

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001074	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2014
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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER OF OPHTHALMOLOGY CONSULTANTS	STREET ADDRESS, CITY, STATE, ZIP CODE 7232 ENGLE RD FORT WAYNE, IN 46804
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K010000	<p>A Life Safety Code Recertification Survey was constructed by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 02/12/14</p> <p>Facility Number: 009567 Provider Number: 15C0001074 AIM Number: 200177420A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Surgery Center of Ophthalmology Consultants 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>This one story facility with a lower level was determined to be of Type III (111) and was fully sprinklered. The facility is located on the lower level and has a fire alarm system with smoke detection in the corridors.</p>	K010000		

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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K010029	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 the corridor door to 1 of 1 soiled linen 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 1 of 2 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 02/12/14 at 2:08 p.m., the corridor door to the soiled linen room lacked a self closing device. There was a</p>	K010029	The soiled linen will be relocated to a room with a self-closing door	04/04/2014			

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K010050	<p>large plastic bin containing numerous trash bags of soiled line stored in the room awaiting laundry service pickup. Based on an interview with the Administrator at the time of observation, soiled linen storage was recently moved to this location.</p> <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 conduct fire drills which met the requirements of the Code for 4 of 4 quarters and ensure the fire drill included the transmission of the fire alarm signal. LSC 21.7.1.2 requires fire drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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. Inform 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 could</p>	K010050	All quarterly fire drills will comply with the NFPA 101, Section 21.7.1.2. Jackie Dayton, RN Supervisor will conduct the drills in coordination with Doug Miller, Administrator	04/04/2014			

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K010064	<p>affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill documentation titled "Fire Drill Report" and interview with the Administrator and the Nursing Supervisor on 02/12/14 at 12:30 p.m., the following was noted:</p> <ul style="list-style-type: none"> <li>a. a fire drill wasn't conducted in the first and second quarters of 2013</li> <li>b. the fire drill always consisted of a tabletop decision during a staff meeting for every quarterly required drill</li> <li>c. the fire drill did not include activation of the fire alarm system nor the transmission of the fire alarm</li> </ul> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2</p> <p>Based on observation and record review, the facility failed to inspect 2 of 3 portable fire extinguishers each month. LSC 21.3.5.2 requires fire extinguishers be provided in accordance with 9.7.4.1. LSC 9.7.4.1 requires portable fire extinguishers shall be installed, inspected and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection</p>	K010064	<p>There are 3 fire extinguishers in the lower level. Two are located at the base of both stairwells outside the walls of the ASC. The third one is located within the walls of the ASC. Jackie Dayton, RN Supervisor checks the one within the ASC; its checklist was up to date. Doug Miller, Administrator checks the other 2 outside the walls of the ASC. Doug has updated the two checklist cards on the extinguishers outside the walls of the ASC. Doug will continue to do</p>	03/31/2014			

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K010115	<p>and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" a fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with, and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect patients evacuated through the main entrance and the back corridor.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Nursing Supervisor on 02/12/14 from 1:50 p.m. to 2:08 p.m., the monthly inspection tag attached to the portable fire extinguishers located in the main entrance corridor and the back corridor lacked documentation of a monthly inspection since November 2013.</p> <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</p>		<p>the monthly checks on them. Jackie will continue doing the monthly checks on the third one.</p>				

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K010130	<p>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>Based on observation and interview, the facility failed to ensure 2 of 3 doors in the smoke barrier wall were 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 all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Nursing Supervisor on 02/12/14 at 11:15 a.m., the doors entering the pre-op room and the post-op rooms were propped open with plastic door wedges. Based on an interview with the Administrator and the Nursing Supervisor at the time of observation, both doors were located in the one hour smoke barrier wall.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure 1 of 1 gas</p>	K010115	<p>Jackie Dayton, RN Supervisor has removed the door wedges so these 2 doors are closed at all times. Doug Miller, Administrator is contacting a door company to have an estimate done on the cost of installing magnetic door closures electronically wired to the fire alarm system. If the cost is prohibitive, we will continue to leave the doors closed at all times. If it is affordable, the installation will be done soon. There is heavy traffic between these doorways. It would be much more convenient if these doors could remain open.</p>	04/30/2014
		K010130	<p>1. As stated in the deficiency, Doug Miller, Administrator has contacted Homeland Security to</p>	04/30/2014

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	<p>fueled water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 21.1.1.3 requires all ambulatory health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affect all patients evacuated through the main entrance.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 02/12/14 at 1:50 p.m., the water heater Inspection Certificate had an expiration date of 11/18/13. Based on an interview with the Administrator at the time of record review, he was aware the certificate had expired and has contacted Homeland Security.</p> <p>2. Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. LSC 4.6.12.2 requires existing life safety features obvious to the public, if required by the Code, shall be either maintained or removed. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires waterflow alarm devices</p>		<p>reinspect the water heater. We are at their mercy when this gets accomplished. Doug will make another attempt at scheduling this inspection</p> <p>2. Doug Miller, Administrator has contacted Shambaugh and Sons, our sprinkler inspection company, and reminded them that inspections must be done quarterly and that it is not acceptable to do two in one quarter if a quarterly inspection is missed</p> <p>3. The emergency steps have been cleared of snow. This will be mentioned to our snow removal contractor that these areas must be included during snow removal next winter</p>	

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	<p>including, but not limited to, mechanical water motor gongs, and pressure switches provide audible or visual signals shall be tested quarterly. Vane type waterflow devices may be tested semi-annually. NFPA 25, 9-4.4.2.1 requires the priming level shall be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires records shall indicate the procedure performed (inspection, test, or maintenance), the organization performed the work, the results and the date. Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and reaction valves. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and Nursing Supervisor on 02/12/14 at 12:40 p.m., a sprinkler inspection for the third quarter of 2013 was not available for review. Based on an interview with the Administrator at the time of record review, Shambaugh</p>						

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	<p>and Sons conducted two inspections in the fourth quarter of 2013 and he thought it was because an inspection had not been conducted in the third quarter.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 3 exits were readily accessible at all times in accordance with LSC Section 21.2.1. LSC Section 21.2.1 refers to Chapter 7. Section 7.1.6.4 requires walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the path of travel. This deficient practice could affect patients evacuated through the rear stairwell exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 02/12/14 at 2:05 p.m., the steps leading up to the sidewalk from the rear emergency exit were covered with six inches of snow. At the time of observation, the Administrator agreed the step should be clear in case of an emergency evacuation.</p>				

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K010144	<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 record 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, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system with in 10 seconds after loss of normal power. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the emergency generator operating log "Generator Maintenance" with the Administrator and the Nursing Supervisor on 02/12/14 at 1:05 p.m., the emergency generator was tested monthly under load for at least 30 minutes however, the monthly load test record did not include the time for the</p>	K010144	Doug Miller, Administrator has notified our generator maintenance company that the specifics of the monthly load test did not include the time for the transfer of power from the main source to the generator. They will include those details from now on	03/31/2014

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	transfer of power from the main source to the generator. This was acknowledged by the Administrator at the time of record review.				