STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001033	A. BUILDING **01** B. WING _____	**03/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER NORTH	**8040 CLEARVISTA PKWY STE 150** **INDIANAPOLIS, IN 46256**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54 Survey Dates: 03/08-09/21 Facility Number: 005973 Provider Number: 15C0001033 AIM Number: 200471420A At this Emergency Preparedness survey, Community Surgery Center North was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54 The facility has 9 operating rooms. Quality Review completed on 03/17/21	E 000		
E 037	EP Training Program CFR(s): 416.54(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ASC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new	E 037		

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E 037	Continued From page 5 and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 416.54(d)(1). This deficient practice could affect all occupants. Findings include: \ Based on record review on 03/08/21 at 10:22 a.m. with the Clinical Director (CD), documentation demonstrating staff knowledge of emergency procedures was not available for review. Based on interview concurrent with record review it was acknowledged by the CD, no records to document staff knowledge could be provided for review. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	E 037		
K 000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Dates: 03/08-09/21 Facility Number: 005973 Provider Number: 15C0001033 AIM Number: 200471420A At this Life Safety Code survey, Community Surgery Center North was found not in	K 000		

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K 000	Continued From page 6 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) 89101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This facility located on the first floor, second floor and basement of a five story building was determined to be of Type II (222) construction and fully sprinklered except for one elevator mechanical room. The facility has a fire alarm system with smoke detection on all levels including the corridors and spaces open to the corridors. The facility has 9 OR's. Quality Review completed on 03/17/21	K 000		
K 100	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section, any LSC Section 20.1 and 20.1 General 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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 Janitor's closet corridor door would close completely and latch into the door frame. This deficient practice could affect staff near the Nurse's station second floor. Findings include:	K 100		

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K 100	Continued From page 7 Based on observation on 03/08/21 at 2:33 p.m. with the Maintenance Technician (MT) the door leading into the Janitor's closet, next to the Nurse's station on second floor would not latch into its door frame. Based on interview concurrent with the observation with the MT it was stated the latching device was tampered with to prevent the door from latching for ease of access. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 100		
K 131	Multiple Occupancies CFR(s): NFPA 101 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 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	K 131		

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K 131	Continued From page 8 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 This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to ensure 1 of 1 occupancy separation fire barrier walls that separated the ASC from the other occupancies was properly installed. NFPA 101, 2012 Edition section 21.3.7 states ambulatory health care facilities shall be separated from other tenants and occupancies by a one hour fire resistance rating wall that extends from the floor slab below to the floor or roof slab above. This deficient practice could affect all occupants. Findings include: Based on review of Architect plans available on 03/09/21 at 10:50 a.m. with the Facilities Manager (FM) and Maintenance Technician (MT), it could not be determined if a one hour fire wall exists which separates the surgery center from the clinic. Based on interview concurrent with architectural plan review, the FM could not definitively conclude there was a one hour fire wall separation between the surgery center and the clinic since the plans did not show evidence of this. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 131		
K 211	Means of Egress - General	K 211		

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K 211	Continued From page 9 CFR(s): NFPA 101 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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure 1 of 5 corridors access were in accordance with Chapter 7. LSC 7.1.10.2.1 requires no furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 2 patients. Findings include: Based on observation on 03/08/21 at 2:24 p.m. with the Maintenance Technician (MT), a large floor machine supply was located in the exit access corridor in the Basement hall, limiting the width of the corridor to 31 inches. Based on interview at the time of the observation, the MT confirmed the storage of the floor machine and said they would find another place to keep it. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference. This was reviewed with the Clinical Director, Administrative	K 211		

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K 211	Continued From page 10 Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 211		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas must meet one of the following: *Contain 1 hour rated enclosure when non-sprinklered *Sprinkler protected with smoke resistive separation *Severe Hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 hazardous areas was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. "Section 21.3.2.1 requires doors to hazardous areas to be self-closing or automatic-closing in accordance with Section 21.2.2.4." This deficient practice could affect staff in the office area. Findings include: Based on observation on 03/08/21 at 2:16 p.m. with the Maintenance Technician (MT), cardboard boxes too numerous to count were stored in the PPE Storage room in the basement and the door lacked a self-closing device to automatically close and latch into the door frame. This was verified by the MT at the time of observation. This was reviewed with the Clinical Director, Administrative	K 321		

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K 321	Continued From page 11 Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 321		
K 351	Sprinkler System - Installation CFR(s): NFPA 101 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 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 3 Elevator machine rooms. NFPA 8.15.5.3 requires Automatic sprinklers in elevator machine rooms shall be of ordinary- or intermediate temperature rating. A.8.15.5.3 ASME A17.1, Safety Code for Elevators and Escalators, requires the shutdown of power to the elevator upon or prior to the application of water in elevator machine rooms or hoistways. This shutdown can be accomplished by a detection system with sufficient sensitivity that operates prior to the activation of the sprinklers (see also NFPA72, National Fire Alarm and Signaling Code). As an alternative, the system can be arranged using devices or sprinklers capable of effecting power shutdown immediately upon sprinkler	K 351		

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K 351	Continued From page 12 activation, such as a waterflow switch without a time delay. This alternative arrangement is intended to interrupt power before significant sprinkler discharge. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room. Findings include: Based on observation on 03/08/21 at 1:12 p.m. with the Maintenance Tech (MT), there was an elevator machine room on Patient hall which was not sprinklered. Based on interview with the MT, it was stated he thought all the elevator machine rooms were sprinklered, they must have missed this one. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference. 2. Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation on 03/08/21 at 1:21 p.m. with the Maintenance Technician (MT), in the Mechanical room on Connecting hall there were four black cables strapped to the steel sprinkler	K 351		

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COMMUNITY SURGERY CENTER NORTH	**8040 CLEARVISTA PKWY STE 150** **INDIANAPOLIS, IN 46256**

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K 351	Continued From page 13 pipe at ceiling level in the middle of the room. Based on interview at the time of observation, the MT acknowledged non sprinkler components were attached to the steel sprinkler pipe and was unaware this condition existed. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference. 3. Based on observation and interview; the facility failed to ensure 2 of 3 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 8.15.5.3 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room. Findings include: Based on observations on 03/08/21 during the tour between 12:00 p.m. to 3:30 p.m. with the Maintenance Technician (MT), two elevator machine rooms in the basement were sprinklered, but there was no visual evidence the two elevator machine rooms were provided with an electrical shunt trip. Based on interview concurrent with the observation with the MT it was stated he did not know what an electrical shunt trip was and doubted the two elevator	K 351		

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K 351	Continued From page 14 machine rooms were equipped with them.	K 351		
K 354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 at Section 15.5.2(6) The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. Section 15.7 (3) (4) When all impaired equipment is restored to normal working order, the fire department has been advised that protection is	K 354		

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K 354	Continued From page 15 restored and the property owner or designated representative, insurance carrier, alarm company, and other authorities having jurisdiction have been advised that protection is restored. This deficient practice could affect all occupants. Findings include: Based on record review on 03/08/21 at 11:01 a.m. with the Clinical Director (CD) the facility provided fire watch documentation but it was incomplete. The plan only contacts the local Fire dept and ISDH during a sprinkler system impairment and failed to notify the Monitoring Co, Owner Operator, Insurance carrier and Heads of staff. Finally the plan failed to call all entities back once the sprinkler system has been restored to normal operation. Based on an interview at the time of record review, the CD acknowledged the fire watch policy and procedure lacked notifying all required entities and then to advise them sprinkler protection has been restored. This was discussed with the CD during the exit conference. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 354		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 355		

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K 355	Continued From page 16 failed to ensure 1 of 1 portable fire extinguishers was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a patient care area but could affect staff in the Basement workshop. Findings include: Based on observations during a tour of the facility with the Maintenance Technician (MT), on 03/08/21 at 1:55 p.m. the ABC portable fire extinguisher located in the Basement workshop was unsupported setting on a file cabinet. Based on interview at the time of observations, the MT acknowledged the portable fire extinguisher was unsupported. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 355		
K 371	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments Smoke compartments do not exceed 25,000 square feet in size. Every story shall be divided into not less than 2 smoke compartments unless one of the following conditions occur:	K 371		

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K 371	Continued From page 17 Facility is less than 5,000 square feet protected by an approved smoke detection system Facility is less than 10,000 square feet protected by an approved, supervised sprinkler system per 9.7 Adjoining occupancy is used as a smoke compartment if all of the following are met: a. Separating wall is 1 hour fire resistive rated b. Doors in the 1 hour rated wall at 1-3/4 inches thick c. Doors in the 1 hour rated wall are self-closing d. Windows in the 1 hour rated wall are fixed fire window assemblies per 8.3 e. The ambulatory health care facility is less than 22,500 square feet f. Access from the ambulatory health care facility is unrestricted to another occupancy 20.3.7.2, 21.3.7.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 first floor one hour smoke barrier walls was properly installed. NFPA 101, 2012 Edition section 21.3.2 states every story of an ambulatory health care facility shall be divided into not less than two smoke compartments. The deficient practice could affect all occupants. Findings include: Based on review of Architect plans available on 03/09/21 at 10.50 a.m., with the Facilities Manager (FM) and the Maintenance Technician the back wall of the lab was identified by the FM and MT as part of the one hour smoke barrier wall, but could not be verified on the architectural plans presented at the time. Based on interview concurrent with architectural plan review, the FM could not definitively conclude the back wall of the lab was part of the one hour smoke barrier wall	K 371		

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K 371	Continued From page 18 since the plans did not show evidence of this. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 371		
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 21.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants. Findings include: Based on observations on 03/09/21 between 10:00 a.m. to 12:30 p.m. with the Maintenance Technician (MT), the following areas in the smoke barrier wall had unsealed penetrations above the	K 372		

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K 372	Continued From page 19 drop ceiling. a. Smoke wall adjacent to fire door # 2461 had a plastic conduit penetrating the smokewall into which one low voltage wire entered and the opening of the conduit was not sealed. b. Above the ceiling of the north wall of the employee breakroom was one small gray wire penetrating the smoke wall which had a one inch opening around it and it was not sealed. c. Above the fire door, north wall of the employee breakroom there were two conduits penetrating the smoke wall and the opening around the conduits were not sealed. d. A black cable and yellow electrical wire penetrated the smoke wall above the ceiling in the corridor outside the breakroom and the hole was not sealed. e. Above television in the Anesthesia office there was a one inch diameter hole unseal. To the right of that was a one inch hole with white wire penetrating the smokewall which was unsealed and finally an eight inch diameter opening in the smoke wall was not sealed. f. In the Patient recovery area there was a one inch diameter opening above the entry doors with two wires penetrating the smoke wall which were not sealed. g. In the Stairwell hall there was a metal electrical conduit penetrating the smoke wall with a two inch hole around the conduit which was unsealed. Also, there was a green electrical conduit penetrating the smokewall with a two inch hole which was unsealed. h. Above the ceiling of the North stairwell wall in the elevator wall, fire caulk has pulled away from an opening in the smoke wall. i. Above the ceiling of the West stairwell wall was an eight inch diameter opening which was not sealed.	K 372		

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K 372	Continued From page 20 j. Above the ceiling of the South stairwell wall was a one foot by 6 inch opening in the brick wall which was not sealed. k. Patient room # 128 had numerous unsealed openings: a. 2" by 2" hole into which a green conduit penetrated. b. 2" by 2" hole into which a green conduit penetrated. c. 2" by 3" hole into which a blue communications wire penetrated. 2. Based on interview at the time of observations, the MT visually confirmed each penetration mentioned in a through k. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference. 2. Based on observation, record review and interview the facility failed to ensure the fixed fire window assembly in the Surgery Scheduling office was protected with a one hour fire rating for 1 of 1 smoke barrier walls. Section 21.3.7.7 Windows in smoke barrier shall be of fixed fire window assemblies in accordance with Section 8.3. Section 8.3.3.1 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 Protective's, except as otherwise specified in this Code. Findings include:	K 372		

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K 372	Continued From page 21 Based on observation on 03/09/21 at 11:01 a.m. with the Maintenance Technician (MT), the fixed fire window installed in the smokewall of the Surgery Scheduling office was not labeled with a fire rating. Based on record review on 03/09/21 at 11:51 a.m. with the Facilities Manager (FM) the architectural plans presented could not verify the fixed glass window in the smokewall in the Surgery Scheduling office was protected with a one hour fire rating. Based on interview concurrent with record review with the FM, it was stated he believed it was a fire rated window, but could not verify the fire rating on the architectural plans. The FM further stated the facility would do what was necessary to make it right. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference.	K 372		
K 511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 511		

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K 511	Continued From page 22 failed to ensure electrical wiring was contained in 7 of 7 junction boxes observed, with a cover. LSC 21.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 300.15 states a box or conduit body shall be installed at each junction point unless otherwise permitted by 300.15(A) through (I). Article 314.28 states boxes and conduit bodies used as pull or junction boxes shall be comply with 314.28 (A) through (E). This deficient practice could affect occupants throughout the facility. Findings include: Based on observations on 03/09/21 during the tour between 10:16 a.m. to 12:30 p.m. with the Maintenance Technician (MT) above the ceiling tiles in the following areas had exposed electrical wiring jutting out of an electrical junction boxes without a cover: a. Above the ceiling of the wall with the cabinets in the Anesthesia office was an electrical junction box without a cover. b. Above the ceiling near the entry doors of the Patient recovery room was an electrical junction box without a cover. c. Above the ceiling of the Stairwell hall were three electrical junction boxes without covers. d. Above the ceiling of the Stairwell hall door was a VAB electrical terminal box with the door left open exposing the components inside. e. Above the ceiling of the hallway adjacent to patient room # 22 through # 25 there was an electrical junction box without a cover. Based on interview concurrent with the observation, the SFSA acknowledged the exposed electrical wiring was not contained in a	K 511		

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K 511	Continued From page 23 junction box with a cover. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference.	K 511		
K 915	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install a Type I Essential Electrical System servicing the patients on general anesthesia in 9 of 9 operating rooms in accordance with the requirements NFPA 99, 2012	K 915		

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K 915	Continued From page 24 edition, Section 6.4.2.2. This deficient practice could affect all patients on general anesthesia. Findings include: Based on interview with the Maintenance Technician (MT) on 03/09/21 at 12:06 p.m., the emergency generator had been replaced with a new generator within the last 4 (?) years and another transfer switch had been added to the system. The MT was asked the location of the critical, life safety and the equipment branches of the essential electrical system and he was unaware of each separate branch locations. He stated he thought the transfer switches were separated by voltage. One transfer switch was used for 120 volts and the second was used for 220 volts. Based on observation with the MT on 03/09/21 at 12:15 p.m., an emergency panel in the waiting room electrical closet contained emergency lighting and various other items but was not labeled and could not be identified as a Life Safety Branch panel. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services, and the Maintenance Technician during the exit conference.	K 915		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		

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K 920	Continued From page 25 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 multi plugs and 3 of 3 power strips were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, multiplugs and power strips shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observations on 03/08/21 during the tour between 1:15 p.m. to 3:00 p.m. with the Maintenance Technician (MT) the following was observed: a) Two power strips were connected into a three prong multi plug in the Manager's office, Back hall. b) One power strip was connected to another	K 920		

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K 920	Continued From page 26 power strip in the OR Manager's office, Back hall. c) On Preop hall in the Preop Coordinator's office there was a mini refrigerator connected to a power strip. Based on interview at the time of observations, the MT acknowledged the misuse of power strips and a multi plugs. This was discussed with the CD during the exit conference. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference.	K 920		
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage *Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. *Greater than 300 but less than 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating. *Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001033	A. BUILDING **01** B. WING _____	**03/09/2021**

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K 923	Continued From page 27 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 3 of 3 cylinders of nonflammable gases such as CO2 were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could possibly affect staff and visitors. Findings include: Based on observation on 03/08/21 during the tour of the facility at 1:55 p.m. with the Maintenance Technician (MT) there were three CO2 cylinder tanks freestanding on the floor in Nourishment room on Patient back hall and were not secured from falling. Based on interview concurrent with the observation it was confirmed by the MT the three CO2 tanks were full and not secured properly to prevent the cylinders from falling. This was reviewed with the Clinical Director, Administrative Coordinator, Executive Director of Surgical Services and the Maintenance Technician during the exit conference.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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