STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001045	A. BUILDING -- B. WING	03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA ENDOSCOPY CENTERS	1801 N SENATE BLVD, STE 710 INDIANAPOLIS, IN 46202

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54. Survey Date: 03/30/21 Facility Number: 006221 Provider Number: 15C0001045 AIM Number: 100380920A At this Emergency Preparedness survey, Indiana Endoscopy Centers was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. The facility has 4 certified Procedure Rooms. Quality Review completed on 04/06/21 The requirement at 42 CFR, Subpart 42 CFR 416.54. is NOT MET as evidenced by:	E 0000	Printed documents. No signature page came through for this. All others uploaded.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required			

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	full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually. The ASC facility must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 0039	As noted in the citation, we conducted an internal table top on covid 19 for our center last year. We also participated in a community based table top with the same topic but was a community based exercise. Somehow this was not conveyed to the surveyor at time of survey. As evidenced, by the attached we did participate in another community based exercise through IFASC dated 10-18-2019. We will keep documentation of all exercises in our EP binder for 2 full years in order to prevent this tag in the future. The director and manger are responsible for this tag. The EP	04/22/2021

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	community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) analyze the ASC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ASC facility's emergency plan, as needed in accordance with 42 CFR 416.54(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation dated 04/28/20 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 for testing the facility's emergency preparedness program twice within the most recent twenty four month period was not available for review. Based on interview at the time of record review, the Director stated the facility is currently experiencing an actual natural or man-made emergency for the Covid-19 pandemic which required activation of the emergency plan and conducted a tabletop exercise for Covid-19 procedures but agreed documentation for a second exercise not related to Covid-19 conducted within the most recent two year period was not available for review. This finding was reviewed with the Director during the exit conference.		activities have been added to our staff education schedule in order to monitor completion via the manager. The attached activity has been added to our EP binder as of 4-22-2021.	

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 03/30/21 Facility Number: 006221 Provider Number: 15C0001045 AIM Number: 100380920A At this Life Safety Code survey, Indiana Endoscopy Centers 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. The facility, located on the seventh floor of a seven story building, was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the four Procedure Rooms and at the main fire alarm panel in the Medical Office Building. Quality Review completed on 04/06/21	K 0000	uploaded signature page	
K 0131 Bldg. 01	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			

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	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 to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. 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			
	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	K 0131	-The center has engaged a contractor to fire caulk all fire wall openings noted in this tag. -All noted openings in the firewall will be sealed per the NFPA to prevent this tag in the future. Any future maintenance work involving the fire walls will be reviewed by the maintenance supervisor upon completion to ensure no new openings were left unsealed to monitor continued compliance.	04/29/2021

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	15C0001045	A. BUILDING 01 B. WING	03/30/2021

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

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	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. 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		-The director is responsible for completion of these repairs. Monitoring: maintenance supervisor. -All fire walls will be sealed by 4/29/2021	

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	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.			
K 0223 Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 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:	K 0223	-The center staff have received remedial education regarding the propping of fire doors. -The door noted needing repair has occurred as evidenced by the attached receipt for said repairs. -Staff education and door repair have occurred to avoid this tag in the future. The management staff will make daily rounds to monitor for proper door closing and staff	04/12/2021

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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.		remediation. -The director and manager are responsible for the education, monitoring and repair completion. -The education was completed 3/31/2021. The door repair was completed 4/12/2021.	
K 0345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm Systems - Testing and Maintenance 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.			

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	Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. 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 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	K 0345	-The landlord will complete the annual fire/smoke detector sensitivity testing for this year. -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 item will be added to an annual maintenance calendar to monitor annual completion per the Manager. -The landlords maintenance supervisor is responsible for completion of this testing with follow up by ASC management -Testing will be completed by 4/29/2021.	04/29/2021

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	NOT completed any 2021 inspections". This finding was reviewed with the Director during the exit conference. 2. 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 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.			

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K 0351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13 Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 10 rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. 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 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. and from 2:25 p.m. to 3:15 p.m. on 03/30/21, the following was noted: a. ceiling tile was missing above the electrical panel identified as "7CBL" and a ceiling tile was also missing above the electrical panel identified as "7EQL" in the "Electrical" room. In addition, numerous holes were noted in the ceiling tile above the electrical panel identified as "7CBH" for the passage of electrical conduits in the room.	K 0351	-The center has engaged a contractor to seal all noted openings and replace ceiling tiles in the electrical and housekeeping rooms. -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 openings were left unsealed. -The director is responsible for completion of this project. Monitoring-maintenance supervisor. -All noted ceiling tile openings will be sealed and tiles replaced by 4/29/2021.	04/29/2021

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	The holes were not firestopped. b. two ceiling tiles were missing in the "Housekeeping" room. In addition, numerous holes were noted in the ceiling tiles above the water heaters in the room for the passage of insulated water lines. The holes were not firestopped. A large hole was noted in the ceiling tile above the wall mounted humidifier in the room which was not firestopped. Based on interview at the time of the observations, the Director agreed there were missing ceiling tiles and holes in ceiling tiles in the aforementioned rooms. This finding was reviewed with the Director during the exit conference.			
K 0353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to provide written documentation or other evidence the sprinkler	K 0353	-The landlord maintenance supervisor will complete the following:	04/29/2021

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	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 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		· water flow alarm testing, including gauges and valves completed by 4/29/21-monitored using annual calendar notation of receipt of documentation, center manager. · remove external loads and materials from the sprinkler piping directly outside of our center door completed by 4/29/21. The center has put in a maintenance request for all sprinkler piping directly outside of our suite to be checked for external loads. The maintenance supervisor will monitor any future work to ensure compliance. · Add 3 sprinkler heads and a corresponding wrench to the riser room cabinet. Annual inspection by center manager will be completed to monitor. Added to annual maintenance calendar. All present by 4/29/21 · Internal sprinkler pipe inspection. The center has requested this report of completion. The landlord will complete by 4/29/21. We will add it to our annual maintenance calendar for review every 5 years to monitor completion. · Clean sprinkler heads in bay 1 and reprocessing room. This was completed by 4/19/21 by the maintenance supervisor. This will be monitored and documented quarterly via a center tour by the maintenance supervisor. The center will lower the curtains	

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	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". 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. 2. 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,		to the required height in bays 7&8 by adding 3” rings to them. Annual monitoring of obstructions of sprinklers will be added to our annual maintenance calendar-manager. 4/29/21 -All noted findings in this tag will be resolved now to avoid this tag in the future. The landlord maintenance supervisor will conduct inspection of the sprinkler heads for dust accumulation on a quarterly basis to assist in these efforts. -The building manager, director and facility manager are all responsible for ensuring completion of all of this tags completion. -All items listed in this POC will be completed by 4/29/2021.	

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	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 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. 3. 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.			

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	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 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. 4. 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			

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	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. 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. 5. 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			

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	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 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. 6. 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			

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	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: (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. 7. 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			

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	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: (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			

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	during the exit conference.			
K 0521 Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2 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 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:	K 0521	-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 their function. The center manager will add the inspection to our annual maintenance calendar to monitor completion (every 4 yrs)of the inspection. -The landlord maintenance supervisor is responsible for completion of this inspection. -The damper inspection/maintenance will be completed by 4/29/2021.	04/29/2021

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	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.			
K 0761 Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 21.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on record review, observation, and interview; the facility failed to document annual	K 0761	-As mentioned in the citation, the fire door repairs are in process.	04/29/2021

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	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 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		We have added the noted door to our annual inspection list-completed 4/12/21. Our contractor will complete repairs by 4/29/21 and has inspected the additional door. -All noted findings in this citation will be repaired and the annual inspection of the additional door will be complete to avoid this tag in the future. The center manager will review the annual report of inspection to monitor for doors needing repairs to remedy quickly. -The director and manager are responsible for ensuring this work is completed. -All work will be completed by 4/29/2021.	

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	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. (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			

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	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. 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			

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	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.			
K 0906 Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Central Supply Gas and Vacuum Piped Systems - Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) Based on observation and interview, the facility	K 0906	-The medical gas room light mount	04/29/2021

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	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 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.		has been repaired and made non-combustible by covering the bare wood. -This repair will be completed in order to avoid this tag in the future. -The director is responsible for monitoring this project. Any future work in the med gas room will be monitored by the maintenance supervisor to ensure all repairs are non-combustible. -The repair will be completed by 4/20/2021.	
K 0911 Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section, any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility	K 0911	-The cards in the LIM panels have	04/29/2021

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	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.		items served notated on them. -The notations have been made to avoid this tag in the future. -The director is responsible for completion of the notations and monitoring for completion or any needed additions. -The notations will be completed by 4/29/2021.	
K 0914 Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at			

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	these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For, LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) 1. 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	K 0914	-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 on 4/12/21. -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 and monitor completion. -The director and manager are responsible for ensuring annual testing is completed, review it and monitor. -All noted testing will be completed by 4/29/2021.	04/29/2021

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	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 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. 2. 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			

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	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. 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.			
K 0918 Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the			

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	10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review, observation, and interview; the facility failed to maintain a complete written record of monthly generator load testing for 5 months of the most recent 12 month period. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010	K 0918	-The centers vendor failed to send all reports of completed monthly generator maintenance and testing prior to summation. The maintenance was completed as required as evidenced by the attachments. Diesel fuel testing will be completed by this vendor and has been added to our	04/29/2021

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	Edition, Section 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. (2) Under operating temperature conditions and at not less than 30% of the nameplate kW rating. Section 8.4.2.3 requires diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff, and visitors in the facility. Findings include: Based on review of "Emergency Generator - Monthly Test Log" documentation 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, emergency generator load testing documentation for the five month period of July 2020 through November 2020 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, the generator is run under load monthly but agreed monthly load testing		list of needed annual testing. -Our vendor has added the fuel testing to our current annual services list to avoid this tag in the future. The center will maintain a list of completed services by this vendor to avoid this tag in the future. -The director and manager are responsible for ensuring this testing and service has been completed and for monitoring for annual completion. -The fuel testing will be completed by 4/29/2021. See attachments showing the cited maintenance was completed on schedule.	

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	documentation for the aforementioned five month period was not available for review at the time of the survey. Based on observations with the Director and the Medical Office Building 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 one diesel fired emergency generator located in the parking garage and was rated at 250 kW. This finding was reviewed with the Director during the exit conference. 2. Based on record review, observation, and interview; the facility failed to ensure an annual fuel quality test was performed for the facility's two diesel fired generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Essential Electrical System (EES) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. 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 an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director agreed documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review.			

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	Based on observations with the Director and the Medical Office Building 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 one diesel fired emergency generator located in the parking garage and was rated at 250 kW. This finding was reviewed with the Director during the exit conference.			