

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001166	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BALL OUTPATIENT.. B. WING	(X3) DATE SURVEY COMPLETED 12/19/2022
NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP , MUNCIE, Indiana, 47303	
(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
K0000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification survey was conducted by the Indiana Department of Health in accordance with Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 12/19/22</p> <p>Facility Number: 012159</p> <p>Provider Number: 15C0001166</p> <p>AIM Number: NA</p> <p>At this Life Safety Code Recertification survey, Ball Outpatient Surgery Center was found not in compliance with Requirements for Participation in 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>This facility located on the second floor of a five-story building with a basement was determined to be of Type I (332) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors.</p> <p>Quality Review completed on 12/22/22</p>	K0000		
K0345	<p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>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</p>	K0345		01/18/2023

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K0345	<p>Continued from page 1 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>This STANDARD is NOT MET as evidenced by:</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 21.3.4.1 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>Based on record review and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 9:45 a.m. and 1:15 p.m., no itemized documentation listing all the appliances inspected was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 10/07/22. Based on interview at the time of records review, the facility representatives stated a visual inspection of the fire alarm system, itemizing all the appliances inspected, six months prior to the annual fire alarm inspection was not conducted.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p>	K0345		
K0353	Sprinkler System - Maintenance and Testing	K0353		01/18/2023

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K0353	<p>Continued from page 2</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants.</p> <p>2. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 2 Electrical rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff only.</p> <p>1. Based on record review and interviews with the</p>	K0353		

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K0353	<p>Continued from page 3 Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 9:45 a.m. and 1:15 p.m., no documentation was available showing an internal inspection of piping had been done. The Director of Facilities stated that they had just recently been made aware of the requirement and that to his knowledge, no 5-year internal pipe inspection had ever been done. Additionally, the facility stated that they are in communication with the contractor, but no 5-year internal pipe inspection had been scheduled.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p> <p>2. Based on a facility tour and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 1:15 p.m. 3:20 p.m., the following locations were missing ceiling tiles which would resist the passage of smoke;</p> <p>A. The electrical room #2635A was missing ceiling tile.</p> <p>B. The electrical/telephone closet near the elevator was missing all ceiling tile. The facility representative believed that was due to work done recently on the elevator.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p>	K0353		
K0923 Bldg. 01	<p>Gas Equipment - Cylinder and Container Storag</p> <p>CFR(s): NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storage</p> <p>*Greater than or equal to 3,000 cubic feet</p> <p>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>*Greater than 300 but less than 3,000 cubic feet</p>	K0923		12/30/2022

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K0923 Bldg. 01	<p>Continued from page 4</p> <p>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating.</p> <p>*Less than or equal to 300 cubic feet</p> <p>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage location was secured against unauthorized entry per NFPA 99 11.3.2.1. This deficient practice could affect 3 staff.</p> <p>Based on record review and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 9:45 a.m. and 1:15 p.m., the oxygen storage room, containing approximately 14 cylinders, had a corridor door which did not have a lock and was not secure from unauthorized entry.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p>	K0923		

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E0000	<p>Initial Comments</p> <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54</p> <p>Survey Date: 12/19/22</p> <p>Facility Number: 012159</p> <p>Provider Number: 15C0001166</p> <p>AIM Number: NA</p> <p>At this Emergency Preparedness survey, Ball Outpatient Surgery Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54</p> <p>Quality Review completed on 12/22/22</p>	E0000		

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