

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151304	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2012
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NAME OF PROVIDER OR SUPPLIER RUSH MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 N MAIN ST RUSHVILLE, IN 46173
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K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).</p> <p>Survey Date: 07/23/12 and 07/25/12</p> <p>Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>The facility was constructed at three different times. The original building built in 1949 is a three</p>	K0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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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	<p>story, non sprinklered building with a basement with a renovation to the first floor, second floor and small basement addition in 1972 of Type I (332) construction and non sprinklered. In 1996, a two story addition to the north of the original building was constructed and is a two story, sprinklered addition with a basement of Type I (332) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building. Both buildings have a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detection in all patient sleeping rooms. The facility has a capacity of 25 and had a census of 9 at the time of this survey.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/31/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 basement smoke barrier walls above the smoke barrier doors was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects any patients using the cafeteria located near the new addition.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 07/25/12 at 12:20 p.m., the basement corridor smoke barrier above the set of smoke barrier doors where the 1997 addition was constructed onto the 1949 original building did not have drywall along the entire length of the smoke barrier wall two feet above the smoke barrier doors to the concrete deck above. This was verified by the maintenance supervisor at</p>	K0025	<p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. We are currently in the process of researching and purchasing fire rated materials to meet or exceed a one half hour fire resistance rating. Once the materials are purchased, they will be properly installed as quick as possible. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? During the month of October 2012 the Director of Facilities, along with the maintenance staff, will evaluate all existing smoke barriers and correct any deficiencies. Routine checks on randomly selected smoke barriers will be performed to assure all barriers meet the life safety codes. Additionally, any new construction requiring a smoke barrier will be constructed to satisfy all life safety</p>	10/25/2012	

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	the time of observation and confirmed at the exit conference on 07/25/12 at 2:50 p.m.		requirements. 3. <i>Who is going to be responsible for numbers 1 and 2 above?</i> The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above. 4. <i>By what date are you, the provider, going to have the finding and/or deficiency corrected?</i> The deficiency mentioned above is not anticipated to be corrected by August 25 th 2012.Plan of action:30 day period #1 (July 26 th 2012 through August 25 th 2012): Research and purchase fire rated materials 30 day period #2 (August 26 th 2012 through September 25 th 2012): Obtain materials from vendor 30 day period #3 (September 26 th 2012 through October 25 th 2012): Install fire rated materials and correct the deficiency no later than October 25 th 2012.		

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K0027	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 16 sets of smoke barrier doors in the original building would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect any patients who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 07/25/12 at 1:50 p.m., the first floor Sleep Study Hall smoke barrier doors were closed on three separate attempts and left a four inch gap in the closed position. This was verified</p>	K0027	<p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. On July 30 th 2012, new hardware was ordered to replace the defective hardware that was preventing the doors to adequately close. When the order is received, they will be installed as quick as possible. After installation, the doors will be tested several times to assure they are working (and seal) properly. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? The Facility and Environmental Services Director (or designate) will perform periodic door inspections to ensure that all doors close and seal properly. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above. 4. By what date are you,</p>	08/25/2012			

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	by the maintenance supervisor at the time of observation and confirmed at the exit conference on 07/25/12 at 2:50 p.m.		<i>the provider, going to have the finding and/or deficiency corrected? The deficiency will be corrected by August 25 th 2012.</i>		

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K0029	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 4 of 12 basement non sprinklered hazardous areas, such as combustibile storage rooms over 50 square feet in size and laboratory rooms, were provided with doors with a fire resistance rating of 45 minutes or a self closing device. This deficient practice could affect any patient using the basement laboratory services area.</p> <p>Findings include:</p> <p>Based on observations on 07/23/12 during a tour of the facility from 10:00 a.m. to 3:30 p.m. and 07/25/12 during a tour of the facility from 10:30 a.m. to 3:00 p.m., the following non sprinklered hazardous area rooms were not provided with forty five minute fire rated doors; the center laboratory room and the basement west</p>	K0029	<p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Two of the four fire doors have been replaced with new 90 minute rated fire doors. This was done on July 30 th 2012. They were also equipped with self closing hardware. The remaining two (The lab Hallway door and the storage closet door next to the boiler room) are on order and will take four weeks to be delivered. They were ordered on July 30 th 2012. Once the remaining two doors arrive, they will be installed as quick as possible. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? During the month of September 2012 the Director of Facilities and Environmental Services will evaluate all doors requiring a fire rating. If one is found to be without a rating (or an inadequate</p>	09/25/2012			

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	laboratory room leading to the basement Laboratory Hall each lacked a door with a fire resistance label, the basement storage room by the boiler room which measured ninety six square feet and stored combustible paper and cardboard boxes lacked a door with a fire resistance label, the basement housekeeping storage room which measured two hundred sixty square feet and stored sixteen wooden shelves of combustible paper, plastic and cardboard boxes was equipped with a ninety minute fire rated door and lacked a self closing device. The four basement doors lacking a fire resistance label and a self closing device were verified by the maintenance supervisor at the time of observation and confirmed at the exit conference on 07/25/12 at 2:50 p.m.		rating), the door will be replaced with one that is. On a routine basis, an inspection will be done by the Facility and Environmental Services Director (or designate) to assure that all doors requiring a fire rating are identifiable as to their ratings (and in compliance with life safety regulations). 3. <i>Who is going to be responsible for numbers 1 and 2 above?</i> The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above. 4. <i>By what date are you, the provider, going to have the finding and/or deficiency corrected?</i> This deficiency will not be corrected by August 25 th 2012. Plan of action:30 day period #1 (July 25 th 2012 through August 25 th 2012): Doors are place on order 30 day period #2 (August 26 th 2012 through September 25 th 2012): Install doors and correct the deficiency no later than September 25 th 2012.		

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K0033	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 16 stairway exits were provided with doors having a fire resistance rating of at least one hour to protect 9 of 9 patients. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1(a) says the separation shall have not less than a 1 hour fire resistance rating where the exit connects three stories or less. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/23/12 during a tour of the facility from 10:00 a.m. to 3:45 p.m. and 07/25/12 during a tour of the facility from 10:25 a.m. to 3:00 p.m. with the maintenance supervisor, the following stairway exit doors lacked a fire resistance rating label; the basement stairway exit door in the Service Hall by the maintenance office, the basement stairway exit door by the kitchen back door, the second floor stairway exit door by the Outpatient Surgery Hall, and the</p>	K0033	<p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. This was corrected on August 9 th 2012. The doors were sent to Premium Supply, Inc. (an architectural door service) where they were evaluated and tagged with a fire rating of 90 minutes. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? During periodic facility checks, all doors requiring a fire rating will be checked. Any newly installed doors (requiring a rating) will be verified to adequately have the correct fire rating before being installed. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? The deficiency has been corrected on August 9 th 2012.</p>	08/09/2012	

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	third floor stairway exit door by the medical staff coordinator office. The four doors were observed by the maintenance supervisor at the time of observations along the sides and top of each door and each door lacked a fire resistance label, which was confirmed at the exit conference on 07/25/12 at 2:50 p.m.			

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K0048	<p>NFPA 101 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. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the transmission of the alarm to the fire department and the use of the kitchen portable fire extinguisher in the written plan for the protection of 9 of 9 patients in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects all patients in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan labeled Rush Hospital Fire or Threat of Fire Plan on 07/23/12 at 10:30 a.m. with the administrator, the Rush Hospital Fire or Threat of Fire Plan did not address the transmission of the</p>	K0048	<ol style="list-style-type: none"> 1. <i>How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</i> The Director of Facilities and Environmental Services will work in collaboration with the Lead Quality and Safety Programs Liaison to update the "Fire or Threat of Fire" emergency plan. This update will correct all deficiencies mentioned. 2. <i>How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?</i> All emergency plans will be reviewed periodically for any updates or changes that may be needed. 3. <i>Who is going to be responsible for numbers 1 and 2 above?</i> The Facility and Environmental Services Director and the Lead Quality and Safety Programs Liaison will be responsible for numbers 1 and 2 above. 4. <i>By what date are you, the provider, going to have the finding and/or deficiency corrected?</i> The deficiency will be corrected no later than August 25 th 2012. 	08/25/2012	

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	alarm to the fire department, and the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. This was acknowledged by the maintenance supervisor on 07/25/12 at the 2:50 p.m. exit conference.			

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K0052	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 74 smoke detector were not installed where air flow would adversely affect its operation. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect any patient in the Sleep Study Hall, which is also located near the information technology suite of rooms.</p> <p>Findings include:</p> <p>Based on an observations with the maintenance supervisor on 07/25/12 during a tour of the first floor from 11:10 a.m. to 12:20 p.m., the Sleep Study Hall smoke detector near the smoke barrier set of doors was located six inches from a return air duct and the information</p>	K0052	<p>1. <i>How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</i> The two smoke detectors in question were evaluated and will need to be rewired to satisfy life safety requirements. A contractor has been scheduled to correct the deficiency.</p> <p>2. <i>How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?</i> During routine facility inspections, the Director of Facilities and Environmental Services will check to make sure all existing smoke detectors are more than three feet from air flow sources.</p> <p>3. <i>Who is going to be responsible for numbers 1 and 2 above?</i> The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above.</p> <p>4. <i>By what date are you, the provider, going to have the finding</i></p>	08/25/2012			

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	<p>technology computer room smoke detector was located two feet from a supply air duct. This was verified by the maintenance supervisor at the time of observations and confirmed at the exit conference on 07/25/12 at 2:50 p.m.</p>		<p><i>and/or deficiency corrected?</i> The deficiency will be corrected no later than August 25 th 2012.</p>				

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(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			
K0067	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 basement egress corridors was not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect any patient using the basement cafeteria, located in the corridor near the food storage room, the food supervisor room, the nutrition room, and the dietary office room.</p> <p>Findings include:</p> <p>Based on observations on 07/23/12 during a tour of the basement from 12:20 p.m. to 3:45 p.m. with the maintenance supervisor, the basement egress corridor by the south kitchen exit was being used as a return air system for the food storage room, the food supervisor room, the nutrition room and the dietary office.</p>	K0067	<p>1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction. At this time, air handling equipment is in the process of being purchased and will be installed to correct this deficiency. 2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future? Periodic inspections will be conducted throughout the facility to verify that every room complies to life safety regulations. Any rooms found to have such deficiencies will be corrected immediately. Also, all new building construction will be planned accordingly to have such air systems put in place. 3. Who is going to be responsible for numbers 1 and 2 above? The Facility and Environmental Services Director will be responsible for numbers 1 and 2 above. 4. By what date are you, the provider, going to have the finding and/or deficiency corrected? This deficiency cannot be completed by August 25 th 2012. Plan of action:30 day period #1 (July 26 th 2012 through August 25 th 2012): Order ventilation materials 30 day</p>	09/25/2012			

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	This was verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 07/25/12 at 2:50 p.m.		period #2 (August 26 th 2012 through September 25 th 2012): Install materials and correct the deficiency no later than September 25 th 2012.	