

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001121	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/10/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST SURGICAL SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 7920 W JEFFERSON BLVD STE 210 FORT WAYNE, IN 46804
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K010000	<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: 12/10/14</p> <p>Facility Number: 003212 Provider Number: 15C0001121 AIM Number: 200413500A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, the Southwest Surgical Suites 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 is located in a suite on the second floor of a two story building, was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the ventilation ducts.</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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K010012	<p>The facility has elected to utilize Categorical Waivers pertaining to clean waste and patient record recycling containers, corridor projections for wheeled equipment, combustible decorations, medical gas alarms, relative humidity levels in anesthetizing locations and power strip use in patient care areas.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>IDR Committee met on 02/19/2015: No changes for K020, K0105 and K0114. K0118 was deleted.-DAustill</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings two or more stories in height and of Type II(000), III (200), or V (000) construction are equipped throughout with a supervised approved automatic sprinkler system in accordance with section 9.7. 20.1.6.3, 21.1.6.3</p> <p>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</p>	K010012	As observed upontour of the building not the facility, the three cables that were attached thebuilding's sprinkler pipe in the elevator machine room will be removed by thebuilding manager.	02/28/2015

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K010020	<p>Systems. 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 could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, three cables were attached to a fifteen foot length of sprinkler pipe in the elevator machine room on the first floor. Based on interview at the time of observation, the Administrator acknowledged three cables were attached to a fifteen foot length of sprinkler pipe in the elevator machine room on the first floor.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Vertical openings such as stairways, elevator shaftways, escalators, and building service shaftways are enclosed in accordance with section 8.2.5. 8.2.5.2, 38.3.1, 39.3.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 vertical opening stairways were provided with 1</p>	K010020	<p>Anne Haddix, Administrator, will work with the building owner to remove the three cables by 2/28/15.</p> <p>Anne Haddix, Administrator, will review the corrective action plan at the next meeting with the Medical Executive Committee on 02/19/15. The Board of Managers will be presented the corrective action plan for review and approval on 02/25/15. A report with the compliance will also be presented at the next Board Meeting.</p> <p>-</p> <p>I respectfully request that this deficiency be re-evaluated. An IDR record has been completed</p>	12/10/2014

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	<p>hour rated doors with self-closing devices. LSC 8.2.5.4 refers to 7.1.3.2 for enclosure of exits. 7.1.3.2.1 requires the separating construction shall meet the requirements of Section 8.2 and the following. (a) the separation shall have not less than a 1-hour fire resistance rating where the exit connects three stories or less. (c) Openings in the separation shall be protected by fire door assemblies equipped with door closer's complying with 7.2.1.8.</p> <p>This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, the following was noted:</p> <p>a. the north stairway door on the second floor was a non-rated solid wood core door.</p> <p>b. the east stairway was not enclosed and lacked fire rated doors at the top and bottom of the stairs. Based on interview at the time of the observations, the Administrator acknowledged the north stairway door on the second floor was not fire rated for one hour or more and the east stairway was not enclosed and lacked fire rated doors at the top and bottom of the stairs.</p>		<p>with supporting documentation and is attached.</p> <p>SouthwestSurgical Suites previously received the same citation. A plan of correction was submitted andaccepted as follows: The entirebuilding is a fully sprinklered building of Type II (000) construction.</p> <p>1. The non-rated solid core wood door at the opening into the North stair enclosure was protected by a close spaced sprinkler water curtain on the tenant side. The existing door with the sprinkler water curtain was used to provide a one (1) hour equivalent opening protective for the stair enclosure.</p> <p>1. The east stairway opening through the second floor was protected with an 18 inch draft stop and close spaced sprinklers not more than 6'-0" o.c., located 6 inches to 12 inches from the draft stop on the side away from the openings. The closed spaced sprinklers in combination with the draft stop will provide equivalent opening protection and limit the movement of smoke and fire from the first floor of the building to the second floor.</p> <p>Evidence of completion of said work was submitted and accepted by theLife Safety Code Section. I haveattached the original submission of applicable standards and support for saidcorrective action plan.</p>				

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K010029	<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 1 of 1 hazardous areas on the first floor were provided with self closing doors. LSC 39.3.2.1 states hazardous areas such as boiler or furnace rooms shall be protected in accordance with Section 8.4. Section 8.4 states doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self closing or automatic closing. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, the sprinkler riser room on the first floor contains two natural gas fired water heaters and the entry door to the room from the corridor was not provided with a self closing device. Based on interview</p>	K010029	<p>As observed upontour of the building not the facility, the building's boiler room door was not self-closing. The door will be equipped by a self-closingmechanism by the building manager. Anne Haddix,Administrator, will work with the building owner ensure completion of this workby 2/28/15.</p> <p>Anne Haddix,Administrator, will review the corrective action plan at the next meeting withthe Medical Executive Committee on 02/19/15 The Board of Managers will bepresented the corrective action plan for review and approval on 02/25/15. A report with the compliance will also bepresented at the next Board Meeting.</p>	02/28/2015

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K010050	<p>at the time of observation, the Administrator acknowledged the entry door to this hazardous area was not provided with a self closing device.</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 document transmission of the fire alarm signal for 4 of 4 first shift quarterly fire drills. LSC 21.7.1.2 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 Evaluation Form" documentation with the Administrator during record review from 10:30 a.m. to 2:00 p.m. on 12/10/14,</p>	K010050	<p>Clearer documentation of transmission of the fire alarm signal for the Center's quarterly fire alarmdrills will occur on the facility drill forms beginning in the first quarterdrills of 2015. Anne Haddix,Administrator, will ensure the form change occurs and is in place by 2/28/15.</p> <p>Anne Haddix,Administrator, will review the corrective action plan at the next meeting withthe Medical Executive Committee on 02/19/15 The Board of Managers will bepresented the corrective action plan and report of compliance for review andapproval on 02/25/15.</p>	02/28/2015

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K010076	<p>documentation for fire drills conducted on the first shift on 03/27/14 at 5:03 p.m., on 04/03/14 at 4:39 p.m., on 09/30/14 at 3:20 p.m. and on 10/27/14 at 10:56 a.m. did not include the transmission of the fire alarm signal. Based on interview at the time of record review, the Administrator acknowledged documentation for the aforementioned fire drills did not include the transmission of the fire alarm signal.</p> <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 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,</p>	K010076	<p>The door to the medical gas room will be equipped by a self-closing mechanism. The four inch conduit will be firestopped. Anne Haddix, Administrator, will oversee the completion of this work by 3/6/15.</p> <p>Anne Haddix, Administrator, will review the corrective action plan at the next meeting with the Medical Executive Committee on</p>	03/06/2015

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	<p>shall be in an enclosure with a fire resistive rating of at least one hour. LSC 8.2.3.2.1(a) states fire doors shall be installed in accordance with NFPA 80 Standard for Fire Doors and Fire Windows, 1999 Edition. LSC 8.2.3.2.1(b) states fire doors shall be self closing or automatic closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. This deficient practice could affect three patients and staff.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, the following was noted for the piped gas supply room:</p> <ol style="list-style-type: none"> <li>a. the entry door to the room from the corridor was not equipped with a self closing device and did not self close.</li> <li>b. a four inch in diameter conduit for the passage of cables through the west wall was not firestopped above the suspended ceiling above the entry door.</li> </ol> <p>Based on interview at the time of the observations, the Administrator acknowledged the entry door to the piped gas supply room was not self closing and the aforementioned opening in the west wall above the suspended ceiling did not</p>		02/19/15 The Board of Managers will be presented the corrective action plan for review and approval on 02/25/15. A report with the compliance will also be presented at the next Board Meeting.	

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K010105	<p>provide one hour fire resistive construction.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an emergency power system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2 Based on 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 21.2.9.2 requires ambulatory health care facilities to provide emergency lighting where general anesthesia or life support equipment is used to be in accordance with LSC Section 7.9. LSC Section 7.9.2.2 states an emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following: (1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply (2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities. LSC Section 7.9.2.5 requires the emergency lighting system to either be in continuous operation or be capable of repeated automatic operation without</p>	K010105	<p>Emergency lighting will be installed in the facility's operating rooms to supplement the fully functioning diesel generator to provide for continuous illumination. Anne Haddix, Administrator, will oversee the completion of this work by 3/6/15.</p> <p>Anne Haddix, Administrator, will review the corrective action plan at the next meeting with the Medical Executive Committee on 02/19/15. The Board of Managers will be presented the corrective action plan for review and approval on 02/25/15. A report with the compliance will also be presented at the next Board Meeting.</p>	03/06/2015

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K010114	<p>manual intervention. This deficient practice could affect three patients and staff in any of the three operating rooms.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, there is no battery operated emergency lighting to provide continuous illumination in each of the three operating rooms at the facility. Based on interview at the time of the observations, the Administrator stated clients in each of the three operating rooms can be completely sedated and rendered immobile using general anesthesia. Based on interview at the time of observation, the Administrator acknowledged an emergency generator is utilized to provide emergency lighting in each of the three operating rooms but there is no battery operated back up emergency lighting system to provide continuous illumination in each of the three operating rooms.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD 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 1¾</p>			

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	<p>inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>1. Based on observation and interview, the facility failed to ensure doors in 1 of 1 fire barriers separating the facility from other tenants and occupancies were 1 3/4 inch thick, solid-bonded, wood core or equivalent and were 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 observation with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, the main entrance door set to the patient waiting room were nonrated glass doors and were not equipped with a positive latching device. Based on interview at the time of observation, the Administrator acknowledged the aforementioned tenant separation doors were nonrated and were not equipped with a positive latching device.</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 one hour fire barriers separating it from an adjoining tenant. LSC Section 21.3.7.1</p>	K010114	<p>I respectfully request that this deficiency be re-evaluated. An IDR record has been completed with supporting documentation and is attached. The three inch by three inch passage of the cables will be fire stopped. Anne Haddix, Administrator, will oversee the completion of this work by 3/6/15. Anne Haddix, Administrator, will review the fire stop plan at the next meeting with the Medical Executive Committee on 02/19/15. The Board of Managers will be presented the corrective action plan for review and approval on 02/25/15. A report with the compliance will also be presented at the next Board Meeting.</p> <p>Southwest Surgical Suites previously received the same citation. A plan of correction was submitted and accepted as follows: The entire building is a fully sprinklered building of Type II (000) construction. The Southwest Surgical Suites used a self-closing laminated or tempered glass door and a laminated or tempered side light at the entrance to the suite with a close spaced sprinkler water curtain on the tenant side. The glass door and side light was used to provide an equivalent 3/4 hour opening protective as the one (1)</p>	12/10/2014

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	<p>requires ambulatory health care facilities to provide fire barriers with one hour fire resistance rating for tenant separation. LSC 21.3.7.3 requires any smoke barrier to be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one hour. LSC Section 8.3.6.1 states annular spaces caused by penetrations in fire barriers from pipes and conduits shall be filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. 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 observation with the Administrator during a tour of the facility from 2:30 p.m. to 4:30 p.m. on 12/10/14, a three inch by three inch opening for the passage of two cables was noted in the tenant separation fire wall above the suspended ceiling by the south exit door of the suite. Based on interview at the time of observation, the Administrator acknowledged the aforementioned opening in the tenant separation fire barrier had a fire resistance rating of less than one hour.</p>		<p>hour walls separating the surgery center from the other tenants of the building. The installation of the close spaced sprinkler water curtain was accepted as the plan of correction. Evidence of completion of said work was submitted and accepted by the Life Safety Code Section. I have attached the original submission of applicable standards and support for said corrective action plan.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001121	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/10/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST SURGICAL SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 7920 W JEFFERSON BLVD STE 210 FORT WAYNE, IN 46804
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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 ensure monthly load testing for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. LSC 21.5.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.3 states emergency generators shall be tested and maintained in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner,</p>	K010144	<p>The dieselgenerator will be tested monthly with the available EPSS load and exercised annuallywith supplemental loads for the total of two continuous hours. Documentation of the operating temperature, percentageof load capacity or minimum exhaust gas temperature for each monthly load test willbe added to the record.</p> <p>Anne Haddix,Administrator, will oversee the completion of this work by 3/16/15.</p> <p>Anne Haddix, Administrator, will review the fire stopplan at the next meeting with the Medical Executive Committee on 02/19/15 The Board of Managers will be presented the corrective action plan for review andapproval on 02/25/15. A report with thecompliance will also be presented at the next Board Meeting.</p>	03/16/2015

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST SURGICAL SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 7920 W JEFFERSON BLVD STE 210 FORT WAYNE, IN 46804
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	<p>based on facility operations. NFPA 110, 6-4.2.2 states diesel powered EPS installations which do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads for a total of two continuous hours. NFPA 110, 6-3.4 requires a written record of inspections, tests, exercising and repairs shall be regularly maintained on the premises. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Log" documentation with the Administrator during record review from 10:30 a.m. to 2:00 p.m. on 12/10/14, monthly load testing documentation for the emergency generator for the period of 12/02/13 through 11/05/14 does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test conducted. Based on interview at the time of record review, the Administrator acknowledged the aforementioned documentation does not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test conducted.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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