STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER NOVAMED PAIN MANAGEMENT CENTER OF NEW ALBANY LL		STREET ADDRESS, CITY, STATE, ZIP CODE 520 W FIRST ST NEW ALBANY, IN 47150	

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K010000	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). Survey Date: 12/17/13 Facility Number: 003733 Provider Number: 15C0001136 AIM Number: 200503680A Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code Recertification survey, Novamed Pain Management Center of New Albany 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. This one story facility with a basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	spaces open to the corridors. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/30/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010020	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. 8.2.5.1, 38.3.1, 39.3.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.2.5.5 requires unless prohibited by Chapters 12 through 42, unenclosed floor openings forming a communicating space between floor levels shall be permitted, provided the following conditions are met: (4) The communicating space is separated from the remainder of the building by fire barriers with no less than a 1 hour fire resistance rating. LSC 8.2.5.5, Exception No.1 requires in buildings protected throughout by an approved automatic sprinkler system in	K010020	The following ceiling areas of the biohazard room, the basement utility room, and the south stairway will each be sealed to ensure fire resistance. This will be accomplished with fire rated caulk and drywall. Based on availability of the fire resistant caulk products, this project will be completed by January 27, 2014. In addition, ther vertical open stairways have had their hardware replaced to wnxure latching enclosure. This was completed on 12/20/2013. Completion and monitoring of this plan of correction will be overseen by the administrator.	01/27/2014

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	accordance with Section 9.7, a smoke barrier in accordance with Section 8.3 shall be permitted to serve as the separation required by 8.2.5.5 (4). LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all patients in the facility. Findings include: Based on observations with the director of nursing on 12/17/13 during a tour of the facility from 9:10 a.m. to 12:55 p.m., the following ceiling smoke barriers were not fire stopped; a. The basement biohazard room ceiling had six inch by six inch square area of drywall missing around a two inch plumbing fixture, a twelve inch by twelve inch area of drywall missing in the center of the ceiling and a two inch gap around an electrical conduit penetration which was not fire stopped. b. The basement utility room ceiling had two, four inch gaps around water pipe penetrations which were not fire stopped and a one inch gap around the square air handler duct penetration which was not fire stopped. c. The south stairway ceiling had a one half inch gap around a water pipe penetration which was not fire stopped. The missing ceiling drywall and			

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	penetrations not firestopped were verified by the director of nursing at the time of observations and acknowledged by the director of nursing at the exit conference on 12/17/13 at 1:00 p.m. 2. Based on observation and interview, the facility failed to ensure the doors to 2 of 4 vertical opening stairways were provided with latching hardware which closed and latched into the door frame. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice affects staff only in the staff office area in the basement. Findings include: Based on observation on 12/17/13 during a tour of the basement staff offices with the director of nursing from 9:20 a.m. to 10:10 a.m., the south basement stairway door failed to self close and latch into the door frame, leaving a one inch gap. Furthermore, the basement delivery			

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	stairway door was missing the latching hardware. This was verified by the director of nursing at the time of observations and acknowledged at the exit conference on 12/26/13 at 1:00 p.m.			
K010051	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 1 of 46 photoelectric smoke detectors was located where airflow would not prevent the operation of the detector. LSC 20.3.4.1 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 use the basement locker room/surgical clothing changing room. Findings include: Based on observation on 12/17/13 at 10:30 a.m. with the director of nursing, the smoke detector in the basement	K010051	The airflow vent in the employee locker room will be relocated to ensure the proper function of the smoke detector. The contractor was notified and is scheduled on January 9, 2014 for assessment. The plan for repair is scheduled for January 15, 2014. The administrator will oversee the completion of this project.	01/27/2014

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	locker room/surgical clothing changing room was located within one foot of a supply air duct. This was verified by the director of nursing at the time of observation and acknowledged by the director of nursing at the exit conference on 12/17/13 at 1:00 p.m.			
K010117	416.44(b)(1) LIFE SAFETY CODE STANDARD Utilities shall comply with section 9.1 Electrical Wiring and Equipment and shall be in accordance with NFPA 70 National Electrical Code. 20.5.1, 21.5.1, 9.1, See also K-147 Based on observation and interview, the facility failed to ensure 3 of 13 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	K010117	The 3 GFCI were noted and will be installed. Due to additional electrical installlation in the center, the administrator has elected to install the GFCI to cooincide with this electrician's visit on February 10, 2014. The administrator will oversee the completion of this project.	02/10/2014

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	deficient practice affects all patients in the facility. Findings include: Based on observations on 12/17/13 during a tour of the surgery suites with the director of nursing from 11:20 a.m. to 12:00 p.m., the following wet locations had an electric outlet within two feet of handwash sinks which were not provided with GFCI protection to prevent electric shock: the substerile room, the surgery suites soiled linen room, the two outlets in the operating room corridor by the ultrasound equipment. Furthermore, all electric panels were checked on 12/17/13 at 12:15 p.m. with the maintenance supervisor, who was called into the facility by the director of nursing to inspect the electrical panels, piped in medical gases, and emergency generator set. The lack of ground fault circuit interrupters in the substerile room, surgery suites soiled linen room, and operating room corridor by the ultrasound equipment was verified by the director of nursing and maintenance supervisor and acknowledged by the director of nursing at the exit conference on 12/17/13 at 1:00 p.m.			

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K010144	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 Based on observation and interview, the facility failed to provide emergency task lighting in and around 1 of 1 emergency generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 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 Section 5-3.1 requires the Emergency Power Supply (EPS) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all patients in the facility. Findings include: Based on observation with the maintenance supervisor on 12/17/13 at 12:40 p.m., the emergency generator, which was located outside and to the east of the main entrance, was housed in a plastic fence with a plastic cover over the fencing. The area where the emergency	K010144	A battery backup emergency light will be purchased and installed in the enclosed generator area. Due to additional electrical installation in the center, the administrator has elected to install the battery powered task lighting to coincide with this electrician's visit on February 10, 2014. The Administrator will oversee the completion of this project.	02/10/2014

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	generator was housed lacked battery backup lighting. This was verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing at the exit conference on 12/17/13 at 1:00 p.m.			