



Certified End Page

UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT

STATE LICENSE NUMBER: 65030201

SURVEY EXIT DATE: 12/17/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396098	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/17/2024
NAME OF PROVIDER OR SUPPLIER: UPMC MAGEE-WOMENS HOSPITAL TRANSITIONAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 HALKET STREET PITTSBURGH, PA 15213		
STATE LICENSE NUMBER: 65030201				
(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)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 65030201 Component 01 Main Building (3rd Floor)</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 16-17, 2023, it was determined that UPMC Magee-Women's Hospital Transitional Care Unit was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a five-story, Type II (222), fire resistive structure, with a basement and attic, that is fully sprinklered. The TCU is located on the third floor which is fully sprinklered.</p>	K 0000		

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0353 SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<p>The insulation will be relocated off of the sprinkler pipe in the 6300 attic. The ceiling tile will be replaced in rooms 5328, 4116, 4118 and 4321. The insulated ductwork will be relocated off of the sprinkler pipe in room 4172. All of these resolutions will be reported to the hospital safety committee and included in the hospital quality assurance program. All sprinkler lines are monitored and will continue to be monitored annually as part of the "Annual Fire and Smoke barrier above the ceiling program." Ceiling tiles are monitored and will continue to be monitored during hazard surveillance rounds by a multi-disciplinary team including representatives from safety, infection control, facilities and environmental services.</p>	<p>Completion Date: 02/15/2025 Status: APPROVED Date: 12/30/2024</p>

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K 0353 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in six instances, affecting four of twenty-seven smoke compartments. Findings include: 1. Observation on December 16, 2024, revealed the following automatic sprinkler system deficiencies: a) 10:00 a.m., there was insulation supported by the sprinkler line in the 6300 attic; b) 10:26 a.m., there was a gap greater than 1/8" in room # 5328 data closet; c) 10:58 a.m., there was a gap greater than 1/8" in room # 4116; d) 11:30 a.m., there was a gap greater than 1/8" in room # 4118. Interview with the Unit Director of TCU, Facility Staff and the Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the automatic sprinkler system deficiencies.	K 0353		

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K 0353 SS=E	Continued from page 3 2. Observation on December 17, 2024, revealed the following automatic sprinkler system deficiencies: a) 10:40 a.m., there was a gap greater than 1/8 inch in the track of the ceiling tile outside of room 4321; b) 10:49 a.m., there was flexible insulated ductwork laying on a sprinkler line above the double doors next to room 4172. Interview with the Unit Director of TCU, Facility Staff, and the Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the automatic sprinkler system deficiencies.	K 0353		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 4 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	The door to room 3430 will be repaired to close and latch. The door decorations will be removed. This will be reported to the hospital safety committee and included in the hospital quality assurance program. Door maintenance and functionality is monitored and will continue to be monitored during hazard surveillance rounds by a multi-disciplinary team including representatives from safety, infection control, facilities and environmental services.	Completion Date: 02/15/2025 Status: APPROVED Date: 12/30/2024

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K 0363 SS=E	Continued from page 5 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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K 0363 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain corridor doors in two instances, affecting two of of 27 smoke compartments. Findings include: 1. Observation on December 17, 2024, revealed the following corridor door deficiencies: a) 10:17 a.m., room #3430 failed to latch when tested; b) 10:30 a.m., there were several doors throughout the facility that had decorations exceeding 50% of the door. Interview with the Unit Director of TCU, Facility Staff, and the Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the corridor door deficiencies.	K 0363		

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K 0372 SS=E	<p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0372	<p>The penetration in the Elevator Room will be sealed to prevent the passage of smoke. The penetration above the double doors next to room 2400.22 will be sealed to prevent the passage of smoke. This will be reported to the hospital safety committee and included in the hospital quality assurance program. Door maintenance is monitored and will continue to be monitored during hazard surveillance rounds by a multi-disciplinary team including representatives from safety, infection control, facilities and environmental services.</p>	<p>Completion Date: 02/15/2025</p> <p>Status: APPROVED</p> <p>Date: 12/30/2024</p>

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K 0372 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls in two locations, affecting four of twenty seven smoke compartments. Findings include: 1. Observation on December 17, 2024, revealed the following smoke barrier deficiencies: a) 10:35 a.m., the Level 6300 Elevator Room, had an unsealed penetration of the smoke wall; b) 11:18 a.m., there was a previously sealed penetration where the fire sealant had been removed or had fallen out, above the double doors, next to Data Room 2400.22 Interview with the TCU Unit Director, Facility Staff, and the Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the unsealed penetrations.	K 0372		

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K 0372 SS=E	Continued from page 9	K 0372		
K 0920 SS=D	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0920	Staff will be informed to plug the coffee pots into the wall in room 1119. This will be reported to the hospital safety committee and included in the hospital quality assurance program. The use of surge protectors are monitored and will continue to be monitored during hazard surveillance rounds by a multi-disciplinary team including representatives from safety, infection control, facilities and environmental services.	<p>Completion Date: 02/15/2025 Status: APPROVED Date: 12/30/2024</p>

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K 0920 SS=D	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain electrical wiring systems and equipment in one instance, affecting one of twenty seven smoke compartments. Findings include: 1. Observation on December 17, 2024, at 11:25 a.m., revealed there were two electric coffee pots plugged into power strip/surge protector in room 1119. Interview with the Unit Director of TCU, Facility Staff, and Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the listed electrical wiring systems deficiency.	K 0920		

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K 0923 SS=E	<p>NFPA 101 Gas Equipment - Cylinder and Container Storage</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p>	K 0923	<p>The cylinder will be secured in room 1213. This will be reported to the hospital safety committee and included in the hospital quality assurance program. Gas cylinders are monitored and will continue to be monitored during hazard surveillance rounds by a multi-disciplinary team including representatives from safety, infection control, facilities and environmental services.</p>	<p>Completion Date: 02/15/2025 Status: APPROVED Date: 12/30/2024</p>

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K 0923 SS=E	Continued from page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly store gas cylinders in one instance, affecting one of 27 smoke compartments. Findings include: 1. Observation on December 17, 2024, at 11:10 a.m., revealed an unsecured cylinder in a storage room on the first floor (room 1213). Interview with the Unit Director of TCU, Facility Staff, and the Safety Manager on December 17, 2024, at 1:00 p.m., confirmed the cylinder was not properly stored.	K 0923		



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