

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001007	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2012
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NAME OF PROVIDER OR SUPPLIER SOUTH BEND CLINIC & SURGICENTER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 211 N EDDY ST SOUTH BEND, IN 46617
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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: 03/07/12</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>Facility Number: 005388 Provider Number: 15C0001007 AIM Number: 100274090A</p> <p>At this Life Safety Code survey, South Bend Clinic and 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>This facility is located on the ground floor of a three story wing attached to the original building and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors.</p>	K0000		

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 Dennis Austill, Life Safety Code Supervisor on 03/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0047	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Exits and ways of travel thereto are marked in accordance with section 7.10. 20.2.10, 21.2.10</p> <p>Based on observation and interview, the facility failed to ensure two paths of exit were visible at both ends of 3 of 5 east-west corridors. LSC 7.10.1.2 requires exits shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice could affect any patients and staff in the center three east-west corridors.</p> <p>Findings include:</p> <p>Based on observations made with the Surgery Center Director and Facilities Manager from 2:54 p.m. to 3:00 p.m. on 03/07/12, the exit signs at the west end of the the three center, east-west corridors could not be seen from halfway down the corridor due to a bulkhead across the end of the corridor which blocked them from view. In addition, an exit sign was not provided at the east end of the east-west corridor outside Bay 5 of the Pre-Op area. Both the Surgery Center Director and the Facilities Manager agreed the west exit signs were blocked from view by the bulkheads and the sign was missing from outside Bay 5 of the Pre-Op area at the time of the observations.</p>	K0047	The Facilities Department relocated 3 exit signs to ensure visibility from any direction of exit access in the pre-op area. One exit sign was installed at the east end of the east/west corridor outside Bay 5. The Facilities Department inspect exit signs monthly.	03/08/2012

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K0048	<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</p> <p>1. Based on record review and interview, the facility failed to provide 1 of 1 sprinkler impairment policies as part of a complete written plan to protect all the patients in accordance with LSC 9.7.6.1 when the sprinkler system will be out of service for four hours or more in a 24 hour period which requires the authority having jurisdiction shall be notified and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. LSC 9.7.6.2 requires impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Chapter 11, Impairments at 11-2 requires the building owner to assign an impairment coordinator. NFPA 25 at 11-5 requires all preplanned impairments shall be authorized by the impairment coordinator with notification of the fire department, authorities having jurisdiction and the supervisors in the areas affected. 11-7 requires all the appropriate people be notified when the sprinkler system is returned to normal working order. This deficient practice</p>	K0048	The All Hazards Emergency Response Plan Policy was implemented and approved by the Medical Executive Committee on 3/20/2012. The SurgiCenter Director and Facilities Manager are responsible for staff education. The Facilities Manager is responsible for the monitoring of the sprinkler system and alarm. The approved policy was mailed in with the original response on 3/23/2012.	03/20/2012			

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	<p>could affect all patients as well as staff in case of a fire while the sprinkler system was impaired.</p> <p>Findings include:</p> <p>Based on review of the Life Safety Management policies at 1:33 p.m. on 03/07/12 with the Surgery Center Director, the policies did not contain specific procedures to follow if the sprinkler system was impaired. There was a policy for when evacuation is necessary, but sprinkler system impairment was not listed as reason to evacuate. This was acknowledged during a discussion of the requirements with the Surgery Center Director at the time of record review.</p> <p>2. Based on record review and interview, the facility failed to provide 1 of 1 fire alarm system impairment policies as part of a complete written plan including procedures to be followed in the event the fire alarm system is out of service for 4 or more hours in a 24 hour period to protect all the patients in accordance with LSC 9.6.1.8 which requires the authority having jurisdiction be notified and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has</p>						

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	<p>been returned to service. The deficient practice could affect all patients as well as staff in case of fire while the fire alarm system was impaired.</p> <p>Findings include:</p> <p>Based on review of the Life Safety Management policies at 1:33 p.m. on 03/07/12 with the Surgery Center Director, the policies did not contain specific procedures to follow if the fire alarm system was impaired. There was a policy for when evacuation is necessary, but fire alarm system impairment was not listed as reason to evacuate. This was acknowledged by the Surgery Center Director at the time of record review.</p>			

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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>Based on observation and interview, the facility failed to ensure the circuit disconnecting means for the fire alarm system was identified in red as the Fire Alarm Circuit Control. LSC Section 20.3.4.1 requires 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, 1999 Edition, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). The circuit(s) and connections shall be mechanically protected. Circuit disconnecting means shall have red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The fire alarm disconnecting means shall be permanently identified at the fire alarm control unit. This deficient practice could affect all the occupants in the facility.</p> <p>Findings include:</p>	K0051	The Facilities Manager identified and labeled in red the circuit breaker for the fire alarm system panel. The Facilities Department will monitor the breaker panel daily.	03/09/2012	

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	Based on observations with the Facilities Manager and Surgery Center Director on 03/07/12 at 3:12 p.m. in the electrical breaker room, the circuit breaker for the fire alarm system panel could not be located, so it could not be determined if it was labeled as required by the Code. The Facilities Manager admitted at the time of observation, the breaker for the fire alarm control panel could not be located.			

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K0115	<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 a positive latcher. Doors are constructed of not less than 1¾ 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, 21.3.7.2</p> <p>Based on observation and interview, the facility failed to maintain the one hour fire resistance rating for 1 of 1 smoke barrier walls dividing the facility into two smoke compartments. This deficient practice could affect patients and staff in the corridor near the Decontam room.</p> <p>Findings include:</p> <p>Based on observations with the Facilities Manager and Surgery Center Director on 03/07/12 at 2:25 p.m., there was a four inch conduit through the smoke barrier wall above the double doors next to the Decontam room which had a bundle of wires less than two inches thick passing through it leaving a gap around the bundle of wires which did not be appear to be protected on either side of the smoke barrier wall. At the time of observation, the Facilities Manager agreed neither end of the conduit appeared to be filled with</p>	K0115	The Facilities Manager filled the conduit located next to the Decontam room with fire stop. The Facilities Manager will monitor and maintain any penetrations in the future.	03/09/2012			

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	any fire rated material.			