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	05/13/2021

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 03/30/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54. Survey Date: 05/13/21 Facility Number: 006221 Provider Number: 15C0001045 AIM Number: 100380920A At this Emergency Preparedness survey, Indiana Endoscopy Centers was found 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 05/18/21	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 03/30/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 05/13/21 Facility Number: 006221 Provider Number: 15C0001045 AIM Number: 100380920A At this PSR survey, Indiana Endoscopy Centers	K 0000		

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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	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 05/18/21			
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 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			

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	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 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	K 0131	The remaining fire barrier intrusions noted upon re-inspection were sealed on 5/13/2021 as evidenced by the attached "corrected deficiency report". As per our original POC, we still plan to have the maintenance supervisor monitor this. Any future maintenance work involving the ceiling or walls will be reviewed by the maintenance supervisor upon completion to ensure no new opening were left unsealed. The director is responsible for completion of this repair project.	05/13/2021

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	tour of the facility from 9:10 a.m. to 10:15 a.m. on 05/13/21, the following openings were noted in the tenant separation fire barrier walls: a. a hole for the passage of an electrical cable was noted above the suspended ceiling in the conference room. b. a one inch hole next to six electrical conduits penetrating the corridor wall above the suspended ceiling of the electrical room. The annular space surrounding a cable above the six electrical conduits which penetrated the wall was also not firestopped c. 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. Based on interview at the time of the observations, the Director stated a firestop contractor repaired the deficiencies as evidenced by the "Corrected Deficiency Report" documentation dated 05/04/21 but 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. This deficiency was cited on 03/30/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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,			

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	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 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. 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. Findings include: Based on observations with the Director during a tour of the facility from 9:10 a.m. to 10:15 a.m. on 05/13/21, pendent sprinklers were installed on the	K 0353	The needed sprinkler heads have been added per the citation by the property manager's contractor. We now have 2 pendant, 2 recessed and 2 sidewall sprinkler heads in a box with a wrench within our facility. Please see the attached photo. The property manager was responsible for obtaining the sprinkler heads and wrench. The center has added ensuring the heads are present to it's annual maintenance schedule in order to monitor this. The center manager and director are responsible for this.	05/21/2021

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	ceiling throughout the facility's suite except in the Procedure Rooms. A new spare sprinkler cabinet with a total of six spare sidewall sprinklers was installed in the red bag waste storage room on the 7th floor. Based on observations with the Property Manager at 10:00 a.m. on 05/13/21, a total of six upright spare sprinklers and at least two spare recessed sprinklers were noted in the two spare sprinkler cabinets in the riser room. No spare pendent sprinklers were installed in the cabinet or noted on the premises. Based on interview at the time of the observations, the Director stated the sprinkler contractor provided them with the spare cabinet and spare sidewalls after the March 2021 Life Safety Code survey but agreed spare sprinklers of the type installed in the facility's suite were not in the spare sprinkler cabinets or on the premises. This finding was reviewed with the Director during the exit conference. This deficiency was cited on 03/30/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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.			

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	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 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:	K 0761	The repairs to fire door #7-002 have been completed as evidenced by the attached Maintenance Log. These repairs were completed 5/14/21. The center manager will review the annual fire door inspection report to monitor for any doors in need of repair in order to remedy deficiencies quickly. The annual door inspection has been added to an annual maintenance calendar to assist in these preventative efforts. The manager and director were responsible for monitoring and confirming repairs to door #7-002. They are also responsible for any future repair needs.	05/14/2021

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	(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. (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: 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, one of thirteen fire door locations did not pass annual inspection. The door set identified as #7-002 had "incorrect clearance". Based on interview at the time of record review, the Director stated purchase orders			

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	have been released and repairs will be done soon. Review of the fire door inspection contractor's "Door Maintenance Log" documentation with the Director at 9:05 a.m. on 05/13/21, the door set identified as #7-002 had been corrected by installing a shim on the top of the doors 05/04/21. 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. Based on observations with the Director during a tour of the facility from 9:10 a.m. to 10:15 a.m. on 05/13/21, the clearance in between the meeting edges of the door set identified as #7-002 had not been changed and there was still not a latching plate for the latching mechanisms near the floor. In addition, the door closing coordinator affixed to the top of the door frame was stuck and did not protrude to correctly coordinate the doors to self close and latch into the door frame. Based on interview at the time of the observations, the Director agreed the contractor did not adjust the clearance in between the meeting edges and did not install latching plates for the lower latching mechanism. This finding was reviewed with the Director during the exit conference. This deficiency was cited on 03/30/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			