

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001045	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER INDIANA ENDOSCOPY CENTERS	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD, STE 410 INDIANAPOLIS, IN 46202
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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: 04/16/14</p> <p>Facility Number: 006221 Provider Number: 15C0001045 AIM Number: 100380920A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Endoscopy Centers 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 located on the fourth floor of a seven story building was determined to be of Type II (111) construction and was fully sprinklered. The facility 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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K010021	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/14.</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 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 1 of 3 exit doors in the tenant separation fire barrier was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice affects all patients, staff and visitors in the patient waiting room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Clinical Manager</p>	K010021	The door stop was removed and it was communicated to staff via staff meeting that this is against life safety code. All doorstops will be thrown away. It will be the responsibility of registration and the clinical manager to ensure that no door stops are used.	05/07/2014

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K010046	<p>during a tour of the facility from 11:20 a.m. to 1:00 p.m. on 04/16/14, the corridor entry door to the patient waiting area was propped in the fully open position with a wedge. Based on interview at the time of observation, the Clinical Manager acknowledged the aforementioned tenant separation fire barrier door was propped open with a wedge and not with a device arranged to automatically close upon activation of the fire alarm system.</p> <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 Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 5 of 8 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery</p>	K010046	<p>The testing log was updated to reflect the necessity of testing the 4 procedure room lights along with the generator room lights. The employee responsible for this was educated. See attachment # 46 The clinical manager will check the log book monthly to ensure that these additional lights are being checked. Any deficiencies will be addressed with the responsible employee.</p>	05/07/2014

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	<p>powered emergency lighting system for not less than 1 ½ hour duration. 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. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for 2013 & 2014" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/2014, the facility maintains a written record of 30 second functional tests at 30 day intervals and an annual 90 minute test for a total of three battery operated emergency lights. Based on observations with the Administrator and the Clinical Manager during a tour of the facility from 11:20 a.m. to 1:00 p.m. on 04/16/14, a total of eight battery operated lights were located in the facility. A battery operated emergency light was located in each of four operating rooms and one light was located inside the emergency generator room in the parking garage. None of these five lights were included in the aforementioned testing logs. Based on</p>			

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K010050	<p>interview at the time of the observations, the Clinical Manager stated the battery operated emergency lights in the operating rooms were installed within the last year and acknowledged the facility does not maintain a monthly written record of individual results for 30 second functional tests and annual tests for five of eight battery powered emergency lights for at least a 1 ½ hour duration.</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 1. Based on record review and interview, the facility failed to document transmission of the fire alarm signal for 1 of 4 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</p>	K010050	<p>A. The necessity of pulling the fire alarm at each drill was communicated to staff via staff meeting. The most recent fire drill was conducted on 4/28/14. See attachment #50 for the fire drill and the attendees. B. The staff was reminded to vary the times of drills via staff meeting. This practice will be monitored by the clinical manager on a quarterly basis. It will also be monitored by our safety director. Any deficiencies in this practice will be addressed with that</p>	05/07/2014

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	<p>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 "Exhibit 2: Fire Drill Checklist" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, documentation for the fire drill conducted on the first shift (7:00 a.m. to 5:00 p.m.) on 02/06/14 did not include the transmission of the fire alarm signal. "No" was listed as the response to "Was the fire alarm signal transmitted?" and "Did the security company receive the alarm signal?" in the aforementioned fire drill report. Based on interview at the time of record review, the Clinical Manager acknowledged documentation for the first shift fire drill conducted on 02/06/14 did not include the transmission of the fire alarm signal.</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills under varying conditions for 3 of 4 calendar quarters. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p>		responsible employee.	

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	<p>Based on review of "Exhibit 2: Fire Drill Checklist" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, first shift (7:00 a.m. to 5:00 p.m.) fire drills conducted on 09/04/13, 12/18/13 and 02/06/14 were conducted at, respectively, 3:00 p.m., 2:30 p.m. and 3:00 p.m. Based upon interview at the time of record review, the Clinical Manager acknowledged documentation for first shift fire drills were not conducted under varying conditions.</p> <p>3. Based on record review and interview, the facility failed to document staff participation in 2 of 4 quarterly fire drills for 1 of 1 shifts. LSC 21.7.2.3 states all personnel shall be instructed in the use of and response to fire alarms. LSC 4.7.2 requires drills shall include suitable procedures to ensure that all persons subject to the drill participate. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Exhibit 2: Fire Drill Checklist" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, documentation</p>			

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K010051	<p>for the first shift (7:00 a.m. to 5:00 p.m.) fire drills conducted on 04/24/13 at 1:00 p.m. and on 12/18/13 at 2:30 p.m. did not list the staff who participated in the fire drill. Based on interview at the time of record review, the Clinical Manager acknowledged documentation for the aforementioned fire drills did not identify the staff which participated in the fire drills.</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 record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 refers to LSC 9.6.1.7 which refers to NFPA 72, the National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2</p>	K010051	Per building management, this testing is scheduled to be completed this week. The clinical manager will follow up with building management to ensure that this is being done and documented on a regular basis and within life safety timeframe requirements. It is the responsibility of the clinical manager to ensure that this requirement is consistently met.	05/14/2014

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K010114	<p>shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of AADCO Alarms & Communication Systems "Inspection and Testing Form" documentation dated 02/07/13 with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, it has been more than one year since the most recent documented fire alarm inspection was performed. Based on interview at the time of record review, the Clinical Manager stated documentation of fire alarm system inspections performed within the most recent twelve month period was not available for review and acknowledged it has been more than one year since the most recent fire alarm system inspection was performed.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are</p>			

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	<p>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 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>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 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 clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Clinical Manager during a tour of the facility from 11:20 a.m. to 1:00 p.m. on 04/16/14, the</p>	K010114	The building contractor has been up to look at the areas that need addressed under this citation. A quote has been recieved from them. We will proceed with fixing them once the PO has been issued. Work will be completed by 8/7/14. It will be the responsibility of the clinical manager, to make sure any building work that may occur that could result in a breach of the firewall, is immediately communicated with construction so that a fix can happen.	08/07/2014

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	<p>following was noted in the tenant separation fire wall:</p> <p>a. a twenty foot long by three feet high section above the ceiling by the corridor door to the patient waiting area had no fire barrier for tenant separation.</p> <p>b. a twenty foot long by one foot high section above the ceiling by Operating Rooms 1 and 2 had one layer of 5/8th inch drywall.</p> <p>c. an eight foot long by three feet high section above the ceiling by the north wall of the patient waiting area had one layer of 5/8th inch drywall.</p> <p>d. a six inch in diameter hole was noted above the ceiling in the north wall of the corridor leading to the internal medicine patient waiting area.</p> <p>e. the annular space surrounding a two foot high by ten inch wide opening for a duct above the ceiling at the surgical suite exit door to the corridor by the internal medicine patient waiting area was not firestopped.</p> <p>Based on interview at the time of the observations, the Clinical Manager acknowledged the aforementioned openings in the tenant separation fire barrier had a fire resistance rating of less than one hour.</p>			

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K010116	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings over 75 ft. in height housing ambulatory health care facilities are provided with a complete approved automatic sprinkler system in accordance with 11.8.</p> <p>1. Based on record review and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 2 of 4 calendar quarters. LSC 11.8.2.1 states an approved, supervised automatic sprinkler system shall be installed in accordance with 9.7. 9.7.5 states sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include: Based on review of Dalmatian Fire Inc.</p>	K010116	Please see attachments labeled "sprinkler inspection" for the missing quarters for the sprinkler checks. These were completed per requirements; it will be the responsibility of the clinical manager to make sure the reports are available. Building maintenance has been notified that the fire pump needs to be inspected, tested and maintained weekly. This will go into effect on 5/12/14. A meeting has been set up (5/15) between the clinical manager and the building manager to ensure that fire pump log has been amended and that weekly checks are happening on a regular basis. It will be the responsibility of the clinical manager to make sure this process happens.	05/12/2014

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	<p>"Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, sprinkler system inspection report documentation for the second quarter (April, May, June) 2013 and third quarter (July, August, September) 2013 was not available for review. Based on interview at the time of record review, the Clinical Manager acknowledged sprinkler system inspection report documentation for the second and third quarter 2013 was not available for review.</p> <p>2. Based on record review, observation and interview; the facility failed to document weekly fire pump inspection, testing and maintenance for 40 of 52 weeks. LSC 11.8.2.1 states an approved, supervised automatic sprinkler system shall be installed in accordance with 9.7. 9.7.5 states all automatic sprinkler and standpipe systems shall be tested, inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. NFPA 25, Chapter 5-1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump assemblies.</p>			

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	<p>Table 5-1.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Chapter 5-3.2.1 requires a weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes.</p> <p>Exception: A valve installed to open as a safety feature shall be permitted to discharge water.</p> <p>5-3.2.2.1. The automatic weekly test timer shall be permitted to be substituted for the starting procedure.</p> <p>The pertinent visual observations specified in Chapters 5-2.2.1, through Chapter 5-2.2.3 shall be performed weekly. Chapter 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Pump Report (Test Procedures)" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, the</p>			

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NAME OF PROVIDER OR SUPPLIER INDIANA ENDOSCOPY CENTERS	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD, STE 410 INDIANAPOLIS, IN 46202
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K010144	<p>facility documented monthly fire pump testing for the twelve month period of May 2013 through April 2014, but does not perform or document weekly fire pump testing. Based on observation with the Administrator and the Clinical Manager during a tour of the facility from 11:20 a.m. to 1:00 p.m. on 04/16/14, the facility has a fire pump located on the ground floor of the building. Based on interview at the time of record review and observation, the Clinical Manager acknowledged documentation of weekly fire pump inspection, testing and maintenance for the most recent twelve month 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 1. Based on record review and interview, the facility failed to ensure monthly load testing for the emergency</p>	K010144	A meeting has been set up next week, between IEC management and building management, so that	06/18/2014

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	<p>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, based on facility operations.</p> <p>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.</p> <p>NFPA 110, 6-3.4 requires a written</p>		<p>monthly generator load testing can be coordinated and performed. Part of the load testing documentation will include the transfer time too. On 5/15, this meeting will occur. It will be the responsibility of the clinical manager to make sure this testing occurs on a regular basis. Logs will be checked.</p>	

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	<p>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 Power Systems-Monthly Report" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, monthly load test documentation for the emergency generator for the twelve month period of May 2013 through April 2014 does not state how long the emergency generator ran and the operating temperature, percentage of load capacity or minimum exhaust gas temperature was not recorded for each monthly load test conducted. Based on review of MacAllister Power System "Load Bank Test Report" documentation dated 01/24/14, the facility conducted an annual load bank test pursuant to NFPA 110, 6-4.2.2. Based on interview at the time of record review, the Clinical Manager stated annual load bank testing is performed instead of recording the percent of nameplate rating and acknowledged monthly load tests were not documented as occurring for at least thirty minutes for monthly generator load testing for the twelve month period of</p>			

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	<p>May 2013 through April 2014.</p> <p>2. 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 12 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 Power Systems-Monthly Report" documentation with the Administrator and the Clinical Manager during record review from 9:35 a.m. to 11:20 a.m. on 04/16/14, documentation of emergency power transfer time to the emergency generator during monthly load tests for the period of May 2013 through April 2014 was not available for review. Based on interview</p>			

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	at the time of record review, the Clinical Manager acknowledged emergency power transfer time during monthly load testing for the aforementioned period was not available for review.			