STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 01 B. WING	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSH MEMORIAL HOSPITAL	1300 N MAIN ST RUSHVILLE, IN 46173

(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
K 000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d). Survey Date: 01/26/15 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A Surveyors Mark Bugni, Life Safety Code Specialist, Mark Caraher, Life Safety Code Specialist 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. The facility was constructed at three different times. The original building built in 1949 is a three story, non sprinkled building with a basement with a renovation to the first floor, second	K 000		

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 determined that other safegaurds 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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	floor and small basement addition in 1972 of Type I (332) construction and non sprinkled except the elevator shaft and dumb waiter shaft enclosures. In 1996, a two story addition to the north of the original building was constructed and is a two story, sprinkled 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 3 at the time of this survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/05/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K 017 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered			

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	buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 basement room in the 1972 nonsprinklered basement addition was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet an Exception. LSC 19.3.6.1 Exception No. 6: Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be permitted to be open to the corridor and unlimited in area, provided that the following criteria are met: (a) The space and the corridors onto which it opens, where located in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4; and (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arranged that a	K 017	**Tag # K-0017** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **A certified contractor will install a new smoke detector in the aforementioned room. The new smoke detector will be tested and put into service by the installer.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to assure all rooms requiring smoke detectors have one.** *3. Who is going to be responsible for numbers 1 and 2 above?*	03/11/2015

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	fully developed fire is unlikely to occur; and (c) The area does not obstruct access to required exits. This deficient practice could affect any number of patients using the basement cafeteria as well as staff or visitors in the vicinity of this area. Findings include: Based on observation with the maintenance supervisor on 01/26/15 at 10:50 a.m., the basement jail cooler room was open to the corridor and the corridor was protected by an electrically supervised automatic detection system but the individual space was not. Furthermore, the open room was used to store two metal refrigerators and had no other storage. Based on interview at the time of observation, the maintenance supervisor acknowledged the jail cooler room was not protected by automatic smoke detectors. This was acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.		**The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiency mentioned above is will be corrected by March 11th 2015.** Plan of action: **30 day period (February 11th 2015 through March 11th 2015): A certified contractor will install a new smoke detector and test it to assure it is functional.**	
K 018 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed			

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	of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of over 20 corridor doors on the second floor would resist the passage of smoke and close and latch into the door frame. This deficient practice could affects eight patients, staff and visitors on the second floor. Findings includes: Based on observations with the maintenance technician during a tour of the second floor from 11:40 a.m. to 1:10 p.m. on 01/26/15, one 1/4 inch in diameter hole was noted by the door handle in the corridor door to the second floor Doctor's Dictation area and four 1/4 inch in diameter holes were noted by the door handle in the corridor door to Room 208 which would each fail to resist the passage of smoke. This was verified by the maintenance technician at the time of observations acknowledged by the director of maintenance at the exit	K 018	**Tag # K-0018** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **The holes in the doors were filled on January 26th 2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to include the inspection of all doors to assure there are no holes that would allow passage of smoke. If a deficiency is found it will be corrected immediately.** *3. Who is going to be responsible for numbers 1 and 2 above?*	01/26/2015

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	conference on 01/26/15 at 3:00 p.m.		**The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiency mentioned above was corrected on January 26th2015.** Plan of action: **Deficiencies were corrected.**	
K 025 Bldg. 01	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 Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 basement ceiling and 2 of 12 smoke barrier walls above the smoke barrier doors were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the	K 025	**Tag # K-0025** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Firestop materials were purchased from Hilti Firestop and the listed smoke barrier penetrations were corrected. The**	02/11/2015

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	penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any number of patients using the basement cafeteria as well as staff or visitors in the vicinity of this area and twenty patients who use the first floor therapy area. Findings include: Based on observations with the maintenance supervisor and maintenance technician during a tour of the basement and first floor on 01/26/15 from 10:30 a.m. to 2:45 p.m., the following locations had ceiling and attic smoke barrier penetrations not firestopped or missing drywall; 1. The basement maintenance workshop ceiling had three electrical conduit penetrations with and one cable bundle penetration with one half inch to three inch gaps not fire stopped. 2. The basement jail cooler room ceiling had a one and one half foot by six inch rectangular area of drywall missing around the furnace plenum. 3. The basement sprinkler riser room ceiling had a six inch by two inch rectangular area of drywall missing.		**deficiencies were corrected on February 11th 2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection. During this inspection, the facility will be checked for any additional smoke barrier penetrations. If any are found, they will be corrected.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiencies were corrected on February 11th 2015.** Plan of action: **All of the observed deficiencies were corrected.**	

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

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	4. The basement cafeteria ceiling had a two inch gap around a soda pop ceiling penetration not fire stopped. 5. The basement emergency generator pump room ceiling had three electrical conduit penetrations with two inch gaps not fire stopped. 6. The basement kitchen smoke barrier wall above the set of smoke barrier doors had a two inch gap around an electrical conduit penetration not fire stopped. 7. The first floor smoke barrier above the therapy room smoke barrier door had six, one inch to two inch gaps around electrical conduit penetrations not fire stopped and a three inch diameter circular area of drywall missing. The above listed basement and first floor ceiling penetrations not fire stopped and missing drywall was verified by the maintenance supervisor and maintenance technician at the time of observations and acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.			
K 029 Bldg. 01	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			

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	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 1. Based on observation and interview, the facility failed to ensure 3 of 7 hazardous areas such as a soiled linen room, trash collection room, and kitchen, were separated from other areas by self closing doors or provided with latching hardware. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 8 patients, staff and visitors on the second floor and any number of patients using the basement cafeteria as well as staff or visitors in the vicinity of this area. Findings include: Based on observations with the maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, the corridor door to the second floor Biohazard Room by Outpatient Surgery and the corridor door to the soiled utility room by the Drug Room on the second floor were each not equipped with a self closing device. Furthermore, based on observation at 10:30 a.m. on 01/26/15 with the maintenance supervisor, the maintenance corridor kitchen set of doors lacked	K 029	**Tag # K-0029** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Findings #1 – To resolve the listed deficiencies, the maintenance department ordered self closing door hardware for the second floor biohazard room door and the second floor soiled utility room. Additionally, the maintenance department ordered latching hardware and additional hardware to correct the deficiencies with the kitchen door. All of the hardware was ordered on February 15th 2015. When the hardware arrives, the maintenance department will immediately proceed to installing the hardware to correct the problems.** **Findings #2 – The maintenance department ordered (and received) Hilti firestop material and resolved all four findings mentioned under findings "2". These were corrected on February 16th 2015.** *2. How are you, the provider,*	03/11/2015

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	latching hardware and had a one inch gap from the bottom to the center of the doors in the closed position. This was verified by the maintenance supervisor and maintenance technician at the time of observations and acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 3 of 5 hazardous areas such as a soiled linen room, trash collection room, and kitchen, were separated from other areas by one hour rated construction. This deficient practice could affect 8 patients, staff and visitors on the first floor and any number of patients using the basement cafeteria as well as staff or visitors in the vicinity of this area. Findings include: Based on observations with the maintenance technician and maintenance supervisor during a tour of the facility from 10:20 a.m. to 3:00 p.m. on 01/26/15, the following basement and first floor hazardous areas had either missing drywall or ceiling penetrations not fire stopped; 1. The basement kitchen ceiling had three, one inch circular areas of drywall missing near the oven hood.		*going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to inspect for deficiencies like the types listed in findings 1 & 2. If such deficiencies are found, they will be corrected immediately.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **Findings #1 – Deficiencies listed under findings #1 will be completed by March 11th 2015.** **Findings #2 - These deficiencies were corrected on February 16th 2015.** Plan of action: **Findings #1** **30 day period (February 11th 2015 through March 11th 2015): Door hardware was ordered. Once received, the hardware will be**	

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	2. The basement little boiler room ceiling had eight metal beam penetrations with two inch gaps not fire stopped. 3. The first floor trash room had a one inch annular space surrounding a four inch in diameter pipe which penetrated the ceiling. 4. The first floor soiled linen chute room had a one inch circular gap around a four inch water pipe not fire stopped. This was verified by the maintenance supervisor and maintenance technician at the time of observations and acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.		**installed on the doors.** **Findings #2 - All of the observed deficiencies were corrected.**	
K 038 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 4 second floor exits were readily accessible for patients without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without	K 038	**Tag # K-0038** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Findings #1 – To resolve this deficiency, an access code was posted on the stairwell exit door facing the corridor. This was resolved on February 11th 2015.**	04/11/2015

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	delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 8 patients, staff and visitors. Findings include: Based on observation with the maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, the second floor stairwell exit by Room 218 was marked as a facility exit to the public way, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the maintenance technician stated not all patients on the second floor have a clinical diagnosis requiring specialized security measures and acknowledged the four digit code was not posted at the second floor stairwell exit by Room 218. 2. Based on observation and interview, the facility failed to provide 15 of over 50 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening		**Findings #2 – The door hardware (for the 15 doors mentioned with deficiencies) was ordered on February 13th 2015. When the hardware is received, the maintenance staff will correct all 15 deficiencies by installing the correct hardware.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to include inspecting the facility for deficiencies like the types listed in findings 1 & 2. If such deficiencies are found, they will be corrected immediately.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **Findings #1 – This deficiency was corrected on February 11th2015.** **Findings #2 – Door hardware has been ordered and the deficiencies**	

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	device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 2 patients, staff and visitors. Findings include: Based on observations with the maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, each of the following corridor doors were equipped with a door handle and a separate deadbolt which could be locked from the corridor side but not unlocked from the room side of the door: a. Patient Billing and Billing Printing Room on the first floor. b. Room 202, Room 206, Biohazard Room by Outpatient Surgery and the Respiratory Therapy Office on the second floor. c. Payroll Office, Infection Prevention &		**will be corrected by April 11th 2015.** Plan of action: **Findings #1 – The deficiency was corrected.** **Findings #2** **30 day period (February 11th 2015 through March 11th2015): Door hardware is ordered.** **60 day period (March 12th 2015 through April 11th2015): Hardware will be received and installed.**	

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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
	Quality Liaison Office, Data Analyst & Clinical Information Specialist Office, Lead Quality & Safety Programs Liaison Office, Dumbwaiter Room, Accounts Payable Office, VP of Finance/CFO Office, Air Handler Room and Education Director's Office on the third floor. Based on interview at the time of the observations, the maintenance technician acknowledged the aforementioned corridor doors each required more than one releasing operation to open the door and could not be unlocked from the room side of the door if the deadbolt was locked.			
K 047 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 16 basement exit signs was continuously illuminated. This deficient practice could affect any number of patients using the basement cafeteria as well as staff or visitors in the vicinity of this area. Findings include: Based on observation with the maintenance supervisor on 01/26/15 at 11:50 a.m., the exit sign located at the	K 047	**Tag # K-0047** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **The exit sign light bulb was changed with a new bulb resolving the illumination problem. This was done on February 11th2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the*	02/11/2015

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	basement stairwell in the maintenance corridor was not illuminated. Based on interview at the time of observation, the maintenance supervisor indicated the light bulb was burned out. This was acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.		*future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to include checking all exit signs for illumination.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiency mentioned above was corrected on February 11th2015.** Plan of action: **Deficiency was corrected.**	
K 050 Bldg. 01	NFPA 101 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded			

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	announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and patients. Findings include: Based on review of Fire Drill Observation Checklists with the maintenance supervisor on 01/26/15 at 9:20 a.m., there was no fire drill documentation for the third shift, second quarter of the year 2014. Additionally, based on interview with the maintenance supervisor during the review of the Fire Drill Observation Checklists, there was no other documentation available for review to verify this drill was conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.	K 050	**Tag # K-0050** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **A reference chart has been created by the Facility Director and posted in the maintenance department signifying what shifts are required to have fire drills on what months. The maintenance staff has been trained on how to use the chart. This was done on February 3rd 2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will review the chart prior to conducting a fire drill to assure the correct shift is being drilled.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding*	02/03/2015

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			and/or deficiency corrected? **The deficiency mentioned above was corrected on February 3rd2015.** Plan of action: **The deficiency was corrected.**	
K 052 Bldg. 01	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 Based on observation and interview, the facility failed to maintain 1 of over 25 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 8 residents, staff and visitors in the vicinity of Room 216. Findings include: Based on observation with the	K 052	**Tag # K-0052** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **The smoke detector located in the corridor outside room 216 was relocated to be more than 3 feet from the air supply. This was corrected on February 15th 2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will**	02/15/2015

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	maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, the smoke detector mounted on the ceiling in the corridor outside Room 216 was located eight inches from an air supply vent. Based on interview at the time of observation, the maintenance technician acknowledged the aforementioned smoke detector was located on the ceiling less than three feet from an air supply vent.		**conduct a monthly facility inspection to assure that all smoke detectors are more than 3 feet from an air supply. If a violation is found, it will be immediately corrected.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiency mentioned above was corrected on February 15th2015.** Plan of action: **The deficiency was corrected.**	
K 074 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance			

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	with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 6 of 6 cubicle curtains in the Outpatient Surgery area were flame resistant. This deficient practice could affect six patients, staff and visitors. Findings include: Based on observations with the maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, six cubicle curtains installed in the Outpatient Surgery had no affixed documentation stating each curtain was inherently flame retardant. Based on interview at the time of the observations, the maintenance technician stated the Outpatient Surgery cubicle curtains had not been treated with a flame retardant material and acknowledged Outpatient Surgery cubicle curtain flame resistant documentation was not available for review.	K 074	**Tag # K-0074** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Documentation was obtained from the vendor (and manufacturer) indicating that the curtains are treated with a flame retardant and are inherently flame resistant. The documentation is on file in the Facility Director's office for future reference. This was done on January 30th 2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **When new cubical curtains are ordered, the Facility Director will assure that the fabric is flame retardant. During the ordering process, documentation will be required from the manufacturer of such claims.** *3. Who is going to be responsible for numbers 1 and 2*	01/30/2015

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			above? **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The deficiency mentioned above was corrected on January 30th2015.** Plan of action: **The deficiency was corrected.**	
K 078 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and are arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 19.3.2.3 Based on observation and interview, the facility failed to maintain relative humidity of equal to or greater than 35% in two of three operating rooms where general anesthesia is utilized. This deficient practice could affect two patients.	K 078	**Tag # K-0078** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Rush Memorial Hospital (RMH) has elected to accept the**	02/25/2015

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	Findings include: Based on observations with the maintenance technician and the Director of Operating Rooms during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, two of three operating rooms where general anesthesia is used and relative humidity is monitored did not maintain relative humidity of equal to or greater than 35%. At the time of the tour, Operating Room 1 was at 25.8% and Operating Room 2 was at 27.2% relative humidity. Based on interview at the time of the observations, the Director of Operating Rooms stated patients in Operating Room 1 and Operating Room 2 can be sedated using general anesthesia and acknowledged each operating room's relative humidity was not maintained equal to or greater than 35%.		**waiver offered by CMS (Centers for Medicare and Medicaid Services) to allow anesthetizing locations to operate with a RH of greater than or equal to 20%, instead of greater than or equal to 35%. This waiver will be set in writing, approved by the CEO of Rush Memorial Hospital and notarized. The approved waiver will be on file for future reference.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The maintenance department will continue to monitor the relative humidity of the operating rooms to assure the relative humidity stays between 20% and 60% RH.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **The waiver will be created and approved by the CEO. Once approved, the document will be filed for future reference.**	

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			Plan of action: **30 day period (February 11th 2015 through March 11th 2015): A document will be created indicating that Rush Memorial Hospital has elected to use the waiver. This will be completed by February 25th 2015.**	
K 144 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:	K 144	**Tag # K-0144** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **Findings #1 – The two generators with deficiencies in findings #1 will be equipped with audible annunciators that will be located in the admissions department. Each remote alarm will comply with the requirements in accordance with NFPA 99, Health Care Facilities, 3-4.1.1.15. The annunciators will be installed, tested and maintained by a**	04/11/2015

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	(a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the patients as well as visitors and staff. Findings include: Based on observation on 01/26/15 at 1:40		**certified contractor.** **Findings #2 – The generator sited in findings #2 will be equipped with a remote manual stop. The manual stop will comply with the requirement in accordance with NFPA 110, 1999 edition, 3-5.5.6. The remote manual stop will be installed, tested and maintained by a certified contractor.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to include inspecting the facility for deficiencies like the type listed in findings 1 & 2. If such deficiencies are found, they will be corrected immediately.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding and/or deficiency corrected?* **Findings #1 – Deficiencies listed under findings #1 will be completed**	

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	p.m. during a tour of the first floor with the maintenance supervisor, the first floor overnight security office was not provided with a remote alarm annunciator for the two emergency generators in a location readily observed by operating personnel at a regular work station such as a nurses' station. Based on an interview with the maintenance supervisor at the time of observation, it was indicated the facility does not have a remote alarm annunciator for the two emergency generators any where in the facility. The lack of remote alarm annunciator's for the two emergency generators was verified by maintenance supervisor at the time of observation and acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station		**by April 11th 2015.** **Findings #2 – Deficiencies listed under findings #2 will be completed by April 11th 2015.** Plan of action: **Findings #1** **30 day period (February 11th 2015 through March 11th 2015): Parts will be ordered** **60 day period (March 12th through April 11th2015): parts will be installed, tested and put into service by a certified contractor.** **Findings #2** **30 day period (February 11th 2015 through March 11th 2015): Parts will be ordered** **60 day period (March 12th through April 11th2015): parts will be installed, tested and put into service by a certified contractor.**	

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	located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility. Findings include: Based on observations on 01/26/15 at 2:20 p.m. during a tour of the two emergency generators with the maintenance supervisor, the two emergency generators lacked a remote shut off device. Based on interview with the maintenance supervisor on 01/26/15 at 2:30 p.m. while at the generators, the maintenance supervisor indicated the generators were over 150 Horsepower and verified there was no remote shut off device for the two generators. This was acknowledged by the director of maintenance at the exit conference on 01/26/15 at 3:00 p.m.			
K 147 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2			

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	Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 8 residents, staff and visitors. Findings include: Based on observations with the maintenance technician during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/26/15, the following was noted: a. a microwave oven was plugged into a power strip in the second floor Breakroom. b. a microwave oven was plugged into a power strip in the third floor Accounts Payable Office. c. a coffee pot was plugged into a power strip in the third floor Human Resources Office kitchenette. Based on interview at the time of the observations, the maintenance technician acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations.	K 147	**Tag # K-0147** *1. How are you, the provider, going to correct the deficiency? If already corrected, include the steps taken and the date of correction.* **The power strips were removed from the coffee pot and two microwaves. The appliances were relocated so that they could be directly plugged into the wall without the need for an extension. This was done on February 11th2015.** *2. How are you, the provider, going to prevent the finding and/or deficiency from recurring in the future?* **The Facility Director (or Maintenance Supervisor) will conduct a monthly facility inspection to assure that extension cords are not used on these types (or any other types) of appliances.** *3. Who is going to be responsible for numbers 1 and 2 above?* **The Facility Director will be responsible for Items 1 & 2 above.** *4. By what date are you, the provider, going to have the finding*	02/11/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 01 B. WING	01/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSH MEMORIAL HOSPITAL	1300 N MAIN ST RUSHVILLE, IN 46173

(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
			and/or deficiency corrected? **The three deficiencies were corrected on February 11th 2015.**	