emergency lighting units were tested by our Chief Engineer on June 20, 2016. Going forward, our Chief Engineer will inspect, maintain, and document findings for these emergency lighting units on a monthly basis. The Director is responsible for assuring that monthly inspections/ maintenance occurs and is properly documented.</p>	06/20/2016

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	<p>2. A battery charging means</p> <p>3. Provisions for one or more lamps mounted on the equipment, or shall be permitted to have terminals for remote lamps, or both, and</p> <p>4. A relaying device arranged to energize the lamps automatically upon failure of the supply to the unit equipment</p> <p>The batteries shall be of suitable rating and capacity to supply and maintain at not less than 87 percent of the nominal battery voltage for the total lamp load associated with the unit for a period of at least 1 hours, or the unit equipment shall supply and maintain not less than 60 percent of the initial emergency illumination for a period of at least 1 hours. Storage batteries, whether of the acid or alkali type, shall be designed and constructed to meet the requirements of emergency service. Unit equipment shall be permanently fixed in place (i.e., not portable) and shall have all wiring to each unit installed in accordance with the requirements of any of the wiring methods in Chapter 3 of NFPA 70. Flexible cord and plug connection shall be permitted, provided that the cord does not exceed 3 feet (914 mm) in length. This deficient practice could affect three patients and staff.</p> <p>Findings include:</p>			

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K 0114	<p>Based on record review with the Chief Engineer and the Director from 9:20 a.m. to 12:00 p.m. on 05/31/16, documentation of operating room battery operated lighting systems monthly and annually functional testing in the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director stated the facility has three operating rooms where general anesthesia is used and battery operated lighting systems are not installed in each of the three operating rooms. Based on observations with the Director at 12:00 p.m. on 05/23/16, battery operated emergency lighting systems were not installed in each of three operating rooms where general anesthesia is used. Based on interview at the time of the observations, the Director stated patients in each of the three operating rooms can be completely sedated and rendered immobile using general anesthesia, an emergency generator is utilized to provide emergency lighting for the facility but acknowledged battery operated emergency lighting systems were not installed in the three operating rooms to provide continuous illumination.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p>						

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Bldg. 02	<p>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 1 3/4 inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors shall be of fixed fire window assemblies in accordance with 8.2.3.2.2. 20.3.7.1, 21.3.7.1</p> <p>Based on observation and interview, the facility failed to ensure other tenants and occupancies were separated by fire barriers with at least a one hour fire resistance rating. Doors in fire barriers separating the facility from other tenants and occupancies are 1 3/4 inch thick, solid-bonded, wood core or equivalent and are equipped with a positive latching device. 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 observations with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16, the following was noted in the tenant separation smoke barrier wall at the main entrance to the patient waiting room from the main lobby of the building:</p> <p>a. the set of main entrance doors were nonrated glass doors which each</p>	K 0114	<p>We discussed the deficiency of the non-rated, glass doors of the main entrance with the door manufacturer and building architects. They pointed out that the installation of a "Water Curtain" in the patient/ family waiting room was approved by the State Fire Marshall's Office prior to construction, as evidence by the attached documents (Attachment H, I, J). With regards to the gaps and positive latch deficiencies, we have received details from the glass manufacturer (Attachment K, L) and will be moving forward with the proposed additions. Edge weathering will be installed to close the gaps around the glass doors and a positive latch device will be added to meet code requirements. This installation will be completed within 90 days for the surveyor's exit conference before August 31, 2016. The Director is responsible for assuring that this installation is properly completed.</p>	08/31/2016

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K 0130  Bldg. 02	<p>measured four feet wide by eight feet high.</p> <p>b. each door in the main entrance door set was provided with a locking device which was 'dogged down' to allow patient and visitor access during normal operating hours. The locking devices would not enable positive latching of the door set if left in the unlocked position.</p> <p>c. a one inch gap was noted in between the meeting edges of the door set on the handle side and on each side of door set on the hinge side.</p> <p>Neither the glass doors nor the gaps maintained the fire resistance rating of the smoke barrier wall.</p> <p>Based on interview at the time of the observations, the Chief Engineer and the Director stated the fire resistance rating of the glass door set might be available but acknowledged the aforementioned door set in the tenant separation wall was not fire rated, was not equipped with a positive latching device and gaps in the door set did not maintain the fire resistance rating of the smoke barrier wall.</p> <p>416.44(b)(1) MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and</p>	K 0130	We are planning to exit our contract with our current Fire	07/31/2016	

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	<p>interview; the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 3 of the past 4 quarters. LSC 20.7.6, 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 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 record review with the Chief Engineer and the Director from 9:20 a.m. to 12:00 p.m. on 05/31/16, documentation of quarterly sprinkler waterflow alarm devices inspection was not available for review. Based on observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16, Simplex Grinnell had affixed a hanging tag to the sprinkler system riser</p>		<p>Protection Company. We will be transferring Fire Protection/ Maintenance/ Inspection Services to USAutomatic Fire &amp; Security. We are in the process of negotiating a new contract with them. They have agreed to provide us with quarterly/ annual sprinkler waterflow alarm device inspection. This service will be completed within 60 days for the surveyor's exit conference before July 31, 2016. The Director is responsible for assuring that this testing is completed and documented on a quarterly and annual basis.</p>		

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	documenting the only quarterly waterflow alarm device testing conducted in the most recent twelve month period was on 09/17/15. Based on interview at the time of record review and observation, the Chief Engineer stated sprinkler waterflow alarm devices was only tested annually and acknowledged the only waterflow alarm device testing conducted in the most recent twelve month period was on 09/17/15.				