

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906
---	--

(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
K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 05/15/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b).</p> <p>Survey Date: 08/15/14</p> <p>Facility Number: 005172 Provider Number: 154005 AIM Number: 100273160A</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this PSR Code survey, River Bend Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 482.41(b), 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 two story facility was determined to be of Type II (222) construction and partially sprinklered. The first floor was fully sprinklered except a kitchen freezer which was attached to the outside of the building. The facility has a fire alarm system with system based smoke alarms</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906
---	--

(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
K010021	<p>in corridors and in hazardous areas. The facility has a capacity of 16 patients and had a census of 15.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 self closing doors to hazardous areas such as a kitchen were held open only by devices</p>	K010021	Replace closers with no hold back feature on door closers.	09/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2014
NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906		
(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	
K010029	<p>which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more patients.</p> <p>Findings include:</p> <p>Based on observation with the maintenance engineer on 08/15/14 at 11:45 a.m., two self closing doors between the food service area and the kitchen stood wide open. Both doors were equipped self closers, but when the doors were pushed wide open, a feature of the self closers prevented the doors from closing without being pulled closed. The maintenance engineer acknowledged at the time of observation, the doors would not automatically close when opened fully.</p> <p>This deficiency was cited on 05/15/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2014	
NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906			
(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			
	<p>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 provide automatic door closers on 5 of 12 doors providing access to hazardous areas such as a kitchen and hazardous materials storage room. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect visitors, staff and 10 or more patients in the center second floor smoke compartment and first floor dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance engineer on 08/15/14 at 11:45 a.m., a rolling steel door which protected the three by four foot opening between the kitchen and dining room was not self closing. The maintenance</p>	K010029	<p>a. Rolling steel door is now closed with both pins in place to secure it from opening. b. We are appealing this issues due to the safety issues it will cause dietary staff in carrying food from the kitchen prep area to the actual serving line. Please see attached Life Safety Code Waiver Request form attached and accompanying documentation.</p>	09/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2014
NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906		
(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	
	<p>engineer acknowledged at the time of observation, the door had to be manually closed to provide separation between the two spaces.</p> <p>b. Based on observation with the maintenance engineer on 08/15/14 at 11:55 p.m., four kitchen access doors equipped with self closers each had no automatic positive latch. Instead the doors were equipped with deadbolt latches which required a key to secure them in their door frames. The maintenance engineer acknowledged at the time of observations, the doors could not latch automatically to secure them in the door frames.</p> <p>This deficiency was cited on 05/15/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				