

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152525	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2012
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 W 86TH ST INDIANAPOLIS, IN 46260
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K0000	<p>A Life Safety Code Certification Survey was conducted for the relocation of an End Stage Renal Disease (ESRD) facility by the Indiana State Department of Health in accordance with 42 CFR 494.60(d).</p> <p>Survey Date: 05/14/12</p> <p>Facility Number: 005139 Provider Number: 152525 AIM Number: 100217180A</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At Life Safety Code survey, Fresenius Medical Care Indianapolis North 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 20, New Ambulatory Health Care Occupancies.</p> <p>This one story facility with a partial second story over the storage room, water treatment room and administrative offices was determined to be of Type II (000) construction and sprinklered. The facility has a fire alarm system with smoke</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>detection in the corridors and in all treatment areas.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0012	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings two or more stories in height and of Type II (000), III (200), or V (000) construction are equipped throughout with a supervised approved automatic sprinkler system in accordance with section 9.7. 20.1.6.3, 21.1.6.3</p> <p>1. Based on record review and interview, the facility failed to provide documentation for the initial automatic sprinkler system acceptance inspection in accordance with LSC 9.7. LSC 9.7.1 requires all automatic sprinkler systems shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13 Section 10-1(2) requires facilities to perform all required acceptance tests. Section 10-2 requires the flushing of piping, hydrostatic tests (pressure), system operational tests (i.e. flow tests of alarms) and provide hydraulic design information sign. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include: Based on review of "FMC-Equipment Record ER-1" quarterly sprinkler system inspection records dated 03/29/12 with the Technical Operations Manager and the Technical Supervisor during record review from 9:40 a.m. to 11:15 a.m. on 05/14/12, an initial automatic sprinkler</p>	K0012	<p>The Governing Body of Indianapolis North met on 6-8-12 to review and adopt a facility specific plan to ensure that the facility is compliant with 2000 edition of Life Safety Code of the National Fire Protection Association. As documented in the 2567 response to the Life Safety Code survey concluded May 14, 2012: . On 5-25-12 Koorsen Fire and Security completed initial inspection of Automatic Sprinkler System and Fire Alarm System. Record of the work performed is maintained in the facility and documented on the ER-1 (equipment repair record). This inspection has been amended on the Facility Life Safety Equipment Schedule / QAI audit tool and will be performed annually going forward, by a qualified vendor, such as Koorsen Fire and Security, next due in May 2013. Quarterly inspections of the Automatic Sprinkler System and Fire Alarm System which began on 3-29-12, as per the Facility Life Safety Equipment Schedule / QAI audit tool, will continue as scheduled and will be performed by a certified NFPA-LSC Company</p>	06/22/2012			

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	<p>system acceptance inspection documentation was not available for review. Based on interview at the time of record review, the Technical Supervisor stated the facility opened in December 2011 and a sprinkler system inspection was performed on 03/29/12 but acknowledged no initial automatic sprinkler system acceptance inspection records were available for review.</p> <p>2. Based on record review and interview, the facility failed to ensure sprinkler inspections were conducted by a qualified person in accordance with LSC 9.7. LSC 9.7.1 requires all automatic sprinkler systems shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 12-1 requires sprinkler systems installed in accordance with this standard shall be properly inspected, tested and maintained in accordance with NFPA 25, 1998 edition, Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 1-4.2 indicates the responsibility for properly maintaining a water based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be</p>		(Koorsen)Record of this work will be maintained in the facility and documented in the ER-1 log (equipment repair log)The Technical Supervisor is responsible to review the quarterly audit results and present/review with the Clinical Manager per the QAI calendarThe Clinical Manager is responsible to present the results to the QAI Commitee for review and oversight		

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	<p>revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience.</p> <p>Exception: Where the owner is not the occupant, the owner shall be permitted to pass on the authority for inspecting, testing, and maintaining the fire protection systems to the occupant, management firm, or managing individual through specific provisions in the lease, written use agreement, or management contract. This deficient practice affects all patients being treated in the facility.</p> <p>Findings include: Based on a review of facility maintenance records with the Technical Operations Manager and the Technical Supervisor during record review from 9:40 a.m. to 11:15 a.m. on 05/14/12, the quarterly sprinkler system inspection on 03/29/12 was conducted by facility staff. Based on interview at the time of record review, the Technical Supervisor stated the facility opened in December 2011 and acknowledged one quarterly sprinkler system inspection was performed on 03/29/12 by facility staff. The Technical</p>						

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	Supervisor indicated staff had received training to conduct the sprinkler inspection but did not have a copy of NFPA 25 available. Based on review of the staff training record, there was no indication of training pertaining to the sprinkler system or mention of NFPA 25.			

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K0021	<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 areas 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 2 stairwell exit doors was one hour fire rated, self closed and latched into the door frame. LSC 20.2.2.1 says the means of egress shall be limited to the types described in 38.2.2. LSC 38.2.2.2.1 says doors complying with 7.2.1 shall be provided and 7.2.1.1.1 says a door assembly shall conform to the general requirements of Section 7.1. LSC 7.1.3.2.1 states an exit required to be separated from other parts of the building shall be separated with not less than one hour fire resistance rating where the exit connects three stories or less and 7.1.3.2.1(c) requires openings in the separation shall be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, Standard for Fire Doors and Fire Windows, at 2-1.4 requires all swinging doors to be closed and latched at the time of fire and 2-1.4.1 requires the door to close and latch each time it is opened. This deficient practice affects any staff or</p>	K0021	On 5-25-12 Central Indiana Hardware installed a new 1.5 hour fire rated door, with self-closing device attached to the door frame. Record of this work performed is maintained in the facility and documented on the ER-1 (equipment repair record)	06/18/2012			

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	<p>visitor exiting second floor training room, break room and administrative offices from the stairwell by the storage room.</p> <p>Findings include:</p> <p>Based on observation with the Technical Operations Manager and the Technical Supervisor during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 05/14/12, the ground floor stairwell exit door by the storage room was observed in the open position, it has no fire resistance rating on the door and the door is not equipped with a self closing device.</p> <p>Based on interview at the time of observation, the Technical Operations Manager acknowledged the ground floor stairwell exit door by the storage room has no fire resistance rating and the door is not equipped with a self closing device.</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 observation and interview, the facility failed to provide exterior emergency lighting for one of six exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect patients, staff and visitors exiting the facility from the front entrance if the facility were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Technical Operations Manager and the Technical Supervisor during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 05/14/12, the front entrance is not provided with exterior emergency lighting. Based on interview at the time of observation, the Technical Operations Manager stated the facility does not have an emergency generator for emergency lighting, the facility has a night shift concluding at 9:30 p.m. and acknowledged no exterior emergency lighting was provided at the front entrance.</p>	K0046	<p>On 5-31-12 Resource Construction Inc. installed and tested a temporary exterior emergency battery backup light at the front entrance for means of egress. The permanent fixture, to match the existing fixtures, has a 3 week lead time, with an estimated installation date of 6-28-12 by Resource Construction Inc., per Purchase Order #4506929653. Record of this work performed is maintained in the facility and documented on the ER-1 (equipment repair record) The lights will be checked per the QAI/LSC checklist monthly to ensure they are in operating condition. The Technical Supervisor is responsible to review the QAI/LSC audit results and present/review with the Clinical Manager per the QAI calendar. The Clinical Manager is responsible to present the results to the QAI Committee for review and oversight.</p>	06/18/2012			

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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 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 review of "FMC Indianapolis North - Facility Specific Fire Safety Plan" documentation with the Technical Operations Manager and the Technical Supervisor during record review from 9:40 a.m. to 11:15 a.m. on 05/14/12, the facility did not have 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. Based on interview at the time of record review, the Technical Supervisor acknowledged there is no written policy in the event the fire alarm</p>	K0048	<p>On 5-17-12, the Governing Body met and adopted Fire Watch Policy #FMS-CS-IC-II-130-016A in the event that the fire alarm system is placed out of service for 4 or more hours within a 24 hour period, for the protection of all patients, staff and visitors, in the event of an emergency. The FMC Indianapolis North – Facility Specific Fire Safety Plan has been updated to reflect this policy. The Clinical Manager Director of Operations, the Technical Supervisor and Biomedical Technician have been designated to perform Fire Watches as trained by the Clinical Manager on 6-14-12. Record of this training will be maintained in personnel files. If a fire watch is required, it will be documented within the QAI with observations as to the efficiency of the fire watch as well as a determination of the default and correction of the sprinkler system requiring the fire watch. If necessary, the Clinical Manager will present the issues to the monthly QAI Committee for review and oversight.</p>	06/18/2012			

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	<p>system is out of service for four hours or more in a twenty four hour period.</p> <p>2. Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC 9.7.6. LSC 9.7.6.1 states where a required automatic sprinkler system is out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified and the building shall either 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. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "FMC Indianapolis North - Facility Specific Fire Safety Plan" documentation with the Technical Operations Manager and the Technical Supervisor during record review from 9:40 a.m. to 11:15 a.m. on 05/14/12, the facility did not have a written policy in the event the sprinkler system is out of service for four hours or more in a twenty four hour period. Based on interview at</p>						

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	the time of record review, the Technical Supervisor acknowledged there is no written policy in the event the sprinkler system is out of service for four hours or more in a twenty four hour period.			

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K0050	<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 document quarterly fire drills for 3 of 3 shifts. LSC 21.7.1.2 requires ambulatory health care facilities to conduct quarterly fire drills for each shift and fire drills shall include the transmission of the fire alarm signal. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Technical Operations Manager and the Technical Supervisor from 9:40 a.m. to 11:15 a.m. on 05/14/12, documentation of fire drills conducted on 3 of 3 shifts since the facility opened in December 2011 was not available for review. Based on interview at the time of record review, the Technical Supervisor stated the facility opened in December 2011 and stated the facility operates for three shifts per day on Monday, Wednesday and Friday and two shifts per day Tuesday, Thursday and Saturday. The Technical Supervisor stated fire drills have been conducted, but acknowledged no written documentation</p>	K0050	<p>On 5-21-12 and 5-22-12, the Clinical Manager provided an in-service to all staff members reviewing the Indianapolis North. The "Facility Specific Fire Safety Plan" Fire/Emergency Drill Observation documentation and attendance sheet are available at the facility. Fire drills were held on 5-21-12, 3 on 3 shifts and 5-22-12, 2 on 2 shifts, to include activation of the fire alarm and staff members' specific roles. Documentation of the drills is available within the facility. Ongoing, fire drills will be held per the QAI quarterly audit tool. A review/observation of the efficiency of the fire drills was discussed during the May 22nd 2012 QAI Meeting. Any opportunities for improvement were noted and will be addressed with the next quarterly drills. The Clinical Manager or designee is responsible to ensure the drills are conducted quarterly per the QAI Calendar, to include both patients and staff, and documentation will be available within the facility. The Clinical Manager is responsible to present the results of the drill to the monthly QAI Committee, as conducted and the QAI</p>	06/18/2012			

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	of fire drills conducted since the facility opened in December 2011 was available for review.		Committee is responsible to review and provide oversight.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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>Based on observation and interview, the facility failed to ensure 6 of 43 smoke detectors were installed in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 20.3.4.1 states fire alarm systems shall be provided in accordance with Section 9.6. LSC 9.6.1.4 states a fire alarm system required for life safety shall be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, Section 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. In NFPA 72, Appendix A, Explanatory Material at A.2-3.5.1 states detectors should not be located in a direct airflow nor closer than three feet from an air supply diffuser or return air opening. This deficient practice affects all occupants in the facility including staff, visitors and patients.</p> <p>Findings include:</p>	K0051	<p>On 5-21-12 Resource Construction Inc. relocated 9 of 43 smoke detectors found within 3 feet of air supply vents or return air openings to be in compliance with the applicable requirements of NFPA 72, National Fire Alarm Code. Record of this work performed is maintained in the facility and documented on the ER-1 (equipment repair record). The Clinical Manager is responsible to present all data to the QAI Committee on the appropriate scheduled date. The QAI Committee is responsible for analysis and trending of the data. The Governing Body is responsible to ensure the audits are occurring and document ongoing resolution of the citations.</p>	06/18/2012			

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	<p>Based on observations with the Technical Operations Manager and the Technical Supervisor during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 05/14/12 the following was noted:</p> <p>a) the smoke detector on the ceiling on the second floor at the top of the stairwell by the storage room was located one foot from an air supply vent.</p> <p>b) two of two smoke detectors on the ceiling in the second floor training room were each located one foot from an air supply vent.</p> <p>c) the smoke detector on the ceiling in the lobby by the receptionist area was located one and half feet from an air supply vent.</p> <p>d) the smoke detector on the ceiling in the treatment area by the lobby entrance was located one and a half feet from an air supply vent.</p> <p>e) the smoke detector on the ceiling in the treatment isolation room was located one and a half feet from an air supply vent.</p> <p>Based on interview at the time of the observations, the Technical Operations Manager and the Technical Supervisor acknowledged the aforementioned smoke detectors were each located less than three feet from an air supply diffuser or return air opening.</p>				