

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001105	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER SOUTH EMERSON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237
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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 42 CFR 416.44(b).</p> <p>Survey Date: 08/13/15</p> <p>Facility Number: 002837 Provider Number: 15C0001105 AIM Number: NA</p> <p>At this Life Safety Code survey, South Emerson 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>This facility located in a one 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 corridor and in ventilation ducts.</p>	K 0000		

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 0021 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Any door with a required fire protection rating, such as stairways, exit passageways, horizontal exits, smoke barriers, or hazardous area enclosures, if held open, is arranged to close automatically by the actuation of the manual fire alarm system and either smoke detectors arranged to detect smoke on either side of the opening or a complete automatic sprinkler system. 20.2.2.3, 21.2.2.3</p> <p>Based on observation and interview, the facility failed to ensure 3 of over 20 corridor doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice affects all patients and staff.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 11:45 a.m. to 12:45 p.m. on 08/13/15, the corridor door to the soiled utility room, the dirty room for utensil cleaning and the washer room were each propped in the fully open position with a wedge on the floor. Based on interview at the time of the observations, the Administrator acknowledged the aforementioned corridor doors were propped in the fully open position with a wedge and not with a device arranged to automatically close upon activation of the</p>	K 0021	<p>Plan of correction was issued to remove all door stops from the facility and advising the staff that doors should not be propped open for any amount of time. (Plan of Correction enclosed) Responsible Party: Kim Foote Date of Correction: 08/24/2015</p>	08/24/2015

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K 0048 Bldg. 01	<p>fire alarm system.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>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>Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 which requires the authority having jurisdiction be notified and the building evacuated or an approved fire watch provided until the fire alarm system has been returned to service. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 9:10 a.m. to 11:45 a.m. on 08/13/15, a written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the Administrator acknowledged a written policy in the event the fire alarm system is out of service for four hours or more in a twenty</p>	K 0048	<p>The policy and procedure for emergency preparedness was re-written to include the fire watch language and what to do if the service is interrupted for 4 hours or more. (Please see policy)Person Responsible: Kim Foote Date of Completion: 09/02/2015</p>	09/02/2015

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K 0051 Bldg. 01	<p>four hour period was not available for review.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the northwest exit vestibule was installed where air flow would not adversely affect its operation. LSC 21.3.4.1 requires ambulatory health care facilities have a fire alarm system in accordance with 9.6. LSC Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to ensure notification of a fire at the location before it could be incapacitated by fire. This deficient practice could affect all patients, staff and visitors.</p>	K 0051	<p>1. A damper or flow regulator will be installed to redirect the air flow away from the smoke director or the HVAC damper will remain closed. 2. Per our discussions the Center passed all aspects of the fire inspection. From my discussions with Koorsen they will place the language of AHU which means that it is noted that at the time of the construction it passes the requirements. It will be up to whomever reviews the fire drill to determine if their standards are met. (Please see letter from Koorsen) Responsible Party: Kim Foote Date of Completion: September 18, 2015</p>	09/18/2015

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	<p>Findings include:</p> <p>Based on observation with the Administrator during a tour of the facility from 11:45 a.m. to 12:45 p.m. on 08/13/15, the smoke detector in the northwest exit vestibule was installed on the ceiling one foot from an air return vent and two feet from an air supply vent. The main fire alarm control unit for the facility is also located in the northwest exit vestibule. Based on interview at the time of observation, the Administrator acknowledged the smoke detector in the northwest exit vestibule was installed on the ceiling one foot from an air return vent and two feet from an air supply vent.</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 8 of 13 duct detectors were arranged to accomplish, without delay, any control functions required to be performed by that device. LSC 21.3.4.1 requires ambulatory health care facilities have a fire alarm system in accordance with 9.6. LSC 21.3.4.5 states operation of any activating device in the required fire alarm system shall be arranged to accomplish, without delay, any control functions required to be performed by that device. LSC 9.6.5.2(3) states smoke management or smoke control systems shall be actuated by the complete fire</p>			

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	<p>alarm system. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Detection Inspection Report" documentation dated 03/06/15 with the Administrator and the Maintenance Consultant during record review from 9:10 a.m. to 11:45 a.m. on 08/13/15, thirteen of thirteen facility duct detectors passed functional testing of the device but "AHU did not shut down" was listed in the comments section of the aforementioned report for eight of the thirteen duct detectors. All facility duct detectors were listed as Notifier Engineering Model FSD-751RP. Based on interview at the time of record review, the Administrator stated the aforementioned eight duct detectors were reevaluated by Koorsen and the facility after 03/06/15 and it was determined the air handling units were not required to shut down because the facility was not subject to Joint Commission requirements. In addition, documentation of why the air handling units were not required to shut down upon duct detector</p>			

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	<p>activation and documentation of any repair or adjustment of the facility ductwork smoke control systems on or after 03/06/15 was not available for review. This was acknowledged by the Administrator at the time of the exit interview at 12:45 p.m. Based on an Internet review of the Notifier Engineering Model FSD-751RP product specifications states "The FSD-751RP air duct smoke detector is a photoelectric detector...allowing detection of a hazardous condition. When sufficient smoke is sensed, an alarm signal is initiated at the fire control panel monitoring the detector and appropriate action can be taken to shut off fans and blowers and change over air handling systems, etc. This can isolate toxic smoke and fire gases or prevent their distribution throughout the areas served by the duct system." Based on observation with the Administrator and the Maintenance Consultant during a tour of the facility from 11:45 a.m. to 12:45 p.m. on 08/13/15, a duct detector and smoke damper were noted in the HVAC ductwork above the suspended ceiling in the corridor outside the women's locker</p>			

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K 0072 Bldg. 01	<p>room.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Draperies, curtains and other loosely hanging fabrics and films serving as furnishing, except curtains at showers, are in accordance with NFPA 701. 20.7.5.1, 21.7.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 facility exits was not used for any other purpose. LSC 21.2.1 states every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. LSC 7.1.3.2.3 states an exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuse. 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 11:45 a.m. to 12:45 p.m. on 08/13/15, a storage room for red bag hazardous waste serves as an intermediate room in the path of egress for the northwest facility exit access. The red bag hazardous waste storage room is marked as a facility exit with an exit sign</p>	K 0072	<p>The dirty room is used for pick up soiled products (red bag). It is an exit meaning it has access to the outside but would not be identified or used for an emergency exit for patients or staff in that area as the stretchers are too large to fit through the door. Emergency evacuation plan was reviewed and identified as a non patient evacuation route. The exit lighting will be removed (See new patient/employee emergency evacuation plan) Person in Charge: Kim Foote Completion date: October 26, 2015 (removal of exit lighting)</p>	08/31/2015

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K 0105 Bldg. 01	<p>in the exit access corridor outside the room. Four bins for red bag hazardous waste were being stored in the aforementioned exit enclosure. Based on interview at the time of observation, the Administrator stated the storage room has outside access for vendor pickup of red bag hazardous waste and acknowledged the aforementioned exit enclosure was being used for storage purposes as well.</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</p> <p>Based on observation and interview, the facility failed to provide emergency lighting in 2 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</p>	K 0105	<p>Upon further inspection the facility has generator service only. On 10/08/2015 an electrician was contacted to install emergency lighting. The lights will be mounted to the wall and hardwired with battery backup. Person Responsible: Kim Foote Completion Date: October 26, 2015</p>	10/26/2015

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	<p>(2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities.</p> <p>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 manual intervention. This deficient practice could affect two patients and staff in either of two operating rooms where general anesthesia or life support equipment is used.</p> <p>Findings include:</p> <p>Based on observations with the Administrator during a tour of the facility from 11:45 a.m. to 12:45 p.m. on 08/13/15, Operating Room 2 and Operating Room 3 were each not provided with battery operated emergency lighting to provide continuous illumination in two of three operating rooms where general anesthesia or life support equipment is used. Each operating room was supplied with a red light switch on the wall and a plug in flash light which required manual intervention to operate. Additional ceiling mounted lighting wired to the facility's electrical system in each operating room operated when the red light switch was flipped to the on</p>			

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K 0130 Bldg. 01	<p>position. Based on interview at the time of the observations, the Administrator stated patients in each of the aforementioned two operating rooms can be completely sedated and rendered immobile using general anesthesia. In addition, the Administrator stated an emergency generator is utilized to provide emergency lighting in each of the aforementioned operating rooms and is also operated by activation of the red light switch but acknowledged there is no battery operated back up emergency lighting system to provide continuous illumination in each of the two operating rooms where general anesthesia or life support equipment is used.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 which requires the authority having jurisdiction be notified and the building evacuated or an approved fire watch provided until the fire alarm system has been returned to service. In addition, sprinkler impairment</p>	K 0130	<p>Additional language was added to our Emergency Preparedness Plan addressing the life safety code (see enclosed policy)Person Responsible: Kim FooteCompleted:09/02/2015</p>	09/02/2015

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K 0144 Bldg. 01	<p>procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator from 9:10 a.m. to 11:45 a.m. on 08/13/15, a written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the Administrator acknowledged a written fire watch policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period was not available for review.</p> <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>			

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	<p>1. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 1 of 12 months. NFPA 99, 3-4.1.1.8 states 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 within 10 seconds after loss of normal power. 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 could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator Log" documentation with the Administrator and the Maintenance Consultant during record review from 9:10 a.m. to 11:45 a.m. on 08/13/15, documentation of emergency power transfer time to the emergency generator for monthly load testing for July 2015 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Consultant stated the facility recently</p>	K 0144	<p>1. A new log was created to monitor the transfer of power with 10 seconds. This will be monitored with the generator safety test. (Log Enclosed)2. A generator stop button has been ordered and once it has arrived will be put in place. (see email from McCallister Power Systems) Person Responsible: Kim Foote Date of Correction: 09/01/2015</p>	09/01/2015			

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	<p>revised emergency generator testing reporting form documentation and acknowledged emergency power transfer time for monthly load testing documentation for July 2015 was not available for review.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level 1 installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower or more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all patients, staff and visitors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001105	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER SOUTH EMERSON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237
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	<p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Consultant during a tour of the facility from 11:45 a.m. to 12:45 p.m. on 08/13/15, a remote shut off device was not found for the 200 kW diesel fired emergency generator. The nameplate on the emergency generator located outside of the building stated the unit was 200 kW and was manufactured December 4, 2000. Based on interview at the time of observation, the Administrator and the Maintenance Consultant acknowledged there is no remote emergency shut off device for the emergency generator.</p>			