STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005082	A. BUILDING: _____ B. WING _____	12/03/2020

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) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00228694 Substantiated: No deficiency related to the allegations is cited. Survey Date: 12/2-3/2020 Facility Number: 005082 Rush Memorial Hospital is in compliance with 410 IAC 15-1.5-6 Nursing Service, Hospital Licensure Rules. QA: 12/10/20	S 000		