STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001045	A. BUILDING 00 B. WING	03/25/2021

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INDIANA ENDOSCOPY CENTERS	1801 N SENATE BLVD, STE 710 INDIANAPOLIS, IN 46202

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Q 0000 Bldg. 00	This visit was for a Recertification survey of an Ambulatory Surgery Center and Focused Infection Control survey. Facility Number: 006221 Survey Date: 03/22-25/2021 & 03/30/2021 Indiana Endoscopy Centers was in compliance with CMS Focused Infection Control Survey for Acute and Continuing Care. QA: 3/26/21 & 04/09/2021	Q 0000		
Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on record review, observation, and interview; the facility failed to ensure 3 of 3 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier (see tag K131), failed to ensure 2 of over 10 areas required to be equipped with self-closing doors was enclosed with a separation of 1 hour fire resistive construction with no impediment to close for doors required to be self-closing (see tag K223), failed to provide documentation to ensure the facility's fire alarm system was inspected and functional tested annually (see tag K345), failed to ensure 1 of 1 fire alarm systems was maintained in accordance with	O 0100	The center has engaged a contractor to seal all noted openings and replace ceiling tiles in the electrical and housekeeping rooms. As related to K131: All noted ceiling tile openings and missing tiles will be sealed/replaced to avoid this tag in the future. Any future maintenance work involving the ceiling will be reviewed by the maintenance supervisor upon completion to ensure no new opening were left unsealed. The	04/29/2021

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

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	9.6.1.3 (see tag K345), failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters (see tag 353), failed to document sprinkler system inspections in accordance with NFPA 25 for 9 of 12 months (see tag K353), failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25 (see tag 353), failed to ensure the supply of spare sprinklers maintained on the premises corresponded to the types and temperature ratings of the sprinklers in the property (see tag 353), failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25 (see tag 353), failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 2 of 10 Bays in the Pre-Op/Post-Op area (see tag 353), failed to ensure 2 of over 20 sprinkler heads in the facility were not loaded with dust in accordance with NFPA 25 (see tag 353), failed to ensure 100 % of fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A (see tag 521), failed to document annual inspection and testing of all fire door assemblies (see tag K761), failed to ensure 1 of 1 piped gas system supply areas used interior finishes of noncombustible or limited combustible materials (see tag K906), failed to identify protected branch circuits in 4 of 4 electrical panels in the four Procedure Rooms in accordance with NFPA 70 (see tag K911), failed to ensure documentation of electrical outlet receptacle testing in patient care rooms was available for review in accordance with NFPA 99 (see tag K914), and failed to provide documentation of the periodic testing of line isolation monitor (LIM) circuits with automated self-testing and		director is responsible for completion for the project. Monitoring-maintenance supervisor. This work will be completed 4/29/21. Fire door propping: The center staff have received remedial education regarding the propping of fire doors. The door noted needing repairs, has occurred as evidenced by the attached receipt for said repairs. As related to K223: Staff education occurred on 3/31/21. The management staff will make daily rounds to monitor for proper door closing and staff remediation. Director and Manager are responsible for education and monitoring. The landlord will complete the annual fire/smoke detector sensitivity testing and sprinkler system testing for this year. As related to K345: The center has reiterated the importance of annual completion of this testing in a timely manner regardless of new system installation to avoid this tag in the future. This will be added an annual maintenance calendar to monitor annual completion per the center manager. The landlord's maintenance supervisor is responsible for completion of this testing with follow by center management. Testing will be complete by 4/29/21. The landlord maintenance	

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	self-calibration in accordance with NFPA 99 (see tag K914). The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.		supervisor will add 3 sprinkler heads and a corresponding wrench to the riser room cabinet. Annual inspection by center manager will be completed to monitor as well as annual maintenance calendar notification. All present by 4/29/21. An internal pipe inspection of the sprinkler system will be completed via the landlord's contractor. This will be added to our annual maintenance calendar for review every 5 years to monitor completion. A test will be completed by 4/29/21. The center will lower the curtains to the required height in bays 7&8 by adding extender rings to them. Annual monitoring of obstructions of sprinklers will be added to our annual maintenance calendar. The center manager is responsible for monitoring. This will be completed by 4/29/21. The landlord's maintenance supervisor has cleaned the sprinkler heads in bay 1 and the reprocessing room. This was completed 4/19/21. This will be monitored and documented quarterly via a center tour by the maintenance supervisor. As related to K345: The center has reiterated the importance of annual completion of this testing in a timely manner regardless of new system installation to avoid this tag in the	

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			future. This will be added an annual maintenance calendar to monitor annual completion per the center manager. The landlord's maintenance supervisor is responsible for completion of this testing with follow by center management. Testing will be complete by 4/29/21. The landlord maintenance supervisor will add 3 sprinkler heads and a corresponding wrench to the riser room cabinet. Annual inspection by center manager will be completed to monitor as well as annual maintenance calendar notification. All present by 4/29/21. An internal pipe inspection of the sprinkler system will be completed via the landlord's contractor. This will be added to our annual maintenance calendar for review every 5 years to monitor completion. A test will be completed by 4/29/21. The center will lower the curtains to the required height in bays 7&8 by adding extender rings to them. Annual monitoring of obstructions of sprinklers will be added to our annual maintenance calendar. The center manager is responsible for monitoring. This will be completed by 4/29/21. The landlord's maintenance supervisor has cleaned the sprinkler heads in bay 1 and the reprocessing room. This was	

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			completed 4/19/21. This will be monitored and documented quarterly via a center tour by the maintenance supervisor. As related to K521: The centers fire damper inspection has been scheduled by the landlord's maintenance supervisor. The damper warning lights and system are now a part of the buildings new fire alarm panel and inspections schedule in order to avoid this tag in the future and monitor function and testing. The center manager will add the inspection to our annual maintenance calendar to monitor completion, every 4 years, of the inspection. As related to K761: The fire door repairs are in process. We have added the noted door to our annual inspection list with the vendor. Its inspection was completed 4/12/21. Our vendor will complete repairs by 4/29/21 on the remaining noted doors. The center manager will add this to the annual maintenance calendar and will review the annual report of inspection to monitor for doors in need of repair to remedy quickly. The center manager and director are responsible for monitoring that the work is completed. As related to K906: The medical gas room light mount has been made non-combustible by covering the bare wood. This	

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			repair was completed 4/20/21. The director was responsible for monitoring this project. Any future work in the medical gas room will be monitored by the maintenance supervisor to ensure all repairs are non-combustible. As related to K911: The identification cards in the LIM panels have items served notated on them. The director is responsible for completion of the notations and monitoring for completion and any needed additions in the future. This will be completed by 4/29/21. As related to K914: The annual testing of the patient bed receptacles has been completed. We have added this to our annual maintenance calendar in order to avoid this tag in the future and monitor annual completion. The center manager and director are responsible for monitoring and ensuring annual testing is complete. All testing was completed 4-12-21. The annual testing of the LIM panels will be completed for 2021. This testing will be added to our maintenance calendar in order to monitor annual completion. The center manager and director are responsible for ensuring annual completion for testing. The testing will be complete by 4/29/21.	

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Q 0101 Bldg. 00	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. 1. Based on observation and interview, the facility failed to identify protected branch circuits in 4 of 4 electrical panels in the four Procedure Rooms in accordance with NFPA 70. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 210.5(A) states the grounded conductor of a branch circuit shall be identified in accordance with Article 200.6. This deficient practice could affect 4 patients and staff in the four Procedure Rooms. Findings include: Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, overcurrent devices in the electrical panels in each of the four Procedure Rooms did not identify circuits protected by the overcurrent devices. Based on interview at the time of the observations, the Director agreed overcurrent devices for the each of the four Procedure Rooms electrical panels did not identify the circuits protected by the device. This finding was reviewed with the Director during the exit conference.	Q 0101	The annual testing of the LIM panels will be completed for 2021. The receptacle testing and inspection has been completed at the patient bed locations. The annual process of testing patient bed receptacles and LIM panels has been initiated and added to our annual testing/maintenance list in order to avoid this tag in the future. The director and manager are responsible for ensuring annual testing is complete. All noted testing will be completed by 4/29/2021. As related to K911: The identification cards in the LIM panels have items served notated on them. The director is responsible for completion of the notations and monitoring for completion and any needed additions in the future. This will be completed by 4/29/21. As related to K914: The annual testing of the patient bed receptacles has been completed. We have added this	04/29/2021

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	2. Based on record review, observation, and interview; the facility failed to ensure documentation of electrical outlet receptacle testing in patient care rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement, or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all patients. Findings include: Based on record review from with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, documentation of an itemized listing of the inspection and testing electrical outlet receptacles at patient bed locations was not available for review. Based on interview at the time of record review, the Director		to our annual maintenance calendar in order to avoid this tag in the future and monitor annual completion. The center manager and director are responsible for monitoring and ensuring annual testing is complete. All testing was completed 4-12-21. The annual testing of the LIM panels will be completed for 2021. This testing will be added to our maintenance calendar in order to monitor annual completion. The center manager and director are responsible for ensuring annual completion for testing. The testing will be complete by 4/29/21.	

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	stated general anesthesia or deep sedation is not used in the four Procedure Rooms, all electrical receptacles in the Procedures Rooms and in the Bays for the Pre-Op/Post-Op area are hospital-grade and agreed receptacle testing documentation was not available for review. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, multiple hospital-grade electrical receptacles were installed in each of the four Procedure Rooms and at each patient bed location in each Bay in the Pre-Op/Post-Op area. This finding was reviewed with the Director during the exit conference. 3. Based on record review, observation, and interview; the facility failed to provide documentation of the periodic testing of line isolation monitor (LIM) circuits with automated self-testing and self-calibration in accordance with NFPA 99, Section 6.3.4.1.4. Section 6.3.4.2.1.1 states a record shall be maintained of the tests required by this chapter and associated repairs or modification. Section 6.3.4.2.1.2 states, at minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect four patients in the four Procedure Rooms. Findings include: Based on record review from with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, line isolation monitor (LIM) circuit testing documentation for the most recent twelve month period was not available for review.			

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	Based on interview at the time of record review, the Director agreed LIM circuit testing documentation for the most recent twelve month period was not available for review. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, each of the four Procedure Rooms had a wall mounted LIM circuit panel with a self-test button. Based on observations at 4:40 p.m. on 03/30/21, the LIM circuit panel in Procedure Room 1 completed a successful self-test when its self-test button was pushed. This finding was reviewed with the Director during the exit conference.			
Q 0104 Bldg. 00	416.44(b)(1)-(3) SAFETY FROM FIRE (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do			

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	not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. 1. Based on observation, and interview, the facility failed to ensure 3 of 3 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane 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 membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section 8.3.5.6.2 states the firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. In addition, doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on observations with the Director during a tour of the facility from 2:25 p.m. to 3:15 p.m. on 03/30/21, the following openings were noted in the tenant separation fire barrier walls: a. a 1/2 inch in diameter open ended conduit for the passage of a cable above the suspended ceiling above the corridor door to the doctor's offices by the conference room. b. a hole for the passage of an electrical cable was noted above the suspended ceiling in the conference room.	Q 0104	The center has engaged a contractor to fire caulk all fire wall opening noted in this tag. The center staff have received remedial education regarding the propping of fire doors. The reprocessing room door noted needing repair has occurred as evidenced by the attached receipt for said repairs. The landlord will complete the annual fire/smoke detector sensitivity testing for this year. The landlord maintenance supervisor will complete the following: water flow alarm testing, including gauges and valves; remove external loads and materials from the sprinkler piping directly outside our center door; add 3 sprinkler heads and a corresponding wrench to the riser room cabinet; internal sprinkler pipe inspection; and clean sprinkler heads in bay 1 and the reprocessing room. As mentioned in the citation, the fire door repairs are in process. We have added the noted missing door to our annual inspection list. Our contractor will complete repairs and inspect the additional door. All of the above will be completed in order to avoid this tag in the future. The landlords maintenance supervisor, center director and center manager are responsible for	04/29/2021

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	c. a 1/2 inch in diameter open ended conduit and the annular space surrounding an insulated pipe above the suspended ceiling above the exit door to the corridor near the break room. d. a two inch by three inch hole above the corridor door set by the electrical room. e. a two inch by three inch hole above the suspended ceiling in the electrical room. f. the annular space surrounding six electrical conduits penetrating the corridor wall above the suspended ceiling of the electrical room. g. a one inch in diameter hole for a cable which penetrated the wall of the patient waiting room near the corridor door to the doctor's offices. h. an eight inch long by two inch high hole for the passage of two electrical conduits and a one inch in diameter hole was noted above the suspended ceiling above the facility exit door to the central corridor by the nurse's station as observed from the central corridor. Based on interview at the time of the observations, the Director agreed the aforementioned openings in the tenant separation walls were not protected to maintain the fire resistance rating of the fire barrier. This finding was reviewed with the Director during the exit conference. 2. Based on record review, observation, and interview; the facility failed to ensure 2 of over 10 areas required to be equipped with self-closing doors was enclosed with a separation of 1 hour fire resistive construction with no impediment to close for doors required to be self-closing. This deficient practice could affect all patients, staff, and visitors Findings include:		completion of al listed. All of the noted repairs as above will be completed by 4/29/2021. As related to K351: The center has engaged a contractor seal all noted openings and replace ceiling tiles in the electrical and housekeeping rooms to avoid this tag in the future. Any future maintenance work involving the ceiling will be reviewed by the maintenance supervisor upon completion to ensure no new openings were left unsealed. The director is responsible for completion for this project. The maintenance supervisor will monitor for future intrusions. This work will be completed by 4/29/21. As related to K131: The center has engaged a contractor to fire caulk all fire wall openings noted in this tag. All openings in the firewall will be sealed to prevent this tag in the future. Any future maintenance involving the fire wall swill be monitored by the maintenance supervisor upon completion to ensure no new openings were left unsealed. The director is responsible for completion of these repairs. This will be completed by 4/29/21. As related to K223: The center staff have received remedial education regarding the propping of fire doors. Staff	

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	15C0001045	A. BUILDING 00 B. WING	03/25/2021

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	Based on review of facility blueprint documentation with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, the clean storage room and the decontamination room were both enclosed with a one hour fire resistance rated wall. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, the corridor door to the clean storage room was propped in the fully open position with linen storage shelf. The door was equipped with a self-closing device and a 45 minute fire resistance rating label was affixed to the door. The corridor door to the decontamination room was propped in the fully open position. The door was equipped with a switch for a powered door closing device set to release with fire alarm system operation but the switch was in the off position. The door was also equipped with a 45 minute fire resistance label. Based on interview at the time of the observations, the Director stated the powered door switch was in the off position because the powered door closing device needed repair and agreed the two corridor doors were propped in the fully open position. This finding was reviewed with the Director during the exit conference. 3. Based on record review and interview, the facility failed to provide documentation to ensure the facility's fire alarm system was inspected and functional tested annually. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states unless otherwise permitted by other sections of this code, testing shall be		education occurred on 3/31/21. The center management will conduct daily rounds to monitor for proper door closing and staff remediation. The noted fire door missing inspection has been completed 4/12/21. This door has been added to our annual list of door inspections to monitor completion annually. The center manager is responsible for this. As related to K345: The landlord will complete the annual fire alarm system including smoke detector sensitivity testing (every 2 years) for this year. The center has reiterated the importance of annual completion of this testing in a timely manner regardless of new system installation in order to avoid this tag in the future. These tests will be added to our annual maintenance calendar to monitor completion per the manager. The landlord's maintenance supervisor is responsible for completion of this testing with follow up by the facility management. Testing will bel completed 4/29/21. As related to K353: The sprinkler testing including water flow alarm testing, gauges and valves will be completed by 4/29/21. The maintenance supervisor is responsible for arranging testing and monitoring completion. The center manager will add this annual test to the	

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	15C0001045	A. BUILDING 00 B. WING	03/25/2021

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	performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Detection Inspection Report" documentation dated 01/30/20 with the Director during record review from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, documentation of fire alarm system inspection and testing within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director stated the facility was closed in March, April, and May 2020 due to the Covid-19 pandemic, but the most recent fire alarm system obtained from the Medical Building Property Manager was 01/30/20. The Director provided an e-mail from the Property Manager dated 03/30/21 at 1:28 p.m. which stated the Building's fire alarm system is being replaced, the facility is in the process of changing the fire alarm system inspection contractor and "Given such we have NOT completed any 2021 inspections". This finding was reviewed with the Director during the exit conference. 4. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states		maintenance calendar to monitor annual completion. The landlord maintenance supervisor will remove external loads and materials from the sprinkler piping directly outside of our center door and will be completed by 4/29/21. The center has put in a maintenance request for all sprinkler piping directly feeding our suite be checked for external loads. The maintenance supervisor will monitor removal and any future work to ensure compliance. The landlord maintenance supervisor has added 3 sprinkler heads and a corresponding wrench to the riser room cabinet. Annual inspection by center manager will be completed to monitor their presence. This will be added to the annual maintenance calendar. All will be present 4/29/21. The landlord maintenance supervisor has scheduled an internal sprinkler pipe inspection. The center has requested this report of completion. The landlord will complete by 4/29/21. Center management will add this to our annual maintenance calendar for review every 5 years to monitor completion. The center has lowered the curtains to the required height in bays 7&8 by adding extender rings to them. Annual monitoring of obstructions of sprinkler heads	

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	sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on record review from with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, fire alarm system smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Director agreed sensitivity testing documentation within the most recent two year period was not available for review. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, the facility has smoke detection in the four Procedure Rooms. This finding was reviewed with the Director during the exit conference. 5. Based on record review, observation, and interview; the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system		will be added to our annual maintenance calendar for the manager to complete. This will be done 4/29/21. The landlord maintenance supervisor will clean sprinkler head sin bay 1 and reprocessing room. This was completed 4/19/21. This will be monitored and documented quarterly via a center tour by the maintenance supervisor. As related to K761: The fire door repairs are in process. We have added the noted door to our annual inspection list-completed 4/12/21. Our contractor will complete the other repairs 4/29/21. The center manager will review the annual report of inspection to monitor doors needing repair to remedy quickly. The door inspection has been added to our annual maintenance calendar.	

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	components and shall be made available to the authority having jurisdiction upon request. Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. Section 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all patients, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Inspection and Testing Report" documentation dated 01/30/20, 05/12/20, 08/25/20 and 10/27/20 with the Director during record review from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, documentation of a quarterly sprinkler system inspection for the first quarter (January, February, March) 2021 was not available for review. Based on interview at the time of record review, the Director stated the facility was closed in March, April and May 2020 due to the Covid-19 pandemic, but she had obtained the three most recent sprinkler system inspection reports from the Medical Building Property Manager and provided an e-mail from the Property Manager dated 03/30/21 at 1:28 p.m. which stated the Building's fire alarm system is being replaced, the facility is in the process of changing the fire alarm system and the sprinkler system inspection contractors and "Given such we have NOT completed any 2021 inspections".			

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	Based on observations with the Director and the Property Manager during a tour of the facility from 4:00 p.m. to 4:25 p.m. on 03/30/21, the sprinkler system inspection contractor had affixed hanging tags to the sprinkler system riser for which documentation of waterflow alarm inspection and testing for the first quarter of 2021 was not available for review. This finding was reviewed with the Director during the exit conference. 6. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 9 of 12 months. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Inspection and Testing Report" documentation dated 05/12/20, 08/25/20			

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	and 10/27/20 with the Director during record review from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, monthly sprinkler system gauge and valve inspections were documented for 3 months of the most recent 12 month period. Based on interview at the time of record review, the Director stated the facility was closed in March, April, and May 2020 due to the Covid-19 pandemic, the Medical Office Building Property Manager performs monthly gauge and valve inspections but agreed additional inspection documentation was not available for review at the time of the survey. Based on observations with the Director and the Property Manager during a tour of the facility from 4:00 p.m. to 4:25 p.m. on 03/30/21, the facility has a supervised wet sprinkler system. This finding was reviewed with the Director during the exit conference. 7. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on observations with the Director during a tour of the facility from 2:25 p.m. to 3:15 p.m. on 03/30/21, cables were affixed to the horizontal sprinkler pipe with cable ties and string at multiple locations above the suspended ceiling in the corridor outside the waiting room door. In			

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	addition, multiple cables were resting on horizontal sprinkler pipe also above the suspended ceiling in the corridor outside the waiting room door. This sprinkler pipe location was perpendicular to the corridor wall. The sprinkler piping at this location served the patient waiting room area. Based on interview at the time of the observations, the Director agreed the aforementioned sprinkler pipe locations were used to support non-system components. This finding was reviewed with the Director during the exit conference. 8. Based on observation and interview, the facility failed to ensure the supply of spare sprinklers maintained on the premises corresponded to the types and temperature ratings of the sprinklers in the property. The facility also failed to ensure a special wrench was provided to be used in the removal and installation of sprinklers. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. Section 5.4.1.6.1 states a special wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all patients, staff, and visitors in the facility.			

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	Findings include: Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. on 03/30/21, recessed sprinklers were installed in the ceiling of each of the four Procedure Rooms and pendent sprinklers were installed on the ceiling throughout the remainder of the facility's suite. Based on observations with the Director and the Property Manager during a tour of the facility from 4:00 p.m. to 4:25 p.m. on 03/30/21, a total of six upright spare sprinklers were noted in the spare sprinkler cabinet in the riser room. No spare recessed sprinklers or spare pendent sprinklers were installed in the cabinet or noted on the premises. No spare sprinkler wrench was noted in the spare sprinkler cabinet. Based on interview at the time of the observations, the Director and the Property Manager agreed a sprinkler wrench and spare sprinklers of the type installed in the facility's suite were not in the spare sprinkler cabinet or on the premises. This finding was reviewed with the Director during the exit conference. 9. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, section 14.2.2. This deficient practice affects all patients, staff, and visitors. Findings include: Based on record review with the Director from 9:25			

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	a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, documentation of an internal pipe inspection conducted within the most recent five year period was not available for review. Based on interview at the time of record review, the Director agreed documentation of an internal pipe inspection was not available for review at the time of the survey. Based on interview with the Medical Office Building Property Manager at 4:00 p.m. on 03/30/21, the Property Manager agreed documentation of an internal pipe inspection was not available for review. Based on observations with the Director and the Property Manager during a tour of the facility from 4:00 p.m. to 4:25 p.m. on 03/30/21, the facility has a supervised wet sprinkler system. This finding was reviewed with the Director during the exit conference. 10. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 2 of 10 Bays in the Pre-Op/Post-Op area. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met:			

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	(1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. This deficient practice could affect all patients, staff, and visitors. Finding includes: Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. on 03/30/21, a privacy curtain with fabric mesh was hung from a ceiling track in Bay 7 and in Bay 8 in the Pre-Op/Post-Op area. The fabric mesh extended to a distance of 19 inches below the ceiling in each of the two Bays as measured with a measuring tape. Based on interview at the time of the observations, the Director agreed the mesh in each privacy curtain did not extend to at least 22 inches below the ceiling and provided sprinkler spray pattern obstruction. This finding was reviewed with the Director during the exit conference. 11. Based on observation and interview, the facility failed to ensure 2 of over 20 sprinkler heads in the facility were not loaded with dust in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced:			

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	(1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. on 03/30/21, the deflector for the sprinkler located on the ceiling in Bay 1 of the Pre-Op/Post-Op area and the deflector for the sprinkler located on the ceiling in the Reprocessing Room by the pass through window each were loaded with dust. Based on interview at the time of the observations, the Director agreed the aforementioned automatic sprinkler locations were each loaded with dust. This finding was reviewed with the Director during the exit conference. 12. Based on record review, observation, and interview; the facility failed to document annual inspection and testing of all fire door assemblies. LSC 21.7.6 Maintenance and Testing states See 4.6.12. LSC 4.6.12 states whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for			

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	compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.			

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	15C0001045	A. BUILDING 00 B. WING	03/25/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all patients, staff, and visitors. Findings include: a. Based on review of facility blueprint documentation with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, the corridor door to the doctor's offices by the conference room is in the tenant separation wall. The tenant separation wall was rated as a one hour fire resistance rated wall. Based on review of the fire door inspection contractor's "Annual Door Inspection 2020" documentation dated 08/05/20, the corridor door to the doctor's offices in the tenant separation wall is not included in the 08/05/20 inspection report documentation. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, the corridor door to the doctor's offices, which was in the tenant separation wall, was affixed with a fire resistance rating label stating the door was rated at 45 minute fire resistance rating.			

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	15C0001045	A. BUILDING 00 B. WING	03/25/2021

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	b. Based on review of the fire door inspection contractor's "Annual Door Inspection 2020" documentation dated 08/05/20 with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, three of thirteen fire door locations did not pass annual inspection. The door set identified as #7-002 had "incorrect clearance". The door set identified as #7-003 had "incorrect clearance (top of door)". The door identified as #7-005 stated "No" to "Appears Compliant?" The inspection report for door #7-005 also stated "Signage larger than 5% face of door pull side NFPA 80-2013: 4.1.4.1". Based on interview at the time of record review, the Director stated purchase orders have been released and repairs will be done soon but agreed fire door repair or replace documentation on or after 08/05/20 was not available for review. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, the clearance in between the meeting edges of the wood door set identified as #7-002 measured 3/16ths of an inch as measured with a measuring tape. In addition, a second latching mechanism was installed for one door in the door set near the floor but there was no latching plate for the door opposite the door with the latching mechanism. The clearance at the top of the door identified as #7-003 measured 1/4th inch as measured with a measuring tape. The same signage appearing in the photograph for the 08/05/20 inspection report documentation was affixed to the door identified as #7-005. Based on interview at the time of the observations, the Director agreed fire door repair or replace documentation on or after 08/05/20 was not available for review. This finding was reviewed with the Director during the exit conference.			

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Q 0108 Bldg. 00	416.44(c) BUILDING SAFETY (c) Standard: Building Safety. Except as otherwise provided in this section, the ASC must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code (NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the ASC, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. 1. Based on record review, observation, and interview; the facility failed to ensure 100 % of fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped	O 0108	The centers fire damper inspection has been scheduled by the landlord's maintenance supervisor. The medial gas room light mount has been repaired and made non-combustible. The damper warning lights and system are now a part of the buildings new fire alarm panel and inspections schedule and the light mount has been repaired in order to avoid this tag in the future. The landlord maintenance supervisor and the director are responsible for completion of the above. The damper inspection/maintenance and light	04/29/2021

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	with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on record review from with the Director from 9:25 a.m. to 12:30 p.m. and from 1:50 p.m. to 2:25 p.m. on 03/30/21, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on interview at the time of record review, the Director agreed documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, fire dampers were observed installed in HVAC duct work above the suspended ceiling throughout the facility. This finding was reviewed with the Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 piped gas system supply areas used interior finishes of noncombustible or limited combustible materials. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 5.1.3.3.2(4) states locations for central supply systems and the storage of		repair will be completed by 4/29/2021. As related to K521: The centers fire damper inspection has been scheduled by the landlord's maintenance supervisor. The damper warning lights and system are now a part of the buildings new fire alarm panel and inspection schedule to prevent this tag in the future and monitor their function. The center manager will add the inspection to our annual maintenance calendar to monitor completion (every 4 years) of the inspection. The landlord's maintenance supervisor is responsible for this testing being completed by 4/29/21. As related to K906: The medical gas room light mount has been repaired and made noncombustible by coving the bare wood. This repair was completed 4/20/21. The director is responsible for monitoring this project. Any future work in themed gas room will be monitored by the maintenance supervisor to ensure all repairs and noncombustible.	

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	positive pressure gases, if indoors, shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. This deficient practice could affect all patients. Findings include: Based on observations with the Director during a tour of the facility from 12:30 p.m. to 1:50 p.m. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, a lighting fixture was affixed to two untreated 2 x 4 wood studs attached to the ceiling of the piped gas supply room. Based on interview at the time of the observations, the Director agreed the two wood studs were not noncombustible or limited combustible materials. This finding was reviewed with the Director during the exit conference.			
S 0000 Bldg. 00	This visit was for a State Licensure survey of an Ambulatory Surgery Center. Facility Number: 006221 Survey Date: 03/22-25/2021 QA: 3/26/21	S 0000		
S 1168 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)			

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	(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially. Based on document review and interview, it could not be determined if the facility performed a triennial review for one (1) of one (1) piece of patient care equipment. Findings include: 1. On 03/25/2021 at 0900 hours, employee, S-1, Director, was requested to provide documentation that the facility performed a triennial review of preventative maintenance activity for the facility defibrillator. Documentation obtained from S-5, Supervisor, Clinical Engineering, specified that "annual assessment and analysis of trends was conducted annually." per the "Medical Equipment Management Plan." 2. Review of the "Medical Equipment Management Plan" PolicyStat ID: 6965096, last approved 09/2019, is an (F3) policy and not a	S 1168	The maintenance plan has been revised as evidenced by the attached. Our biomed contractors do annual assessment of all equipment. They didn't acknowledge the triennial need notation. It is included on pg 16. They also made this maintenance plan ASC specific. I also attached the log that shows the PM's were completed as required. The plan has been revised in order to avoid this tag in the future. The center director and maintenance supervisor are responsible for this tag. The revisions were completed 4/20/2021.	04/20/2021

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	policy approved by the board of managers of (F1) for use. The policy also did not contain specific verbiage indicating that annual or triennial analysis was provided to (F1) for use. 2. In interview on 03/25/2021 at 1120 hours, employee, S-1, Director, indicated there was no additional triennial analysis documentation for review, and that, "Medical Equipment Management Plan," PolicyStat ID: 6965096, last approved 09/2019, is not an (F1) policy.			