

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001131	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER ELKHART CLINIC ENDOSCOPY AND SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2117 W LEXINGTON AVE ELKHART, IN 46514
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K0000	<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: 02/22/12</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>Facility Number: 003903 Provider Number: 15C0001131 AIM Number: 200263270A</p> <p>At this Life Safety Code survey, Elkhart Clinic Endoscopy and Surgery Center LLC 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 20, New Ambulatory Health Care Occupancies.</p>	K0000		

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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	<p>This facility is located on the south side of a one story building determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and most rooms.</p> <p>Quality Review by Dennis Austill, Life Safety Code Supervisor on 02/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0046	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 2 battery powered backup lights were tested monthly for 30 seconds and annually for a 90 minute duration to ensure the lights would provide lighting during periods of power outages. LSC 20.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Standard for Emergency and Standby Power Systems, at 5-3.1 requires Level 1 or Level 2 Emergency Power System (EPS) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all patients in the facility.</p>	K0046	<p>1. Maintenance staff has been instructed on how to conduct the monthly and annual tests on all battery backup emergency lighting. Annual testing was completed in February. Monthly testing for March will be completed by 3/23/12. A record of the testing will be kept on the form "Battery-operated Emergency Lights - Test Log."2. The administrator will audit the log quarterly to ensure appropriate testing has been completed in a timely manner and recorded as instructed. The administrator will follow up with the maintenance manager if corrections are needed.3. The maintenance manager is responsible for #1, ensuring he or his staff performs the monthly and annual testing, replaces batteries as needed, and records the checks on the appropriate form. The administrator is responsible for #2, ensuring that maintenance has performed and recorded the checks as instructed.4. The deficiency will be corrected by 3/23/12.</p>	03/23/2012			

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	<p>Findings include:</p> <p>Based on review of the Preventive Maintenance Checklist with the administrator at 1:51 p.m. on 02/22/12, a record of the annual or monthly testing of emergency lights was not found. During observation of the generator with the maintenance supervisor at 3:10 p.m. on 02/22/12, there was a battery powered light mounted on a pole above the emergency generator and another battery powered emergency light within the metal generator enclosure. The maintenance supervisor said they tested the lights monthly but they never wrote anything down.</p>				

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K0048	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD 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>1. Based on record review and interview, the facility failed to provide 1 of 1 sprinkler impairment policies as part of a complete written plan to protect all the patients in accordance with LSC 9.7.6.1 when the sprinkler system will be out of service for four hours or more in a 24 hour period which requires the authority having jurisdiction shall be notified and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. LSC 9.7.6.2 requires impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Chapter 11, Impairments at 11-2 requires the building owner to assign an impairment coordinator. NFPA 25 at 11-5 requires all preplanned impairments shall be authorized by the impairment coordinator with notification of the fire department, authorities having jurisdiction and the supervisors in the areas affected. 11-7 requires all the appropriate people be notified when the sprinkler system is returned to normal working order. This deficient practice</p>	K0048	<p>K0048</p> <p>1. The deficiency has been corrected through development of a fire watch policy. The policy was approved on 3/9/12; staff will be educated on the policy and it will be implemented by 3/23/12.</p> <p>2. In the future, when there is an impairment of the sprinkler or fire alarm system, the policy "Fire Protection Systems out of Service" will be followed.</p> <p>3. The administrator is responsible for #1 and #2 above.</p> <p>4. The deficiency will be corrected by 3/23/12.</p>	03/23/2012			

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	<p>could affect all patients as well as staff in case of a fire while the sprinkler system was impaired.</p> <p>Findings include:</p> <p>Based on review of the Life Safety Management policies at 1:51 p.m. on 02/22/12 with the administrator, the policies did not contain any procedures to follow if the sprinkler system was impaired. This was acknowledged by the administrator at the time of record review.</p> <p>2. Based on record review and interview, the facility failed to provide 1 of 1 fire alarm system impairment policies as part of a complete written plan including procedures to be followed in the event the fire alarm system is out of service for 4 or more hours in a 24 hour period to protect all the patients in accordance with LSC 9.6.1.8 which requires the authority having jurisdiction be notified and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. The deficient practice could affect all patients as well as staff in case of fire while the fire alarm system was impaired.</p> <p>Findings include:</p>				

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K0050	<p>Based on review of the Life Safety Management policies at 1:51 p.m. on 02/22/12 with the administrator, the policies did not contain any procedures to follow if the fire alarm system was impaired. This was acknowledged by the administrator at the time of record review.</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</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times. This deficient practice could affect all occupants of the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Drill Evaluation Forms on 02/22/12 at 1:51 p.m. and interview with the administrator, the facility has just one shift each day and the fire drill records for the last four quarters indicated all the fire drills were held between 3:00 p.m. and 3:30 p.m. This was acknowledged by the administrator at the time of record review.</p>	K0050	<p>K0050</p> <ol style="list-style-type: none"> The deficiency will be corrected by holding quarterly fire drills at unexpected times under varying conditions. The timing of subsequent drills will be at least 1 hour or more from the time the last drill was held. The deficiency was corrected on 2/29/12; a drill was held at 1:40 pm. The previous drill had been held at 3:15 pm. In the future, drills will be held at varying times under varying conditions each quarter. The administrator is responsible for #1 and #2. The deficiency was corrected on 2/29/12. 	02/29/2012			

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K0051	<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 5 of 91 smoke detectors were installed where air flow would not adversely affect the operation. LSC Section 20.3.4.1 requires facilities to be in accordance with LSC Section 9.6. 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, A-2-3.5.1 explains detectors should not be located in a direct airflow or closer than 3 feet from an air supply diffuser or return. This deficient practice could affect any occupants in the building .</p> <p>Findings include:</p> <p>Based on observations made with the maintenance supervisor on 02/22/12 between 2:25 p.m. and 3:14 p.m., the following smoke detectors were located less than three feet from an air supply or</p>	K0051	<p>K00511. The deficiency is being corrected by having Simplex Grinnell move any detectors that are closer than three feet to any air supply diffuser or return. A technician was at the facility on 3/5/12 and moved several detectors; a second visit to finish the work should be completed by 3/23/12. The maintenance manager is aware of where the circuit breaker for the fire alarm panel is located; it will be labeled in red as FIRE ALARM CIRCUIT CONTROL by 3/23/12.2. We will ensure that all smoke detectors are moved as required to be in compliance with code. In the future, construction or repairs will be monitored by the manager of maintenance and the administrator to ensure finished work meets Life Safety code. We will ensure that the circuit breaker for the fire alarm panel is labeled in red as FIRE ALARM CIRCUIT CONTROL and will perform random (quarterly at minimum) audits to ensure the labeling remains intact.3. The maintenance manager and administrator are responsible for #1 and #2.4. The deficiencies will</p>	03/23/2012			

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	<p>return vent: the smoke detector in the administrator's office was located one foot from an air vent, the smoke detector in the file room was located one foot from an air vent, the smoke detector in the soiled linen room was located six inches from an air vent, the smoke detector in the back entry was located one foot from an air vent and the smoke detector in the family room was located ten to 12 inches from an air vent. The maintenance supervisor acknowledged the aforementioned smoke detectors were near the air vents and understood how that might affect their operation.</p> <p>2. Based on observation and interview, the facility failed to ensure the circuit disconnecting means for the fire alarm system was identified in red as the Fire Alarm Circuit Control. LSC Section 20.3.4.1 requires facilities to be in accordance with LSC Section 9.6. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 1999 Edition, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). The circuit(s) and connections shall be mechanically protected. Circuit disconnecting means shall have red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM</p>		be corrected by 3/23/12.	

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	<p>CIRCUIT CONTROL. The fire alarm disconnecting means shall be permanently identified at the fire alarm control unit. This deficient practice could affect all the occupants in the facility.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm panel and electrical breaker boxes in the basement electrical room with the maintenance supervisor at 3:01 p.m.. on 02/22/12, the maintenance supervisor did not not know exactly where the circuit breaker for the fire alarm panel was located. It was soon found in one of the locked breaker boxes, but it was not labeled in red. This was acknowledged by the maintenance supervisor at the time of observation.</p>						

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K0064	<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 record review, observation and interview; the facility failed to maintain a record of monthly inspections for each fire extinguishers in facility for 12 of the last 12 months. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires monthly fire extinguisher inspections with at least the date of inspection and the initials of the person performing the inspection 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. In addition, NFPA 10, 4-3.4.1 requires personnel making inspections shall keep records of all fire extinguishers inspected and 4-3.4.3 says the records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist, or in an electronic system that provides a permanent record. This deficient practice could affect all patients, staff and visitors.</p>	K0064	<p>K00641. The deficiency has been corrected. The facility has been checking each fire extinguisher every month for the past 12 months and has recorded the check on the facility's monthly preventive maintenance form rather than on each extinguisher's tag. The March 2012 checks have been recorded as instructed on 2/22/12, on each extinguisher's tag. 2. In the future, each month the check will be recorded on the tag attached to each extinguisher. The administrator will perform random (quarterly at minimum) audits of the checks to ensure they are completed as instructed.3. The ASC supervisor and administrator are responsible for #1 and #2.4. The deficiency was corrected on 3/1/12.</p>	03/01/2012			

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	<p>Findings include:</p> <p>Based on review of the facility's Preventive Maintenance Checklist at 1:55 p.m. on 02/22/12 and interview with the administrator, there was a single entry for the month, Fire Extinguishers, and then a single check mark to indicate they all were checked. During the tour with the maintenance supervisor from 2:26 p.m. until 3:17 p.m. on 02/22/12, the inspection tag on the fire extinguisher in the hall just outside the conference room lacked any documentation of monthly inspections. According to interview with the maintenance supervisor, the person doing the inspections did not know they were allowed to write on the tags. The inspection tag on the fire extinguisher in the corridor between Endo 1 and Endo 2 was also blank as was the one observed in the basement mechanical room.</p>				

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K0077	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99</p> <p>Based on record review and interview, the facility failed to maintain a record of the initial acceptance tests for the medical gas systems NFPA 99, Health Care Facilities, 4-3.4.1.1 requires inspection and testing of all new piped gas systems, additions, renovations, temporary systems or repaired systems to assure the facility by a documented procedure that all the applicable provisions of this document (Code) have been adhered to and the system integrity has been achieved or maintained. The documentation pertaining thereto shall be maintained on site within the facility. This deficient practice could affect any of the patients using the medical gases.</p> <p>Findings include:</p> <p>Based on review of the facility's maintenance records with the administrator at 2:05 p.m. on 02/22/12, an initial acceptance test was not available for review. Interview with the administrator at the time of record review resulted in a call to the maintenance supervisor, and he did not have the records either.</p>	K0077	<p>K00771. The deficiency has been corrected. The administrator contacted the facility's architect from 2004, who delivered a copy of the report on 3/2/12. The record of the initial acceptance tests for the medical gas system was scanned and an electronic copy was saved; a copy was also emailed to the maintenance manager for reference. A hard copy was printed and placed in the facility's Life Safety manual. The manual is maintained in the administrator's office.2. The report in hard copy will be kept on file in the Life Safety manual, maintained in the administrator's office at the facility. An electronic copy exists on the administrator's computer hard drive; a copy was also sent to the maintenance manager. The administrator will perform periodic (quarterly) audits of the manual to ensure the report is present as required.3. The administrator is responsible for #1 and #2.4. The deficiency was corrected 3/2/12.</p>	03/02/2012			

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K0115	<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 a positive latcher. Doors are constructed of not less than 1¾ inch thick 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</p> <p>Based on observation and interview, the facility failed to maintain the one hour fire resistance of the wall dividing the facility into two smoke compartments. This deficient practice could affect any of the patients in the facility.</p> <p>Findings include:</p> <p>Based on observation at 2:48 p.m. on 02/22/12 with the maintenance supervisor, there was a hole roughly two inches wide and eight inches long in the drywall of the one hour separation wall above the ceiling next to the doctors' dictation alcove. When the maintenance supervisor saw the hole with the wires running through it, he said they were probably for the cameras which had been installed and agreed it should be repaired.</p>	K0115	<p>K01151. The facility will ensure a proper repair is made to the hole noted during the survey in the 1-hour fire wall dividing the facility into two smoke compartments.2. In the future, construction projects or repairs will occur under the supervision of the maintenance manager and facility administrator to ensure compliance with Life Safety code. Random (quarterly at minimum) audits of the facility will be performed by the maintenance manager and administrator to ensure the facility is properly maintained in compliance with code.3. The maintenance manager and administrator are responsible for #1 and #2.4. The deficiency will be corrected by 3/23/12.</p>	03/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001131	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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K0144	<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</p> <p>1. Based on record review and interview, the facility failed to ensure the load testing documentation for 1 of 1 emergency generators during the past 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintaining the minimum exhaust gas temperatures, or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This</p>	K0144	<p>K01441. The facility will correct the deficiency by reviewing the correct procedure and documentation of generator load testing with a MacAllister Power technician and appropriate maintenance staff, including the maintenance manager. The tech will be present at the facility on 3/13/12 to review correct procedure and discuss recordkeeping, in addition to answering any questions maintenance staff may have. A remote manual stop for the generator will be installed on 3/13/12.2. Maintenance staff will record all necessary information on the "Emergency Generator – Monthly Test Log" each month when the generator is tested under load. The administrator will periodically audit the log (quarterly at minimum) to ensure that data is being recorded properly as required. Necessary corrections will be reviewed with the maintenance manager. The location and purpose of the remote emergency stop for the generator will be reviewed with all maintenance staff and appropriate ASC staff.3. The maintenance manager is responsible for #1. The administrator is responsible for</p>	03/23/2012

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	<p>deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Emergency Generator Log (weekly) on 02/22/12 at 2:03 p.m. with administrator, the records included a start and stop time and a monthly load test, but there was no indication of the exhaust gas temperature, the operating temperature or what percentage of the nameplate load was produced. This was discussed with the administrator at the time of record review, and she said they had been discussing revising the generator log.</p> <p>2. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level 1 and 2 installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37,</p>		#2.4. The deficiency will be corrected by 3/23/12.				

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	<p>Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's maintenance records with the administrator at 1:51 p.m. on 02/22/12, the generator was installed in 2004. This was verified with the maintenance supervisor during observation of the generator at 3:10 p.m. on 02/22/12 when the manual stop on the generator control panel was observed. When asked if another remote stop was located in the vicinity, but away from one located inside the metal housing for the generator, he said there wasn't. No other manual stop device was observed in the vicinity.</p>						