STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMS EYE SURGERY CENTER	6836 HOHMAN AVENUE HAMMOND, IN 46324

(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
K 000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/23/15 Facility Number: 005913 Provider Number: 15C0001029 AIM Number: 200390130A Surveyor: Dennis Austill, Life Safety Code Specialist At this Life Safety Code survey, Williams Eye 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 21, Existing Ambulatory Health Care Occupancies. This one story facility was fully sprinklered and was determined to be of Type V (111) construction. The facility has a fire alarm system with manual pull stations provided at all the exits.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The facility has elected to utilize a Categorical Waiver pertaining to relative humidity levels in anesthetizing locations. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 02/27/15.			
K 047 Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 4 exits signs were continuously illuminated in accordance with LSC section 7.10. LSC section 7.10.5.2 requires exit signs to be continuously illuminated. This deficient practice affects all occupants in the facility including staff and patients. Findings include: Based on observation with the Nurse Manager at 12:00 p.m. on 02/23/15, the exit sign above the employee exit door was not illuminated. Based on interview at the time of observation, the Nurse	K 047	Maintenance personnel replaced burned out exit sign. Nurse Manager will add the exit sign to the preventative maintenance checklist which is conducted monthly to ensure the Exit signs are always illuminated.	02/23/2015

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	Manager acknowledged the exit sign was not illuminated.			
K 050 Bldg. 01	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 review of fire drill documentation and interview, the facility failed to conduct 4 of 4 fire drills at unexpected times. This deficient practice affects all occupants in the facility including staff, visitors and patients. Findings include: Based on review of the "Fire Drill Checklist" documentation with the Nurse Manager at 10:50 a.m. on 02/23/15, fire drills were not conducted at unexpected times in that all four drills conducted in 2014 were after business hours between 4:00 p.m. to 5:00 p.m. on 12/16/14, 09/29/14, 06/25/14 and 03/31/14. Based on interview at the time of review, the Nurse Manager acknowledged the fire drills conducted during 2014 occurred in the evening after patients had gone to minimize interruption of surgical procedures.	K 050	All future fire drills will be varied in times as well as varied conditions. The Nurse Manager will ensure that a variety of realistic scenarios at various times with staff and patients present are conducted to ensure that the drills are not established as routine.	03/05/2015
K 130	NFPA 101 MISCELLANEOUS			

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Bldg. 01	OTHER LSC DEFICIENCY NOT ON 2786 1) Based on record review, observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. 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. Findings include: Based on record review with the Nurse Manager at 10:50 a.m. on 02/23/15, the "Fire Sprinkler Inspection Report" dated 1/14/15 indicated, "system pressure gauge dated 2009." Based on observation at 11:55 a.m., the pressure gauge on the sprinkler system had a manufacture date	K 130	Valley Fire Protection Systems, our vendor for the sprinkler system, will on March 6, 2015 replace the gauge on the sprinkler system which is currently dated 2009. Please find attached the 5 year internal pipe inspection conducted on January 24, 2013. The Nurse Manager will schedule all future sprinkler inspections with the vendor and ensure that compliance is met.	03/06/2015

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	listed as 2009 and no recalibration date was provided on the pressure gauge. Based on interview at the time of observation, the Nurse Manager acknowledged she had thought the sprinkler vendor had replaced the gauge when the vendor had been back to the facility earlier this month. 2) Based on record review and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was examined every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Nurse Manager at 10:50 a.m. on 02/23/15, the "Fire Sprinkler Inspection Report" dated			

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	1/14/15 indicated, "recommend 5 yr check valve + Internal Pipe Inspection." Based on interview at the time of observation, the Nurse Manager acknowledged documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review.			
K 144 Bldg. 01	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 Based on review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum	K 144	The weekly generator log has been adapted to include the load percentage. Please find attached the revised weekly generator log for your review. The Nurse Manager will monitor the weekly generator log to ensure that the necessary information is documented.	03/05/2015

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	exhaust gas temperatures as recommended by the manufacturer. 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 affects all patients, staff and visitors. Findings include: Based on review with the Nurse Manager on 02/23/15 at 12:30 p.m., the emergency generator was listed on a weekly checklist and did not include any information regarding the aforementioned test methods. Based on interview at the time of review, the generator starts and transfers to emergency power automatically on a weekly basis.			