

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001071	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 02/22/2021
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NAME OF PROVIDER OR SUPPLIER MICHIANA ENDOSCOPY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 53830 GENERATIONS DR STE A SOUTH BEND, IN 46635
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54</p> <p>Survey Date: 02/22/2021</p> <p>Facility Number: 009761 Provider Number: 15C0001071 AIM Number: 200156540A</p> <p>At this Emergency Preparedness survey, Michiana Endoscopy Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54</p> <p>The facility has 4 certified operating rooms.</p> <p>Quality Review completed on 02/25/21</p>	E 0000		
K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 02/22/2021</p> <p>Facility Number: 009761 Provider Number: 15C0001071 AIM Number: 200156540A</p> <p>At this Life Safety Code survey, Michiana Endoscopy Center was found not in compliance with Requirements for Participation in</p>	K 0000		

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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K 0131 Bldg. 01	<p>Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>The original facility opened in 1997 with two procedure rooms at 4,034 square feet, then in 2002, expanded to 7,740 square feet and four procedure rooms. It is located in a one story building determined to be of Type II (111) construction and was nonsprinklered. The facility has a fire alarm system with smoke detection in the corridors. The facility is protected by a Type 1 Emergency Power Battery System.</p> <p>Quality Review completed on 02/25/21</p> <p>NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab</p>			

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	<p>to roof slab.</p> <p>* Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches.</p> <p>* Doors are self-closing and are kept in the closed position, except when in use.</p> <p>* Windows in the barriers are of fixed fire window assemblies per 8.3.</p> <p>Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1, 42 CFR 416.44</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 Occupancy Separation walls was maintained to ensure the fire resistance of the barrier. LSC 6.1.14.4.2 requires occupancy separations to meet the requirements of Chapter 8. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>During a facility tour with the Center Director on 02/22/2021 from 1:40 p.m. to 2:20 p.m., the following conditions were found:</p>	K 0131	<p>The administrator is responsible to ensure ongoing compliance with Life Safety Code and to ensure the corrective actions are completed.</p> <p>a) The three unsealed penetrations identified above the lay-in ceiling tiles in the North wall in the file room around the communication cables were sealed with approved UL listed fire stopping material (Photo #1 and #2 Attachment uploaded)</p> <p>b) A subcontractor was hired to complete the wall located in the separation wall that was noted not to have been completed to roof deck. The wall was repaired to the roof deck and sealed with an approved fire-stop system to maintain the original fire resistance rating of the construction. (Photo #3 Attachment uploaded)</p> <p>c) A contractor was obtained to repair the self-latching device on the fire door closure in the staff</p>	03/09/2021	

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	<p>a) Three unsealed penetrations above the lay-in ceiling tile in the file room in the north wall around communications cable approximately 4 inches by 4 inches in size.</p> <p>b) One portion of the occupancy separation wall, approximately one foot by three feet was not completed up to the roof deck above it.</p> <p>c) The staff break room opened to the corridor, which was outside of the ASC Occupancy. The self-closing device had been removed from the door and it would not self-close.</p> <p>d) The office door to the same corridor, was equipped with a self-closing device, however, was propped open with a rubber wedge.</p> <p>Based on interview at the time of each observation, the Center Director agreed that there were unsealed penetrations, that the wall did not go up to the roof deck above, and that the specified doors in the occupancy separation would not self-close.</p> <p>These deficient findings were reviewed with the Center Director at the time of exit.</p>		<p>break-room. The staff break-room opens to the corridor, the door was repaired. (Photo #4 Attachment uploaded)</p> <p>d) The rubber wedge was promptly removed to release the propped office door that was equipped with a self-closing device.</p> <p>Center Leader educated all staff via in-service to reinforce it is unacceptable to use door stops or wedges for propping open fire doors.</p> <p>System Change To prevent this from happening again, the administrator will monitor for above ceiling work order request to ensure any penetrations are identified and sealed promptly. The administrator held a staff meeting to discussed the finding of propped fire doors with wedges being prohibited and will conduct daily rounds for four consecutive weeks to ensure the doors are not propped with wedges or other objects. A signage on the door states to keep fire door closed at all times.</p> <p>Responsible Party and Monitoring The administrator is responsible to ensure all corrective actions are complete and will report the results of all the repaired penetrations, completed wall to roof deck, and repair of the self-latching door assembly;y and daily monitoring for no use of door stops or wedge to the QAPI</p>	

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K 0345 Bldg. 01	<p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm Systems - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 33.3.3.4.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all building occupants.</p> <p>Findings include:</p>	K 0345	<p>committee and Governing Board. Any episode of non-compliance will be immediately corrected.</p> <p>====> ====></p> <p>K0345 Fire Alarm System: POC: The administrator conducted the visual semi-annual Fire Alarm System inspection using the current device inventory sheet. The visual inspection was performed to ensure all fire alarm devices are intact with no abnormal alarms or warnings. The inspection was performed and all devices checked out without problems. (Completed Fire Alarm Visual Inspection Form # 5 Attachment uploaded) System Changes: To prevent this from happening again, the administrator implemented a new semi-annual visual inspection form and placed the next due date for</p>	03/09/2021

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K 0511 Bldg. 01	<p>During record review with the Center Director on 02/22/2021 at 1:13 p.m. the facility was able to provide documentation of an annual fire alarm tests and inspections, dated 08/21/2019 and 08/24/2020. However, the facility was unable to provide documentation of a semi-annual fire alarm visual inspection between those dates, or subsequent to 08/24/2020. Based on interview at the time of record review, the Center Director agreed that a semi-annual visual inspection was not conducted.</p> <p>This deficient finding was reviewed with the Center Director at the time of exit.</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 2 of 2 electrical junction boxes observed were maintained in a safe operating condition. LSC 21.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff</p>	K 0511	<p>the inspection on the EOC calendar. Responsible Party and Monitoring: The administrator is responsible to ensure semiannual visual inspections of the Fire Alarm devices are completed and reported the results of the visual inspection to the QAPI committee and the Governing Board. The next semi-annual due date of the visual fire alarm device inspection was added to the EOC calendar.</p> <p>K511: Utilities Gas and Electric Plan of Correction: The administrator hired a qualified electrician to install covers on the 2 exposed junction. The work was completed.(Photo #6 Attachment uploaded)</p> <p>System Changes: To prevent this from happening again, the Center Leader ensured a qualified electrician to complete the repairs</p>	03/08/2021

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	<p>working in the file room.</p> <p>Findings include:</p> <p>During a tour of the facility with the Center Director on 02/22/2021 at 2:17 p.m. two electrical junction boxes without a cover and with exposed electrical wiring were noted above the lay-in ceiling tile in the file room. Based on interview at the time of the observation, the Center Director agreed that the observed electrical junction box was not provided with a cover and exposed conductors were visible.</p> <p>This deficient finding was reviewed with the Center Director at the time of exit.</p>		<p>and install covers on the 2 exposed junction boxes.</p> <p>Responsible Party and Monitoring The administrator is responsible to ensure the work is complete and will ensure that any work conducted above the ceiling will approved prior to the working being conducted. The results of the completed work and the monitoring of above ceiling work orders was reported to the QAPI committee and Governing Board.</p>		