

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

PRINTED: 03/16/2021

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2021
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NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP COD 9202 N MERIDIAN STREET SUITE 150 INDIANAPOLIS, IN 46260
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54.</p> <p>Survey Date: 01/29/21</p> <p>Facility Number: 005392 Provider Number: 15C0001011 AIM Number: 100274160A</p> <p>At this Emergency Preparedness survey, Surgery Care Center Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54.</p> <p>Quality Review completed on 02/02/21</p>	E 0000		
K 0000  Bldg. 02	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 01/29/21</p> <p>Facility Number: 005392 Provider Number: 15C0001011 AIM Number: 100274160A</p> <p>At this Life Safety Code survey, Surgery Care Center Inc. 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,</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0211 Bldg. 02	<p>Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This facility, located on the first floor of a two-story building with a basement, was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all patient care areas.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review completed on 02/02/21</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 first floor exit corridor means of egress was continuously maintained free of obstructions. LSC 7.1.10.2.1 states no furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice affects all patients and staff in the facility who use the second floor.</p> <p>Findings include:</p>	K 0211	At the time of the interview, it was pointed out by the surveyor that a wheelchair was blocking an exit corridor. The wheelchair was immediately folded. Wheelchairs are now kept folded and in the assigned wheelchair "nook" This correction was performed by building maintenance and observed by the Surgical Care Center Administrative Assistant. Surgical Care Staff has been	01/29/2021			

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K 0241 Bldg. 02	<p>Based on observation on 01/29/21 at 12:20 p.m. during a tour of the facility with the Administrative Assistant and the Maintenance Man, the north-east exit corridor from the Pre-op / Post-op area contained two wheelchairs within the exit path of egress. Based on an interview at the time of the observation, the Administrative Assistant and the Maintenance Man agreed that the wheelchairs were within the exit path of egress. The Maintenance Man then folded up the wheelchairs clearing the exit egress path removing the issue.</p> <p>NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment 2012 NEW Meets the requirements of section 7.4. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 20.2.4.1 through 20.2.4.5, 7.4 Based on observations and review of the available construction documents, the facility failed to provide and maintain the two exits remotely located from each other in the Pre-Op / Post-Op areas of the Ambulatory Surgical Center. NFPA 101, 2012 edition, section 20.2.4.s states, "Not less than two exits of the types described in 38.2.2 that are remotely located from each other shall be provided for each floor or fire section of the building." This deficient practice affects all the</p>	K 0241	<p>instructed that all exit corridors need to be clear of any obstructions, such as wheelchairs. This was all done on or before 2/4/2021. The Director of the Surgical Care Center will be responsible for continued compliance.</p> <p>The surveyor pointed out that there were remote exit signs that were not separated by the minimum of 1/3 of the maximum diagonal of the area being served. In the case of the Pre-op/Post-op , the distance was 31' 4 ". Upon exit of the surveyors, building maintenance came into the Surgical Care Center and removed</p>	01/29/2021

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K 0291 Bldg. 02	<p>occupants of the ASC.</p> <p>Findings include:</p> <p>Based on record review of the First Floor Plan (sheet A1.11) provided by the facility Maintenance man of the building, the maximum overall diagonal of the area of the Pre-Op / Post-Op area is approximately 94'. Remote exits must be separated by not less than 1/3 of the maximum diagonal of the area being served. In the case of the Pre-Op / Post-Op, this distance is 31'-4". The exit signs in the PACU direct occupants to exit through Passage #104 and Passage #A155. These exit access paths are separated by approximately 20'. Based on an interview at the time of the observation, the facility Maintenance man agreed that the exits within the Pre-Op / Post-Op area were not remote and stated that he would change the exit signage to direct staff to exit out the other end of the Pre-Op / Post-Op area. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.</p> <p>NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9</p> <p>Based on record review and interview, the facility failed to ensure emergency lighting testing of at least 30 seconds monthly or of at least 1½ hour duration was provided in accordance with LSC 7.9 for six of six battery-operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting</p>	K 0291	<p>one of the exit signs in the pre-op/post-op area. This then corrected the deficiency. Removal of the sign will ensure that this will not be a problem in the future. The Director of the Surgical Care Center is responsible for continued compliance.</p> <p>No battery-operated emergency lights are available in the facility operating rooms. Documentation of a 30-second monthly test or an annual 90-minute test on the battery-operated emergency lights</p>	02/26/2021	

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K 0345  Bldg. 02	<p>Equipment requires an annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 ½ -hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff and patients if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on record review on 01/29/21 at 11:19 a.m. with the Administrative Assistant, it was unclear as to if the facility had battery-operated emergency lights or not as she did not know. Upon arrival of the facility Maintenance Man at 12:15 p.m., he was asked if the facility had battery-operated emergency lights, and he said that they did. When asked if he was documenting a 30 second monthly test or an annual 90-minute test on the battery-operated emergency lights, he stated that he was doing monthly tests, but had no documentation showing that he was doing so. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.</p> <p>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</p>		<p>will be conducted after the battery-operated emergency lights are installed by Barth Electric Company on 2/20/2021. Installation of battery-operated emergency lights and documentation of testing will correct this deficiency. The Surgical Care Center Director is responsible for monitoring installation and ongoing testing and documentation of the emergency lighting.</p>		

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	<p>complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> <li>a. Control unit trouble signals</li> <li>b. Remote annunciators</li> <li>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)</li> <li>d. Notification appliances</li> <li>e. Magnetic hold-open devices</li> </ul> <p>This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review on 01/29/21 between 8:30 a.m. and 12:20 p.m. with the Administrative Assistant, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Upon the arrival of the Maintenance Man at 12:15 p.m. he could not locate any documentation of a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, both the Administrative Assistant and the Maintenance Man agreed that documentation of a visual semi-annual fire alarm system inspection could not be provided at the</p>	K 0345	<p>Fire alarm systems require visual inspection and documentation be performed semi-annually or more often if required by the authority having jurisdiction, using these steps:</p> <ul style="list-style-type: none"> <li>a. Control unit trouble signals</li> <li>b. Remote annunciators</li> <li>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)</li> <li>d. Notification appliances</li> <li>e. Magnetic hold-open devices</li> </ul> <p>Building maintenance is responsible for completion of visual inspection and documentation.</p>	02/26/2021

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K 0761 Bldg. 02	<p>time of this survey. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.</p> <p><b>NFPA 101</b> Maintenance, Inspection &amp; Testing - Doors Maintenance, Inspection &amp; 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. 20.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on record review and observations, the facility failed to perform and document an annual fire door assembly inspection and testing for 3 of 4 fire door assemblies. This deficient practice affects all the occupants of the ASC.</p> <p>Findings include:</p> <p>Based on record review on 01/29/21 between 8:30 a.m. and 12:20 p.m., the facility could not provide the required fire door assemblies inspection and testing documentation. Based on observations during the tour of the building with the facility aintenance provider on 01/29/21 between 1:00 p.m. and 2:00 p.m., the following was noted: 1) A fastener was missing from the door closer on</p>	K 0761	<p>The facility failed to perform and document an annual fire door assembly inspection and testing for 3 of 4 door assemblies. An inspection has been scheduled with Access Door Assembly (ADA).</p> <p>A fastener was missing from the door closer on the 45-minute fire-rated assembly between ASC Waiting #A100 and Lobby #B101. At the time of the above inspection, this deficiency will be repaired.</p>	02/26/2021	

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K 0913  Bldg. 02	<p>the 45-minute fire rated assembly between ASC Waiting #A100 and Lobby #B101.</p> <p>2) A gap between the fire rated door and frame was observed at the 45-minute fire rated door assembly between ASC Support (Bulk Storage) #150 and Electrical #A152.</p> <p>3) The latch did not properly engage the strike to provide positive latching on the 45-minute fire rated door between ASC Support (Bulk Storage) and Water Softener #A149.</p> <p>Based on an interview at the time of the aforementioned items, the facility Maintenance Man acknowledged that he could not provide an annual fire door assembly inspection, and also commented that he was unaware the requirement for said door inspection. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.</p> <p>NFPA 101 Electrical Systems - Wet Procedure Locations Electrical Systems - Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected</p>		<p>A gap between the fire-rated door and frame was observed at the 45-minute fire-rated door assembly between ASC Support (Bulk Storage) #150 and Electrical #A152. This deficiency will also be repaired at the time of the fire door assembly inspection.</p> <p>The latch did not properly engage the strike to provide positive latching on the 45-minute fire-rated door between ASC Support (Bulk Storage) and Water Softner #A149. This deficiency was repaired on 1/29/2021 by the building maintenance representative.</p> <p>An annual fire door assembly inspection will be performed. This will avoid all of the above from happening in the future. The Director of the Surgical Care Center is responsible for scheduling and confirming the inspection is performed and documented annually.</p>				

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	<p>by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.</p> <p>6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 6 Operating rooms were provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. (7) Sinks - Located in areas other than kitchens where receptacles are installed within 1.8 m. (6 ft.) of the outside edge of the sink. This deficient practice could affect any patients as well as staff in the Operating rooms and the immediate area.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and the facility Maintenance man on 01/29/21 at 12:45 p.m., the following was noted:</p> <ol style="list-style-type: none"> <li>1) Several of the GFCI switches located along the outer wall in Operating Room #6 were tested and failed to trip shutting off the power to the electrical outlet.</li> <li>2) Several of the GFCI switches located along the outer wall in Operating Room #5 were tested and failed to trip shutting off the power to the electrical outlet.</li> <li>3) Several of the GFCI switches located along the outer wall in Operating Room #3 were tested and failed to trip shutting off the power to the</li> </ol>	K 0913	<p>The Center failed to ensure 3 of 6 operating rooms were provided with a ground fault circuit interrupter (GFCI) protection against electric shock. On 2/20/2021 Barth Electric inspected GFCI outlets in operating rooms 1, 2, 3, 4, 5 and 6. All outlets tripped indicating proper function.</p> <p>As part of the annual maintenance program, electrical outlets will be inspected for proper function by CBRE, building maintenance, documented and reported to the Director of the Surgical Care Center.</p>	02/26/2021			

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K 0916 Bldg. 02	<p>electrical outlet. When tested, none of the outlets popped the build in circuit or popped a circuit breaker in the nearby circuit breaker box. When asked if any of the outlets were GFCI protected, the Maintenance man said he thought that they were. The Maintenance man acknowledged the receptacles in the above-mentioned Operating rooms were not tripping the ground fault circuits and were not functioning as intended. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. * Note, I only had access to 3 of the 6 O.R. rooms within this A.S.C. as the others were in use for procedures at the time of this Life Safety Code Survey.</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, it was determined that the facility failed to provide an alarm annunciator for 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 21.2.9.2 requires where general anesthesia or life-support equipment is used, each</p>	K 0916	The Center failed to provide an alarm annunciator for 1 of 1 generator sets in accordance with NFPA 101, 2000 edition Life Safety Code. The facility is required to have a remote annunciator storage battery	02/26/2021	

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	<p>ambulatory health care facility shall be provided with an essential electrical system in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, 3-4.1.1.15 requires that a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular workstation. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load</li> <li>2. When the battery charger is malfunctioning</li> </ol> <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure</li> <li>2. Low water temperature</li> <li>3. Excessive water temperature</li> <li>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply</li> <li>5. Overcrank (failed to start)</li> <li>6. Overspeed</li> </ol> <p>This deficient practice could affect all patients, staff, and visitors within the facility.</p> <p>Findings include:</p> <p>Based on interview during record review on 01/29/21 at 10:38 a.m., the facility Administrative Assistant said the facility had an emergency generator. Upon the arrival of the facility Maintenance Man at 12:15 p.m., the facility tour began. During the tour at approximately 1:20 p.m. the annunciator panel was observed to be in the Bulk Storage room. When asked if the Bulk Storage room was an area that was continually</p>		<p>powered be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular workstation. The Electrical Company, Barth Electric who installed all the original electrical work in the facility, has been scheduled on 2/20/2021 to relocate the remote annunciator to the front registration office where it will be readily observed by personnel during hours the Center is opened. The Director of Nursing is responsible for confirming this relocation occurs</p>	

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NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP COD 9202 N MERIDIAN STREET SUITE 150 INDIANAPOLIS, IN 46260
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K 0918  Bldg. 02	<p>manned or supervised, the Administrative Assistant stated that staff frequented the area for supplies, but that it was not a continually supervised area. Based on interview at the time of the observation, the Administrative Assistant and the Maintenance Man both agreed that the facility generator annunciator panel was not located within an area that was readily observed by operating personnel, or at a regular workstation. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.</p> <p>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 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</p>			

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	<p>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)</p> <p>Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) 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. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K 0918	<p>No monthly generator load testing documentation for the facility was available at the time of the audit. The monthly testing log did not list the % of load that the generator was running at. The monthly generator log will be updated to include the % of load that the generator is running at. This test will be exercised at least once monthly for a minimum of 30 minutes using proper methods. Documentation of this monthly test will be added to the record.</p> <p>All of the above deficiencies have been corrected or will be corrected on or before 2/26/2021. The steps listed above will prevent this deficiency from recurring in the future. The Director of the Surgery Center is responsible for monitoring this.</p>	02/26/2021

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

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	Based on review on 01/29/21 at 11:19 a.m. with the Administrative Assistant, there was no monthly load testing documentation for the facility generator available for record review. Upon the arrival of the Maintenance Man at 12:15 p.m., the generator testing documentation was located and reviewed. At that time, it was noted that the monthly testing log did not list a percentage of load that the generator was running at. The load information to show the actual load percentage for the diesel-powered generator was not being documented. Based on interview at the time of record review, the facility Maintenance man acknowledged the generator ran under load monthly but does not achieve 30 % of the name plate rating. He further stated that he would start to document the percentage of load moving forward with his documentation. During the exit conference with the facility Administrative Assistant and the Maintenance man at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.			