STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38C0001000	A. BUILDING _____ B. WING _____	09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVEJOY SURGICENTER, INC	933 NW 25TH AVENUE PORTLAND, OR 97210

(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
Q 181	Continued From page 7	Q 181		
Q 221	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. This STANDARD is not met as evidenced by: Based on documentation review, it was determined that the facility's notice of patient's rights given to the patient and the posted notice of patient's rights did not have the correct name of the SA to which patients may report complaints or concerns, or the correct web site information for the Medicare Beneficiary Ombudsman, as required by rule. Findings include: (1) Documentation Review: On 05/19/15 review of documentation in the Lovejoy Surgicenter Notice of Patient Rights, updated 1/15/15, revealed the following: (a) "file a complaint with the State Department of Health Services regardless of whether you use the grievance process. You can contact the State Department of Health Services at: Oregon	Q 221		7/22/15

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Q 221	Continued From page 8 Department of Healthcare Licensure and Certification" The name of the SA was incorrect. (b) Documentation also listed contact information for the Office of the Medicare Beneficiary Ombudsman which included the website http://www.medicare.gov/Ombudsman/resources.asp. The website information for the CMS Ombudsman was incorrect.	Q 221		
Q 231	416.50(f)(1) PRIVACY The patient has the right to - (1) Personal privacy This STANDARD is not met as evidenced by: - Based on observation and interview, it was determined that the ASC failed to provide privacy for patients in pre-op and post-op areas, as required by rule. Findings include: (1) On 05/20/15 at 9:10 AM two patients (#22 & #23) occupied adjoining pre-op bays with the curtain between each bay pulled only 1/3 of the length of the gurney. Observation revealed that the doctor and the CRNA came in to discuss the upcoming procedure with Patient #22. Patient #23 was crying in the next bay over. At 9:15 AM the pre-op medical assistant (MA 1) stated during an interview that the curtains were not extended completely around the gurneys so that staff could view each patient. Observation	Q 231		5/23/15

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Q 231	Continued From page 9 revealed that it was possible to view each patient if the curtains were extended the full length between the gurneys. By not extending the curtain the entire length of the gurneys, the ASC failed to provide privacy for these two patients. (2) On 05/20/15 at 11:00 AM the same two patients (#22 & #23) were in adjoining post-op (PAR) bays. These bays face out into the semi-restricted hallway. The curtains were fully extended between the gurneys, but open to view from the hall. Patient #22 was discussing birth control methods with RN 2, while Patient #23 was recovering from anesthesia and was observed to be crying. By not pulling the curtains the entire length of the beds, and blocking view from the hallway, the ASC failed to provide privacy for these two patients.	Q 231		
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview and professional guidelines, it was determined that the ASC failed to ensure that a sanitary environment was maintained per professional standards of practice in the following areas:	Q 241		5/23/15

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Q 241	Continued From page 10 (1) Injection practices, (2) Hand hygiene, and (3) Pre-clean of sterilized instruments. Findings include: (1) Injection practices: Observation of Patient #22 from admission through discharge on 05/20/15 from 7:15 AM to 11:30 AM, revealed the following: (a) At 9:15 AM, CRNA 1 placed a peripheral IV catheter into Patient #22's left arm. He/she attached the IV tubing from a previously prepared Lactated Ringers 1 liter bag to the peripheral IV and started the infusion into the patient #22. He/she then inserted a pre-drawn medication syringe into a port of the IV tubing without using an antiseptic swab to clean the port, as recommended by professional standards of practice. The online APIC position paper on "Safe injection, infusion, and medication vial practices in health care" released in April 2010 highly recommends to "Disinfect IV ports and vial stoppers by wiping and using friction with a sterile 70 isopropyl alcohol, ethyl/ethanol alcohol, iodophor, or other approved anti-septic swab. Allow the port to dry before accessing." This standard of practice, should have been performed even when the IV tubing was new out of the package, or the medication vial was newly opened. (b) At 9:25 AM,Patient #22 was moved into OR #2. Observation revealed CRNA 1 draw up medication into a syringe and again insert the medication into the port of the IV tubing without using an antiseptic swab to clean the port, as	Q 241		

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Q 241	Continued From page 11 described by professional standards of practice. (c) At 11:30 AM, observation of the anesthesia cart in OR #2 revealed a multi-dose vial of Lidocaine (local anesthetic) was found to have a multiple-access port (also know as a medication vial adapter) inserted into the rubber septum. This was a break in sterile procedure, as described by professional standards of practice. CDC website "Injection Safety > Information for Providers > FAQs regarding Safe Practices for Medical Injections" on 07/02/15 revealed: " (Question) Is it acceptable to leave a needle or other device inserted in the septum of a medication vial for multiple medication draws? (Answer) No. A needle or other device should never be left inserted into a medication vial septum for multiple uses. This provides a direct route for microorganisms to enter the vial and contaminate the fluid." (2) Inadequate hand hygiene:Observation of Patient #22 from admission through discharge on 05/20/15 from 7:15 AM to 11:30 AM, revealed the following: CRNA 1 was observed in pre-op and assessing Patient #22. He/she checked the patient's vital signs, asked questions, and documented in the patient's chart. He/she put on gloves to insert the peripheral IV catheter. Once he/she completed inserting the IV and medication administration, he/she took off the gloves, discarded them into the trash, and left the room. Observation failed to reflect that CRNA 1 performed adequate hand hygiene at any time during his/her care of Patient #22. This failure resulted in 4 breaks in the recommended protocol for hand hygiene;	Q 241		

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Q 241	Continued From page 12 specifically 1) coming into room; 2) working with patient and equipment; 3) putting on gloves, or ; 4) taking off gloves. The online CDC/HICPAC "Guideline for Hand Hygiene in Health-Care Settings" released on 10/25/02 and reviewed on 07/02/15 recommends the following: "B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items. Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items C. Decontaminate hands before having direct contact with patients E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient J. Decontaminate hands after removing gloves" (3) On 05/21/15 at 2:00 PM, the ST 1 described how pre-cleaning was done for instruments prior to sterilization. When asked how the enzymatic detergent was measured out, along with the water for dilution, the Scrub Tech stated that he/she pumped the bottle an exact number of times, but that the water was filled in the sink to an unmeasured amount. The Medline Instrument Care and Handling	Q 241		

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Q 241	Continued From page 13 brochure found on the Medline company website on 07/02/15 included the directions for use of the "Medline Single or Dual Enzymatic Detergent." The directions for pre-soaking or manual washing of "delicate instruments and scopes" revealed the technician should mix "1oz. of detergent to 1 gallon of water." If the water was not measured, it was not possible to verify whether the concentration of the detergent was correct and failed to follow the manufacturers direction. The ASC failed to ensure that the pre-clean solution was mixed according to manufacturers directions and standards of practice.	Q 241		

Annabelle D. Henry, JD, MBA
Manager, Health Facility Licensing & Certification Program
Health Care Regulation and Quality Improvement Program
800 NE Oregon Street, Suite 305
Portland, OR 97232

10-12-15A10:23 RCVD

Joy Staples, Administrator
Lovejoy Surgicenter
933 NW 25th Ave.
Portland, OR 97210

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

ALLEGATION OF COMPLIANCE – LIFE SAFETY CODE
October 2, 2015

Dear Ms. Henry,

This letter is to serve as an Allegation of Compliance to correct the Condition-level deficiencies within the 30-day timeline – September 28, 2015 to October 28, 2015 – as stated in your cover letter. This Allegation of Compliance will list the deficiencies and reflect the facility's corrections as well.

<u>The facility failed to ensure the sprinkler system was continuously maintained & in reliable condition</u>.

The current maintenance director will begin immediate technical competency training for inspecting the building fire protection sprinkler system thru the online courses available at NFPA.org to correct this deficiency. This training will be required during orientation of all new personnel who obtain the maintenance director position to prevent reoccurrence of this deficiency. The maintenance director will review the technical training materials annually to ensure competency.
The maintenance director will conduct weekly and monthly checks of the sprinkler system to ensure proper operation and reduce risk of injury to building occupants.
A record will be kept on file in the "Fire and Life Safety" binder to ensure compliancy of this deficiency. A copy of the record will be submitted to the administrator each month and reviewed quarterly during the QA meetings to ensure compliancy.
The last annual test/inspection of the building fire protection sprinkler system was on 5/4/15, but was not available upon request during the site survey. The sprinkler system has been inspected annually on a continuing basis thru Delta Fire, Inc. All reports of the annual inspection will be kept on file in the "Fire and Life Safety" binder for availability upon request.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 28, 2015.

The facility failed to maintain emergency preparedness plan current & readily available to all staff, affecting the entire building:

The emergency preparedness plan will be reviewed and updated immediately to correct this deficiency. The emergency preparedness plan will be available to all personnel on each floor of the building – basement, 1st and 2nd floor.
The emergency preparedness plan will be reviewed and updated annually during the 2nd quarter QA meeting – July of each year. Contact information and changes in assignments will be updated during the quarterly staff meetings to ensure compliancy or more frequently, as needed.
The emergency preparedness plan will be included in the orientation checklist for new personnel to authenticate after reviewing the plan.
Shaarie Torah will be contacted annually – October of each year prior to the annual in-service – to ensure no changes have been made to the short-term evacuation agreement.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 20, 2015.

The facility failed to provide fired drills for all staff affecting the entire building:

An unexpected fire drill will be conducted quarterly as required by regulation to correct this deficiency. Fire drills will be critiqued to ensure the effectiveness of the plan and all personnel are prepared to handle a fire emergency. A record of deficiencies (if any) during a fire drill will be kept on file in the "Fire and Life Safety" binder and solutions will be implemented during the fire drill.
Fire drills will be conducted quarterly during the following months to ensure compliancy – January, April, July & October of each year. All personnel will sign an attendance sheet to ensure training protocols have been met and all personnel are prepared to handle a fire emergency.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 20, 2015.

The facility failed to install fire alarm system in accordance with NFPA 72 "private mode" systems.

Technical competence training will begin immediately for the maintenance director to complete before 10/28/15 thru online courses available at NFPA.org to correct this deficiency. This training will be required during orientation of all new personnel who obtain the maintenance director position to prevent reoccurrence of this deficiency. The maintenance director will review the technical training materials annually to ensure competency.
The maintenance director will conduct monthly checks and maintain a monthly record of the building fire alarm system to ensure proper operation of the fire alarm system and reduce risk of injury to building occupants.

A monthly record will be kept on file in the "Fire and Life Safety" binder. A copy of the monthly record will be submitted to the administrator each month and reviewed for quality assurance.
Sensitivity testing of the fire alarm system will be tested in October and then every 2 years as required by the NFPA. A record of this testing will be kept on file in the "Fire and Life Safety" binder.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 28, 2015.

The facility failed to ensure that no curtains of highly flammable character were used in the facility.

The privacy curtains located in the recovery room will be replaced with flame retardant fabric to correct this deficiency. These curtains were purchased over 18 years ago and documentation has not been located to provide evidence that the curtains in the recovery room are flame retardant.
A certificate from the manufacturer providing evidence of flame retardant curtains will be kept on file in the "Fire and Life Safety" binder at the front desk for availability upon request during future inspections and to prevent reoccurrence of this deficiency.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 28, 2015. (Please note, these curtains will need to be customized to be suitable for our recovery room needs and may take 4-6 weeks for the curtains to be made and installed in our facility – the process will be expedited, if possible).

The facility failed to ensure that piped in medical gas systems comply with NFPA 99.

An annual inspection/test of the facility's piped medical gas system will be conducted to correct this deficiency. A maintenance contract will be implemented with Multnomah Medical Gas Services to ensure the piped medical gas system is inspected and tested annually – October of each year.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 12, 2015.

The facility failed to maintain the emergency lighting in a manner that would ensure reliability in the event of loss of power in accordance with NFPA 111.

The emergency lighting will be maintained by conducting annual 90-minute testing of the battery back up to correct this deficiency.
A record to indicate an annual 90-minute testing of the battery back up for the emergency lighting was completed will be kept on file in the "Fire and Life Safety" binder for availability upon request.
The maintenance director will submit a copy of this record to the administrator in October and then annually to ensure compliancy.

The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 28, 2015.

The facility failed to maintain the emergency generator in a manner that would ensure reliability in the event of loss of power in accordance with NFPA 110.

Technical competence training for the emergency generator will begin immediately for the maintenance director to complete before 10/28/15 thru the online courses at NFPA.org to correct this deficiency. This training will be required during orientation of all new personnel who obtain the maintenance director position to prevent reoccurrence of this deficiency. The maintenance director will review the technical training materials annually to ensure competency.
The maintenance director will document monthly tests for the emergency generator. A monthly record for the emergency generator will be kept on file and a copy will be submitted to the administrator each month and reviewed for quality assurance.
A test of the emergency generator has been scheduled and will be conducted annually. A maintenance contract will be implemented with EC Power Systems to ensure the emergency generator is inspected and tested annually – October of each year.
The maintenance director and administrator will be responsible for ensuring this plan is implemented for this deficiency.
The completion date for correction of this deficiency will be on October 12, 2015.

Lovejoy Surgicenter is committed to providing the highest quality of care to our patients and appreciates the information to allow us to do so. Please review the Plan of Correction for a more detailed report of correcting these deficiencies.

Sincerely,

Joy Staples, Administrator
Lovejoy Surgicenter
503-221-1870

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K 000	INITIAL COMMENTS This report documents the findings of the recertification Life Safety Code survey conducted August 19, 2015. The facility was found to need significant correction to be in substantial compliance with 42 CFR Part 416 (NFPA 101, 2000 Edition) requirements for Ambulatory Health Care Facilities. Conditions were found that created a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient, which constitutes a conditional level. Refer to the Amended CMS 2567 Report generated by the health survey team that reflects the Condition-Level deficiency at Tag Q-100, and the 09/28/2015 cover letter that describes the timeframe's and the processes necessary to implement an acceptable plan of correction and return to compliance.	K 000		
K 012	416.44(b)(1) LIFE SAFETY CODE STANDARD Buildings two or more stories in height and of Type II(000), III (200), or V (000) construction are equipped throughout with a supervised approved automatic sprinkler system in accordance with section 9.7. 20.1.6.3, 21.1.6.3 This STANDARD is not met as evidenced by: Based on observations, record review and interview during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to ensure the sprinkler system was continuously maintained &	K 012	ORIGINAL	

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

JOY STAPLES — Administrator — 10.2.15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1 in reliable operating condition. This resulted in the potential for system failure during fire emergencies (LSC 4.6.12.1, NFPA 13 3-2.91, .2, .3, NFPA 25 9.6.2.1, .2 & 8.17.4.6). Findings include, but are not limited to: 1. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there were no weekly or monthly checks being conducted on the building fire protection sprinkler system. 2. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no current annual test/inspection of the building fire protection sprinkler system. The last documented test was dated 02, 2014. 3. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no documentation that the new building maintenance director has been provided training for technical competence for inspecting the building fire protection sprinkler system. 4. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the building maintenance director did not have access to the proper standard (NFPA 25) for testing/maintaining the building fire protection sprinkler system.	K 012		
K 048	416.44(b)(1) LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1	K 048		

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K 048	Continued From page 2 This STANDARD is not met as evidenced by: Based on interviews and record review during the survey, it was determined through on-going dialog with the Maintenance Director and Administrator, that the facility failed to maintain emergency preparedness plan current & readily available to all staff, affecting the entire building. This resulted in the potential for limited staff effectiveness during emergency conditions (LSC 20/21.7.1.1). Findings include, but are not limited to: 1. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the plan has not been kept current. The maintenance director started 01/22/2015. The plan provided for review still lists the previous maintenance director for contact. 2. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the plan provided for review does not include a local hazard assessment for the City of Portland. 3. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., and dialogue with the Facility Administrator the emergency preparedness plan provided for review does not have an agreement for a short term evacuation site in the event that the facility needs to be evacuated during an emergency.	K 048		
K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at 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.	K 050		

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K 050	Continued From page 3 20.7.1.2, 21.7.1.2 This STANDARD is not met as evidenced by: Based on observations, interviews and record review during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to provide fire drills for all staff affecting the entire building. This resulted in the potential for inadequate staff knowledge during fire emergencies, potentially exposing patients to smoke and fire in the facility (LSC 20/21.7.1.2, A. 20/21.7.1.2). Findings include, but are not limited to: 1. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the drill records provided for review indicated that the last fire drill conducted in the facility was 12/19/2014. 2. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the fire drill documentation indicated that drills are only required 2 times per year. Drills are required quarterly.	K 050		
K 051	416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1, 21.3.4.1 This STANDARD is not met as evidenced by:	K 051		

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	38C0001000	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/19/2015

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LOVEJOY SURGICENTER, INC	933 NW 25TH AVENUE PORTLAND, OR 97210

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K 051	Continued From page 4 Based on record review and interview during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to install fire alarm system in accordance with NFPA 72 " private mode " systems. This resulted in the potential for system and device failure during fire emergencies (LSC 20/21.3.4, 9.6). Findings include, but are not limited to: 1. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., records reviewed indicated that monthly checks of the building fire alarm system are not being completed. 2. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no documentation that the new building maintenance director has been provided training for technical competence for inspecting the building fire alarm system. 3. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the building maintenance director did not have access to the proper standard (NFPA 72) for testing/maintaining the building fire alarm system. 4. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no documentation of sensitivity testing being conducted on the building fire alarm system.	K 051		
K 074	416.44(b)(1) LIFE SAFETY CODE STANDARD Combustible decorations are flame retardant. 20.7.5.4, 21.7.5.4	K 074		

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K 074	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and interview during the survey, it was determined through on-going dialog with the Administrator that the facility failed to ensure that no curtains of highly flammable character were used in the facility. This resulted in the potential for excessive fire spread (LSC 21.7.5.1). Findings include, but are not limited to: 1. On 08/19/2015, at 11:34 a.m., privacy curtains in the recovery area lack a tag indicating fire restiveness. The administrator and maintenance director were not aware of any files currently that would contain documentation regarding the material of the curtains.	K 074		
K 077	416.44(b)(1) LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99. This STANDARD is not met as evidenced by: Based on observations, record review and interview during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to ensure that piped in medical gas systems comply with NFPA 99. This resulted in the potential for injury to patients during medical procedures. Findings include but are not limited to: 1. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no documentation provided for an annual	K 077		

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K 077	Continued From page 6 inspection/test of the buildings piped medical gas system.	K 077		
K 105	416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an emergency power system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2 This STANDARD is not met as evidenced by: Based on record review and interview during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to maintain the emergency lighting in a manner that would ensure reliability in the event of loss of power in accordance with NFPA 111. This resulted in the potential for injury to patients and staff during medical procedures in the event of loss of utility power to the building. Findings include, but are not limited to: 1. On 08/19/2015 during record review between 8:00 a.m. and 8:45 a.m., there were no records indicating annual 90 minute testing of battery backed up emergency lighting in the facility.	K 105		
K 106	416.44(b)(1) LIFE SAFETY CODE STANDARD The ASC with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99. 3.4.2.2, 3.4.2.1.4 Required emergency generator is tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Supplies.	K 106		

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	38C0001000	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2015**

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K 106	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview during the survey, it was determined through on-going dialog with the Maintenance Director that the facility failed to maintain the emergency generator in a manner that would ensure reliability in the event of loss of power in accordance with NFPA 110. This resulted in the potential for injury to patients and staff during medical procedures in the event of loss of utility power to the building. Findings include, but are not limited to: 1. On 08/19/2015 during record review between 8:00 a.m. and 8:45 a.m., monthly test documentation is not being completed for the emergency generator. 2. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the last annual testing of the emergency generator was 09/23/2013. There are no records that the new generator has been load tested. 3. On 08/19/2015 at 11:15 a.m., the alphanumeric read out on the generator indicated that the unit is past due for service. 4. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., there was no documentation that the new building maintenance director has been provided training for technical competence for inspecting/testing the building emergency generator.	K 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 106	Continued From page 8 5. On 08/19/2015, during record review between 10:15 a.m. and 11:00 a.m., the building maintenance director did not have access to the proper standard (NFPA 110) for testing/maintaining the building emergency generator.	K 106		

Oregon Health Authority

Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 305
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

July 31, 2015

Ms. Joy Staples,
Lovejoy Surgicenter, Inc
933 Nw 25th Avenue
Portland, OR 97210

Dear Ms. Staples:

This letter provides notification that your plan of correction for the Medicare recertification survey and the State relicensing survey, completed on May 22, 2015, has been received, reviewed and accepted by Health Care Regulation and Quality Improvement. A surveyor may contact you by phone or mail regarding any follow-up that may be necessary to assess your implementation of the plan of correction.

Thank you for your cooperation.

Sincerely,

Megan L Gobble RN

Megan Gobble, Registered Nurse
Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0372.