STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001193	A. BUILDING -- B. WING	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MICHIANA SURGERY CENTER LLC	3212 HICKORY ROAD, SUITE A MISHAWAKA, IN 46545

(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: 10/20/21 Facility Number: 013086 Provider Number: 15C0001193 AIM Number: NA At this Emergency Preparedness survey, Michiana Surgery Center Llc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. The facility has 2 certified Operating Rooms. Quality Review completed on 10/26/21 The requirement at 42 CFR, Subpart 42 CFR 416.54. is NOT MET as evidenced by:	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

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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	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 416.54(a)(1) and 42 CFR 416.54(a)(2). The plan must be reviewed and updated at least every 2 years. In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include	E 0006	(1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach A risk assessment with hazard vulnerability was completed with associated plan has been developed after reviewing Michiana Surgery Center's surrounding area. An all hazards approach including: Naturally occurring events Technologic and critical infrastructure events Human related events, including emerging infectious diseases (EID) threats	11/22/2021

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	emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" documentation dated 10/08/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. In addition, it could not be determined if the risk assessment included a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on interview at the time of record review, the Clinical Manager stated the facility has developed Covid-19 policies and procedures but agreed the facility-based and community-based risk assessment documentation did not include emerging infectious diseases and an-all hazards approach. This finding was reviewed with the Clinical Manager during the exit conference.		Involving hazardous materials Hazard summary SDS for the (2) chemicals within Michiana Surgery Radius Including procedures for addressing emergency events The hazards in Michiana Surgery Center area will be reviewed along with the plan every (2) years. Responsible person: Admin (will update) and the Governing Board will approve the assessment.	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b),			

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	§485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not			

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	limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least every 2 years in accordance with 42 CFR 416.54(b). This deficient practice could affect all occupants. Findings include: Based on review of Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" documentation dated 10/08/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the facility-based and community-based risk assessment documentation did not include emerging	E 0013	(1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach A risk assessment with hazard vulnerability was completed with associated plan has been developed after reviewing Michiana Surgery Center's surrounding area, including emerging infectious diseases hazard risk assessment. Documentation of Ebola, Zika and the Flu season and the likely hood of exposure are contained in the policy The Admin will monitor the CDC and Indiana State	11/23/2021

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	infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. In addition, it could not be determined if the risk assessment included a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach. As a result, emergency preparedness policies and procedures developed for the facility were not based on a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on interview at the time of record review, the Clinical Manager stated the facility has developed Covid-19 policies and procedures but agreed the facility-based and community-based risk assessment documentation did not include policies and procedures based on an-all hazards approach. This finding was reviewed with the Clinical Manager during the exit conference.		Department of Health news releases and update the staff on new information received. An all hazards approach including: Naturally occurring events Technologic and critical infrastructure events Human related events, including emerging infectious diseases (EID) threats Involving hazardous materials Hazard summary SDS for the (2) chemicals within Michiana Surgery Radius Including procedures for addressing emergency events The hazards in Michiana Surgery Center area will be reviewed along with the plan every (2) years. Responsible person: Admin (will update) and the Governing Board will approve the assessment.	
E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 416.54(b)(5). This deficient practice could affect all	E 0024	To ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge	11/26/2021

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	occupants. Findings include: Based on review of Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" documentation dated 10/08/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, emergency preparedness policies and procedures did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Clinical Manager agreed emergency preparedness policies and procedures did not include a policy on volunteers. This finding was reviewed with the Clinical Manager during the exit conference.		needs during an emergency in accordance with 42 CFR 416.54(b)(5). Michiana Surgery Center policy:EOC.SF.100.00, states that the facility will not be integrated currently in the city wide disaster response program whether drill or actual due to the minimal number of hours of operation and staff present at the facility. Michiana Surgery Center does not utilize volunteers. The policy will be reviewed every two years and updated. Responsible person: Admin.	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ASC facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 416.54(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" documentation dated 10/08/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, emergency preparedness policies and procedures did not expressly state the role of the facility under a waiver declared by the Secretary, in accordance	E 0026	1.Emergency preparedness policy and procedure Plan will state the role of the facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act. 2.Emergency Preparedness Policy Plan will be be reviewed and revised by the Governing Board on an annual basis to ensure that our conditions of participation are met for the 1135 Waiver as well as all other Emergency Preparedness Requirements - including but not limited to on-going QAPI meetings, and collaboration with	11/24/2021

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	with Section 1135 of the Act. Based on interview at the time of record review, the Clinical Manger agreed the emergency preparedness plan for the facility did not expressly state the role of the facility under a waiver declared by the Secretary. This finding was reviewed with the Clinical Manager during the exit conference.		local authorities and healthcare facilities. 3. Responsible person: Admin and the Governing Board.	
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification			

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	Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance in accordance with 42 CFR 416.54(c)(2). This deficient practice could affect all occupants. Findings include: Based on review of Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" documentation dated 10/08/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the emergency preparedness communication plan did not include notification of the Indiana Department of Health. Based on interview at the time of record review, the Clinical Manager agreed the emergency preparedness communication plan did not include notification of the Indiana Department of Health. This finding was reviewed with the Clinical Manager during the exit conference.	E 0031	Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance in accordance with 42 CFR 416.54(c)(2) are located and have been located in the blue folder located in the nurses station on the solution cart in the nurses Pre OP area. This list will be updated as changes occur. Responsible person: Admin. Clinical Policies & Procedures Manual "Emergency Preparedness Management Plan" the emergency preparedness communication plan has now been revised to include notification of the Indiana Department of Health. This policy plan will be reviewed	11/24/2021

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			every (2) years. Person responsible: Admin	
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: 10/20/21 Facility Number: 013086 Provider Number: 15C0001193 AIM Number: NA At this Life Safety Code survey, Michiana Surgery Center Llc 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 is located on the first floor of a one story building and was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in HVAC duct work and at the main fire alarm control panel. Quality Review completed on 10/26/21	K 0000		
K 0291 Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in			

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	accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 Based on observation and interview, the facility failed to ensure 1 of over 10 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect one male staff member in the restroom for the men's locker room. Findings include: Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, the battery operated emergency lighting system in the restroom in the men's staff locker room failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Clinical Manager provided documentation showing a replacement battery operated emergency lighting system had been ordered but agreed the aforementioned battery operated emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Clinical Manager during the exit conference.	K 0291	Battery powered emergency lights will be maintained in accordance with LSC 7.9. LSC 7.9.2.6. Maintaining light in a properly charged condition will be monitored monthly by the Safety officer and the deficient light will be reported to the Admin. which the Property Manager will then be notified for compliance. Monthly 30 second tests will be implemented and recorded by the safety Officer The safety officer will continue to be diligent in her monthly E-light inspections. Emergency light in men's restroom has been replaced. Responsible person: Safety Officer, Admin. and Property Manager	11/11/2021

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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. 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 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 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Important Notice" documentation dated 12/09/19 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the facility's fire and security system's communication system is in need of an upgrade. The 12/09/19 documentation stated "your current fire and/or security system utilizes a 3G/4G cellular communicator to transmit messages to and from the Koorsen monitoring center. When your community is upgraded to	K 0345	1. 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 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. Inspection of alarm system has been inspected and the upgrade to 5G is being implemented. To prevent from occurring in future the correspondence from Fire company will be reviewed closely. Responsible person : Admin. and Safety Officer 2. 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	11/24/2021

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	LTE cell towers, the communicator in your system will no longer be able to communicate with the Koorsen monitoring center, leaving you and your property at risk. In order to maintain a secure, reliable connection between your fire and/or security system and the Koorsen monitoring center, your system MUST be updated! If your system is not updated, you will lose connection to the Koorsen monitoring center". Review of the fire alarm system inspection contractor's "Repair Service Ticket- Description of work" documentation dated 04/07/21 stated "advised customer they will have to upgrade their communication panel due to the 3G/4G service shut off within the next 10-12 months". Based on interview at the time of record review, the Clinical Manager stated she was not aware if the communication system has been upgraded or has been scheduled to be updated. These findings were reviewed with the Clinical Manager during the exit conference. 2. Based on record review and interview, it could not be assured all facility fire alarm system initiating devices were 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. Table 14.4.5 Testing Frequencies states initiating devices shall be functional tested annually. This deficient practice could affect all patients, staff, and visitors.		NFPA 72, National Fire Alarm and Signaling Code. The fire alarm system initiating devises have been proven functional as evidenced by a fire drill with an alarm pull with Fire Marshall present and verified the signal went through to the firehouse and ADT. To ensure the signal is going through a drill with activation of alarm will be held annually as evidenced by fire drill documentation. Responsible person: Admin. to schedule these drills. 3.Duct annual detector inspection was functionally tested by Koorsen and present in the fire safety book and the compliance binder. Inspections will take place semi-annually. Responsible person: Safety Officer and Admin. b. Remote annunciators Will be inspected semi annually by Koorsen. Responsible person: Safety Officer and Admin. c.& d. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices An annual duct inspection will be scheduled utilizing a fire safety	

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	Findings include: Based on review of the fire alarm system inspection contractor's "Element of Performance 3" documentation dated 08/13/19 and 08/18/20 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the results of functional testing for 2 of 2 duct detectors in the facility were documented as "Visual" and listed as "Inaccessible" in the "Comments" section of the two reports. In addition, the result of functional testing 2 of 2 duct detectors in the facility listed on "Device Inspection Report" documentation dated 10/05/21 stated "visual only". Based on interview at the time of record review, the Clinical Manager stated additional fire alarm inspection and testing documentation within the most recent twelve month period was not available for review and agreed it could not be assured the facility's two duct detectors had been functional tested within the most recent twelve month period. This finding was reviewed with the Clinical Manager during the exit conference. 3. 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 Section 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: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors,		book. The Safety officer will inform the Admin. when the inspection is due and Admin. will schedule the inspection with Koorsen and Bloofield. Responsible person: Admin. and Safety Officer The fire alarm system has been inspected and documentation is stored onsite. e .All fire doors (29 doors) and assemblies have been checked and have passed inspections. A copy can be found in the compliance binder and the fire safety book. Annual Fire door inspections will be completed as evidenced by documentation. The schedule book of inspections will be utilized to ensure timely inspections are completed. Responsible person: Admin. and Safety Officer *Further inspections will be recorded and kept on site. *All duct DETECTORS have been completed and will be verified and inspected *Fire alarm system will be maintained and tested per LSC101 and NFPA 72. *The fire alarm was pulled on the 4th quarter fire drill with the Fire Marshall and the signal went to the fire house and ADT as intended.	

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	etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on review of the fire alarm system inspection contractor's "Element of Performance 3" documentation dated 08/18/20 and "Device Inspection Report" documentation dated 10/05/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, documentation of a visual semi-annual fire alarm system inspection six months after 08/18/20 was not available for review. Based on interview at the time of record review, the Clinical Manager stated the facility had not been closed due to the Covid-19 pandemic at any point on or after March 2020 and agreed documentation for a semi-annual visual fire alarm system inspection six months after 08/18/20 was not available for review at the time of the survey. This finding was reviewed with the Clinical Manager during the exit conference.		*Fire alarm inspections will be maintained on site *MSC currently have no hold open devices Inspection schedule has been provided to the safety officer in her binder and she will notify the Admin as to when inspections are to be scheduled and the Admin. will make contact and schedule inspections. Responsible person: Admin. and Safety Officer	
K 0346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Fire alarms that are out of service for 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility	K 0346		11/03/2021

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	failed to provide a complete written policy for the protection of patients indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of "Fire Watch Plan" documentation dated June 2016 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the fire watch plan for fire alarm system impairment was incomplete. The plan failed to include contacting the Indiana Department of Health. Based on interview at the time of record review, the Clinical Manager agreed fire watch documentation for fire alarm system impairment did not state to contact the Indiana Department of Health. This finding was reviewed with the Clinical Manager during the exit conference.		Fire alarm "out of service" Fire watch Plan during system impairment has been revised to instruct notifying Indiana State Department Of Health. Staff will be trained about the policy revisions. Policies will be reviewed and revised by the Governing Board no less than 3 years during Board meetings as evidenced by meeting minutes. The board will be presented policies annually in a rotation to ensure policies are kept up to date. Staff will be educated on any revisions. Responsible person: Admin.	
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 _____			

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	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 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, 2011 Edition, Section 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:	K 0353	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. Quarterly sprinkler system inspection has been completed by Koorsen and is located in compliance book and in the Fire Safety binder. Quarterly inspection will be scheduled. Responsible person: Safety Officer and Admin. Control valves have been provided and are in place. A monthly walk through to ensure the signage remain in place. Responsible person: Safety Officer Main drain sign has been provided and in place. A walk through monthly will be completed. Responsible person: Safety Officer	11/12/2021

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	Based on review of the sprinkler system inspection contractor's "Sprinkler System Inspection" documentation dated 05/18/21 and 10/05/21 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, quarterly sprinkler system inspection documentation for the third quarter (July, August, September) 2021 was not available for review. In addition, it had been 140 days in between the two most recent documented sprinkler system inspections in the second quarter (April, May, June) 2021 and the fourth quarter (October, November, December) 2021. Based on interview at the time of record review, the Clinical Manager stated the facility had not been closed due to the Covid-19 pandemic at any point on or after March 2020 and stated quarterly sprinkler system inspection documentation for the third quarter 2021 was not available for review. Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, the sprinkler system inspection contractor had affixed hanging tags to the sprinkler system riser for which documentation of waterflow alarm inspection for the third quarter of 2021 was not available for review. This finding was reviewed with the Clinical Manager during the exit conference. 2. Based on observation and interview, the facility failed to ensure the minimum supply of spare sprinklers was maintained on the premises. 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		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. Contractor for sprinkler system has completed the inspections. (6) spare sprinkler heads and wrench are in the sprinkler room. A monthly walk through will be done to ensure proper number of sprinkler heads and spare wrench is present. Responsible person: Safety Officer 5 year sprinkler test has been performed with no deficiencies. Report is on file on site. Utilizing the safety book will alert the Safety Officer of when to schedule the 5 year inspection. Responsible person: Safety Officer and Admin. Koorsen will be MSC's fire contractor. The safety officer has a better knowledge of the inspections and the frequency along with the Admin. The fire binder contains the schedule of inspections for reference. The safety Officer will inform the Admin to schedule NFPA 25, 2011 Edition, Section	

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	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 Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, a total of two spare sprinklers were noted in the spare sprinkler cabinet in the riser room. Based on interview at the time of the observations, the Clinical Manager stated additional spare sprinklers have been ordered and agreed the minimum supply of spare sprinklers of the type installed in the facility's suite were not maintained in the spare sprinkler cabinet. This finding was reviewed with the Clinical Manager during the exit conference. 3. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, section 14.2.2. This deficient practice affects all patients, staff, and visitors. Findings include:		13.3.1 states each control valve shall be identified and have a sign indicating the system or portion of the system it controls. All control valve signs are in place after contacting Koorsen. During the Fire Safety Officer's monthly walk through she will ensure all signs are present. Responsible person: Safety Officer	

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	Based on review of the sprinkler system inspection contractor's "Inspection & Test Report" documentation dated 02/05/18 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, documentation of an internal pipe inspection conducted within the most recent five year period was not available for review. The 02/05/18 inspection documentation stated 5-year due 2018. Review of the sprinkler system inspection contractor's "Inspection & Test Report" documentation dated 08/30/19 also stated "5-year due 2018". Based on interview at the time of record review, the Clinical Manager stated documentation of a current internal pipe inspection was not available for review at the time of the survey. Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, the facility has a supervised wet sprinkler system. This finding was reviewed with the Clinical Manager during the exit conference. 4. Based on record review, observation and interview; the facility failed to provide signage for the facility's sprinkler system in accordance with NFPA 25. 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, 2011 Edition, Section 13.3.1 states each control valve shall be identified and have a sign indicating the system or portion of the system it controls. This deficient practice could affect all patients, staff, and visitors in the facility. Findings include:			

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	Based on review of the sprinkler system inspection contractor's "Inspection & Test Report" documentation dated 02/12/20 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the facility's sprinkler system was missing one control valve sign. The comments section of the 02/12/20 inspection report stated "Missing (1) Control Valve sign". Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, the main drain control valve for the facility's sprinkler system was missing its signage. Based on interview at the time of the observations, the Clinical Manager agreed the the main drain control valve for the facility's sprinkler system was missing its signage. This finding was reviewed with the Clinical Manager during the exit conference.			
K 0354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service 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) Based on record review and interview, the facility	K 0354		11/12/2021

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	failed to provide a complete written policy containing procedures to be followed for the protection of all patients 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, 2011 Edition, Section 15.5.2 requires the fire department, insurance carrier, the alarm company, the property owner or designated representative and other authorities having jurisdiction be notified. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Fire Watch Plan" documentation dated June 2016 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the fire watch plan for automatic sprinkler system impairment was incomplete. The plan failed to include contacting the Indiana Department of Health. In addition, the plan also failed to include notification of the insurance carrier for automatic sprinkler system impairment. Based on interview at the time of record review, the Clinical Manager agreed fire watch documentation for automatic sprinkler system impairment did not state to contact the Indiana Department of Health and the insurance carrier. This finding was reviewed with the Clinical Manager during the exit conference.		Fire Alarm "out of service" policy has been updated to include contacting the Indiana State Department of Health, facility insurance company, and the alarm company (ADT) and the Fire Marshall/Department. Staff will be trained on the updated policy. The policies will be reviewed by the Governing Board no less than every three years. The policies will be put on the minutes by the Admin. to be reviewed during the quarterly meetings. Responsible person: Admin.	
K 0372	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	Barrie 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 Based on record review, observation and interview; the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. LSC 21.3.7.5 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a wall constructed as a smoke barrier floor/ceiling assembly shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of facility blueprint documentation with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the vacuum pump room for the facility's piped gas system was constructed with separation from adjoining spaces with one hour fire resistance rated construction. Based on	K 0372	Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. Correction- Admin. has contacted the property manager> this manager has engaged Bloomfield to scrape and remove all foam from penetrations and replace with 3M fire barrier rated red putty sealant IC 15Wb+. Documentation will be kept on-site. The SDS fire putty information is contained in the compliance book for review. Prevention- anytime work is completed on premises Admin. will do a walk through with property manager to ensure properly rated supplies are being used.	11/12/2021

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	observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, foam was used to firestop ceiling penetrations in the vacuum pump room above the automatic transfer switch and above the entrance door to the room for electrical conduits. Based on interview at the time of the observations, the Clinical Manager did not have documentation stating the UL listing and the fire resistance rating of the foam used to firestop the ceiling penetrations. This finding was reviewed with the Clinical Manager during the exit conference.		Responsible person: Admin. and the Property Manager	
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	K 0521	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. An inspection has been completed of the fire damper and will be	11/12/2021

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	with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on record review with the Clinical Manager from 10:25 a.m. to 2:30 p.m. on 10/20/21, documentation of current fire damper inspection and maintenance was not available for review. The review of "Addendum" documentation dated 2016 from the fire alarm system inspection contractor quoting costs for services stated "quote to replace the fusible link associated with the damper in the O2 room" indicated the facility has at least one fire damper. Based on interview at the time of record review, the stated fire damper inspection documentation within the most recent four year period was not available for review. Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, one fire damper was noted in the wall of the piped gas room between the piped gas room and the vacuum pump room. Documentation affixed to the fire damper indicated the fire damper was manufactured 06/25/13. Current inspection documentation was not affixed to the fire damper. This finding was reviewed with the Clinical Manager during the exit conference.		performed and documentation of the inspection will be maintained on-site every four years per standard. A documented tag has been placed for reference. The facility will coordinate a schedule to perform fire damper inspections every four years. This schedule will be maintained in binder with the Safety Officer. The safety officer will inform the Admin. that a inspection is due and she will contact the appropriate company and schedule it. Responsible person: Safety Officer and Admin.	

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K 0712 Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first shift for 1 of 4 quarters. This deficient practice affects all patients, staff and visitors. Findings include: Based on review of "Fire Drill Evaluation Form" documentation with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, December) 2020 was not available for review. Based on interview at the time of record review, the Clinical Manager stated the facility operates one shift per day and agreed documentation of a fire drill conducted on the first shift in the fourth quarter of 2020 was not available for review. This finding was reviewed with the Clinical Manager during the exit conference. 2. Based on record review and interview, the	K 0712	LSC 21.7.1.4 states fire drills in ambulatory health care facilities shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. An unannounced fire drill was performed on 11/3/2021. The Admin. contacted the Fire Marshal and was present for the drill. The alarm system was tested at this time. Fire Marshal ensured the alarm went to the fire station without difficulty. The Fire Marshall documented the drill and timed the event. Documentation is available on site. The Admin. will continue to schedule education and fire drills quarterly with at least (1) being unannounced and with the Fire Marshall present for activation of the fire alarm.	11/03/2021

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	facility failed to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 3 of 4 quarters. LSC 21.7.1.4 states fire drills in ambulatory health care facilities shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Evaluation Form" documentation with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, first shift fire drills conducted on 01/11/21, 05/11/21 and on 09/30/21 were conducted at, respectively, 11:30 a.m., 1:04 p.m. and 3:48 p.m. Documentation for each fire drill did not include activation of the fire alarm system and transmission of the fire alarm signal. Based on interview at the time of record review, the Clinical Manager stated the facility operates one shift per day and agreed documentation of the activation of the fire alarm system and transmission of the fire alarm signal for the aforementioned three first shift fire drills was not available for review. This finding was reviewed with the Clinical Manager during the exit conference.		Documentation of the fire drills will be kept on-site. Responsible person: Admin. will be responsible to schedule Fire Drills	
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			

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	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 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	K 0761	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. All doors were inspected Responsible person: Admin (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. All doors were inspected for defects in glazing and passed. Responsible person: Admin. and Safety Office (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. Above were all inspected and passed.	11/22/2021

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	door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (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 Fire/Smoke Door Inspection Checklist" documentation dated December 2018 with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21,		Responsible person: Admin. and Safety Officer (4) No parts are missing or broken. No parts are missing from doors. Inspection completed and passed. Responsible person: Admin and Safety Officer (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. Door clearances do not exceed standards Inspected and passed. Responsible person: Admin. and Safety Officer (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. Inspection completed and passed. Responsible person: Admin. and Safety Officer 1.)This inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin.	

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	documentation for current annual fire door inspections was not available for review. Based on interview at the time of record review, the Clinical Manager stated the most recent documented fire door inspections were in December 2018 and agreed documentation for current annual fire door inspections was not available for review. Based on review of facility blueprint documentation at the time of record review, the corridor wall for the vacuum pump room for the facility's piped gas system was constructed as a one hour fire resistance rated wall. Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, a 3-hour fire resistance rating label was affixed to the corridor door to the vacuum pump room. This finding was reviewed with the Clinical Manager during the exit conference.		2.)Glazing inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 3.)No parts are missing or broken inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 4.).No parts are missing or broken inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies	

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			have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 5.)Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7 inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 6.) Self closing device is operational and closes completely when operated from the full open position inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the	

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	15C0001193	A. BUILDING 01 B. WING	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MICHIANA SURGERY CENTER LLC	3212 HICKORY ROAD, SUITE A MISHAWAKA, IN 46545

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			schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 7.) No coordinator is installed at Michiana Surgery Center 8.) Latching hardware operates and secures the door when it is in closed position and inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin. 9.)Auxiliary hardware inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin.	

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			when inspection is due and Admin. will schedule the inspection. Responsible person: Admin and Safety Officer 10.) No field modifications have been made to the door assembly that may void the label the inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the inspection. Person responsible: Safety Officer and Admin 11.) Gasketing and edge seals where required are inspected to verify their presence and integrity the inspection will be completed no less than annually, and has recently been completed and documentation is onsite in the fire binder and the compliance binder, each door and assemblies have passed all inspections. The Safety Officer maintains the schedule utilizing the inspection binder and will inform the Admin. when inspection is due and Admin. will schedule the	

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			inspection. Person responsible: Safety Officer and Admin	
K 0902 Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Other Gas and Vacuum Piped Systems - Other List in the REMARKS section, any NFPA 99 Chapter 5 Gas and Vacuum 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 5 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure the vacuum pump room for the facility's piped gas system was maintained with a minimum one-hour fire resistance rating construction. This deficient practice could affect all patients. Findings include: Based on review of facility blueprint documentation with the Clinical Manager during record review from 10:25 a.m. to 2:30 p.m. on 10/20/21, the vacuum pump room for the facility's piped gas system was constructed with separation from adjoining spaces with one hour fire resistance rated construction. Based on observations with the Clinical Manager during a tour of the facility from 2:30 p.m. to 4:00 p.m. on 10/20/21, foam was used to firestop ceiling penetrations in the vacuum pump room above the automatic transfer switch and above the entrance door to the room for electrical conduits. Foam was also used to firestop penetrations of the back wall of the room behind the furnaces. Based on	K 0902	3M rated fire putty has replaced the foam in all firestop ceiling penetrations in the vacuum pump room above the automatic transfer switch and above the entrance door to the room for electrical conduits. 3M fire putty has also replaced and is used at the firestop penetrations of the back wall of the room behind the furnaces. All areas mentioned were scraped free from the foam and replaced with the fire rated 3M product. The SDS information can be reviewed in the compliance book on site. Any future construction the 3M fire putty will be utilized. A walk through will occur during and after any construction with the Admin. and the Property Manager. Responsible person: Admin. and	11/18/2021

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	interview at the time of the observations, the Clinical Manager did not have documentation stating the UL listing and fire resistance rating of the foam used to firestop the ceiling and wall penetrations in the vacuum pump room. This finding was reviewed with the Clinical Manager during the exit conference.		Property Manager	