

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001166	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/24/2015
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NAME OF PROVIDER OR SUPPLIER  BALL OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification survey was conducted by the Indiana State Department of Health in accordance with Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 02/24/15</p> <p>Facility Number: 012159 Provider Number: 15C0001166 AIM Number: None</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code Recertification survey, Ball Outpatient 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.</p> <p>The facility was located on the second floor of a five story medical pavilion building with a basement and was determined to be of Type I (332) construction and fully sprinkled. The</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 0029 Bldg. 01	<p>facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/03/15.</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 doors to 1 of 3 hazardous areas, such as a general storage room, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any patients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 02/24/15 at 11:15 a.m. with the clinical director, the</p>	K 0029	<p>Responsible: The Clinical Director Corrective Action: The clinical director entered work order MA-1502964 requesting proper door closure installation on this door so it would close and latch properly. Job was completed on 3/18/15. The clinical director will ensure this door is added to the Environment of Care (EOC) committee checklist so regular monitoring of proper function of this door will be attained. Work order showing job completion, listed as Exhibit 1 on attachment titled "Life Safety 3.18.15 Life Safety Survey -Exhibits 1, 2, 3"</p>	03/18/2015

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K 0051 Bldg. 01	<p>general supply room, which measured two hundred thirty four square feet and stored fifteen shelves of combustible plastic surgery supplies, and plastic nursing supplies stored in one hundred six cardboard boxes, lacked a self closing device on the room door. This was verified by the clinical director at the time of observation and acknowledged at the exit conference on 02/24/15 at 12:55 p.m.</p> <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 Based on observation and interview, the facility failed to ensure 2 of 24 photoelectric smoke detectors were located where airflow would not prevent the operation of the detectors. LSC 21.3.4.1 refers to LSC 9.6. LSC 9.6 refers to NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by the air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice affect staff who work near the clean supply room and the environmental service room.</p>	K 0051	<p>Responsible: The Clinical Director Corrective Action: The clinical director entered work order MA-1502966 on 3/10/15 requesting the location of 2 photoelectric smoke detectors, in the 2 indicated areas, be moved beyond 2 feet of the supply air duct. Clinical director witnessed job completed on 3/13/15. Work order showing job completion, listed as Exhibit 2 on attachment titled "Life Safety 3.18.15 Life Safety Survey -Exhibits 1, 2, 3"</p>	03/13/2015

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K 0113 Bldg. 01	<p>Findings include:</p> <p>Based on observations on 02/24/15 during a tour of the facility with the clinical director from 9:50 a.m. to 12:55 p.m., the smoke detector located in the corridor by the clean supply room and the smoke detector in the environmental service room were both located within two feet of a supply air duct. This was verified by the clinical director at the time of observations and acknowledged by the clinical director at the exit conference on 02/24/15 at 12:55 p.m.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Designated aisles, corridors, passageways, and exitways are provided with illumination in accordance with section 7.8. 20.2.8, 21.2.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit discharge paths was provided with a double lighting fixture on emergency powered illumination. LSC 21.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.8. LSC 7.8.1.4 requires illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.20 ft-candle (2 lux) in any designated area.</p>	K 0113	<p>Responsible: The Clinical Director Corrective Action: The clinical director entered work order MA-1502967 on 3/10/15 requesting the first floor emergency room outside exit be provided with a single light fixture on the emergency power breaker panel. Maintenance supervisor ordered parts to complete job on 3/13/15 and states job will be completed by 3/26/15. Clinical director will ensure "on time" job completion. This exit lighting will be added to the Environment of Care (EOC) committee checklist</p>	03/26/2015			

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K 0147  Bldg. 01	<p>This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the clinical director on 02/24/15 at 12:05 p.m., the surgery suite south stairway enclosure discharges to the first floor emergency room exit. Furthermore, the first floor emergency room outside exit was provided with a single light fixture on the emergency power breaker panel. Based on an interview with the clinical director on 02/24/15 at 12:15 p.m., the hours of operation for the facility are from 8:00 a.m. to 5:00 p.m. and staff usually come into the facility a half hour before and stay a half hour after closing hours, which could leave the exterior of the first floor emergency room exit in darkness at the start and end of the daily shift. The lack of double light fixture outside the first floor emergency room exit was verified by the clinical director at the time of observation and acknowledged at the exit conference on 02/24/15 at 12:55 p.m.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code 9.1.2, 20.5.1</p>		so regular monitoring of this exit lighting will be attained. Work order showing job progress and date of expected completion, listed as Exhibit 3 on attachment titled "Life Safety 3.18.15 Life Safety Survey -Exhibits 1, 2, 3"	

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	<p>Based on observation and interview, the facility failed to ensure 5 of 16 wet locations were provided with ground fault circuit interrupters (GFCI) to prevent electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20, Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all patients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/24/15 during a tour of the facility with the clinical director from 9:40 a.m. to 12:55 p.m., the following wet locations had electric outlets within two feet of handwash sinks or wash tub basins not provided with GFCI protection to prevent electric shock: The electric outlet in the surgery suite soiled utility room by operating room #2 next to the wash tub</p>	K 0147	<p>Responsible: The Clinical Director Corrective Action: The clinical director entered work order MA-1502967 on 3/10/15 requesting installation of GFCI protection to prevent electric shock in the following areas: outlet in the surgery suite soiled utility room by operating room #2 next to the wash tub basin, the two electric outlets in the decontamination room next to the double sink, the extended stay room #2 two electric outlets next to the handwash sink, the extended stay room #4 two electric outlets next to the handwash sink, and the extended stay room #3 two electric outlets next to the handwash sink. Work order showing job completion, listed as Exhibit 3 on attachment titled "Life Safety 3.18.15 Life Safety Survey -Exhibits 1, 2, 3." Extended stay room #3 was changed as well.</p>	03/16/2015

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	<p>basin, the two electric outlets in the decontamination room next to the double sink, the extended stay room #2 two electric outlets next to the handwash sink, the extended stay room #4 two electric outlets next to the handwash sink, and the extended stay room #3 two electric outlets next to the handwash sink. Furthermore, all electric panels were checked on 02/24/15 at 11:55 p.m. with the clinical director and none of the listed locations were provided with GFCI protection in the electric breaker panels. The lack of ground fault circuit interrupters in the surgery suite soiled utility room, decontamination room, extended stay room #2, extended stay room #4, and extended stay room #3 was verified by the clinical director at the time of observations and acknowledged by the clinical director at the exit conference on 02/24/15 at 12:55 p.m.</p>			