

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152602	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2014
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NAME OF PROVIDER OR SUPPLIER  LIBERTY DIALYSIS MONTICELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 810 S SIXTH ST MONTICELLO, IN 47960
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K010000	<p>A Life Safety Code Recertification Survey for an End Stage Renal Disease (ESRD) facility was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.60(d).</p> <p>Survey Date: 08/27/14</p> <p>Facility Number: 010668 Provider Number: 152602 AIM Number: 200387680B</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At Life Safety Code survey, Liberty Dialysis Monticello was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 494.60(d), 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 was located on the second floor of a two story fully sprinklered building determined to be of Type II (111) construction. The facility has a fire alarm system with hard wired 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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K010014	<p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/16/14.</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 Interior finish on walls and ceilings of exits, enclosed corridors, and exit access furnishing is Class A or B (offices Class A, B, or C.) 38.3.3.2, 39.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A, or B in 2 of 2 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Operations Director and Maintenance Director on 08/27/14 at 1:00 p.m., wood wainscoting covered the lower half of the exit corridor walls in the south smoke compartment and three walls in the reception/waiting area in the north smoke compartment. The Maintenance Director said at the time of record review on 08/27/14 at 2:50 p.m., no documentation was immediately available to demonstrate the siding</p>	K010014	<p>Wood wainscoting will be removed and drywall will be patched and painted. This task will be completed by 10-16-2014. ATOM will be responsible for insuring that the task is completed and reported in QAI by 10-31-2014.</p>	10/31/2014
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K010050	<p>exhibited a flame spread classification of Class A or B.</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 Based on record review and interview, the facility failed to provide evidence fire drills documenting staff training and participation were conducted on every shift during 3 of the past 4 quarters.</p> <p>Findings include:</p> <p>Based on a review of Code Red Drills on 08/27/14 at 3:10 p.m. with the Operations Director and Maintenance Director for the past year, records for fire drills showed no drill for the fourth quarter of 2013. No staff participation in fire drills was evidenced for fire drills during the second quarter of 2013 and the third quarter of 2013. The Operations Director acknowledged at the time of record review, the records did not show all staff were trained and participated in fire drills each quarter.</p>	K010050	<p>Fire drills will be conducted on Friday October 3rd 2014. An in-service record of all documentation needed for the drills will be present in the facility and presented in QAI meeting before October 31st 2014. All staff and patients were informed about emergency procedures. Drill documentation. Fire drills are scheduled quarterly and clinic Manager is responsible for conducting fire drills. Director of Operations will provide oversight. Fire drill compliance will be reviewed in QAI quarterly.</p>	10/31/2014
K010076	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care</p>			

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K010114	<p>Facilities, and NFPA 101.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside. 4.3.1.1.2, 20.3.2.4, 21.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases in the Bio Med room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Operations Manager and Maintenance Director on 08/27/14 at 1:10 p.m., one oxygen e-cylinder was stored without support in the Bio Med room. The Maintenance Director acknowledged at the time of observation, the cylinder was improperly stored.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p>	K010076	On 8-27-14 the oxygen cylinder was chained securely and stored in a designated location. Clinic manager will report compliance monthly as part of QAI.	10/31/2014			

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	<p>Ambulatory health care occupancies are 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 ensure a 1 of 2 doors in a one hour fire barrier providing separation from other tenants occupying the same building was fire rated. LSC 20.3.7.1 requires ambulatory health care facilities shall be separated from other tenants and occupancies by walls having not less than a 1 hour fire resistance rating. This deficiency could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Operations Manager and Maintenance Director on 08/27/14 at 1:30 p.m., the door providing separation between the facility and adjacent occupancy failed to latch when permitted to self close. Additionally there was no fire rating on the door. The Maintenance Director acknowledged at the time of observation, there was no way to determine whether the door met the fire resistance required in a one hour fire barrier.</p>	K010114	Non fire rated exit doors will be replaced with 1 hour fire rated doors by 10-16-2014. ATOM will be responsible for insuring task is completed. Task completion will then be reported in QAI by 10-31-2014.	10/31/2014

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K010130	<p>Based on observation and interview, the facility failed to ensure 1 of 2 fire exit doors was provided with a door knob readily operated under all lighting conditions. LSC 21.2.1 requires compliance with Chapter 7. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Operations Manager and Maintenance director on 08/27/14 at 1:30 p.m., the south exit door had a locking door knob and deadbolt. The Maintenance Director acknowledged the doors could require more than a single action to open the door if both were latched.</p>	K010130	Dead bolt will be removed by 10-16-2104. ATOM will be responsible for insuring task is completed. Task completion will then be reported in QAI by 10-31-2014.	10/31/2014
K010146	416.44(b)(1) LIFE SAFETY CODE STANDARD The ASC with no life support equipment has			

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	<p>an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of normal source in accordance with NFPA 99. 3.6.3.1.1</p> <p>Based on record review and interview, the facility failed to ensure 6 of 6 battery powered emergency lighting fixtures was tested annually for 1 1/2 hours. LSC 7.8.2.2 allows the use of battery operated emergency lighting used as permitted under Section 7.9. LSC 7.9.3 requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours and monthly testing at 30 day intervals for not less than 30 seconds. Written records of visual inspections and tests shall be kept. This deficiency affects all occupants.</p> <p>Findings include:</p> <p>Based on review of service, maintenance, inspection and test records with the Operations Manager and Maintenance Director on 08/27/14 at 2:25 p.m., a record of an annual 1 1/2 hour test of the six battery powered emergency lighting fixtures located throughout the facility was not found. In addition, the checklist provided as evidence of monthly testing noted "check emergency lighting under full load" with a column for the date completed and initial. The document did</p>	K010146	<p>On 9-4-2014 the 90 minute load test was completed and documented. See attached log. Each emergency light was numbered to track routine testing requirements. Biomedical technician will be responsible for completion of tasks. ATOM will provide oversight and report compliance in QAI.</p>	10/31/2014

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	not identify the monthly test method, the location of each fixture, and whether the fixture passed or failed the test. The Maintenance Director confirmed at the time of record review, evidence for 1 1/2 hour annual and 30 second monthly testing of emergency lighting was incomplete.				