

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

PRINTED: 06/20/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/27/2023
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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C 000	INITIAL COMMENTS  This visit was for a Critical Access Hospital re-certification survey.  Facility Number: 005082  Survey Date: 6/19/2023 - 6/20/2023 and 6/26/23-6/27/23  QA: 7/7/23	C 000		
C 910	PHYSICAL PLANT AND ENVIRONMENT CFR(s): 485.623  §485.623 Condition of Participation: Physical Plant and Environment This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, failed to document 36-month period emergency generator testing for 2 of 3 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, failed to exercise 1 of 3 emergency generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2., failed to ensure an annual fuel quality test was performed for the facility's three diesel fuel fired emergency generators. NFPA 99, Health Care Facilities Code, 2012 Edition, failed to ensure documentation of the transfer time to the alternate power source was within 10 seconds for monthly load tests conducted for 3 of 3 emergency generators for the most recent 12-month period, failed to ensure 3 of 3	C 910	8/21/23	

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

TITLE

(X6) DATE

04/29/2024

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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C 910	Continued From page 1  emergency generators was allowed a 5-minute cool down period after a load test for the most recent twelve-month period, facility failed to ensure in 1 of 2 interior exit enclosures were not used for storage, failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3.  The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	C 910		
C 914	MAINTENANCE CFR(s): 485.623(b) , 485.623(b)(1)  The CAH has housekeeping and preventive maintenance programs to ensure that--  (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all kitchen staff.	C 914		8/11/23

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C 914	<p>Continued From page 2</p> <p>Findings include:</p> <p>Based on review of the kitchen fire suppression system inspection contractor's inspection documentation dated 10/13/22 with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director and the Project Manager during record review from 9:30 a.m. to 12:45 p.m. on 06/27/23, documentation of semiannual kitchen fire suppression system inspection six months after 10/13/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated inspection contractor reports may have been e-mailed to the previous Maintenance Director's e-mail account for which he did not have access to but agreed documentation of semiannual fire suppression system inspection six months after 10/13/22 was not available for review at the time of the survey.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director and the Project Manager during the exit conference.</p> <p>Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 2 of 3 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS</p>	C 914		

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C 914	<p>Continued From page 3</p> <p>shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager from 10:00 a.m. to 4:30 p.m. on 06/26/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's emergency generators identified as Generator #1 (rated at 300 kW) and Generator #2 (rated at 500 kW) was not available for review. Based on interview at the time of record review, the Project Manager stated the facility has three diesel fuel fired emergency generators, Generator #3 is the only one of the three generators which had thirty-six month period testing conducted on 03/09/23 and agreed supplemental load testing documentation for four hours within the most recent three-year period for Generator #1 and Generator #2 was not available for review.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p>	C 914		

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C 914	<p>Continued From page 4</p> <p>Based on record review and interview, the facility failed to exercise 1 of 3 emergency generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2.</p> <p>Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.</p> <p>Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Test Log" documentation with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, the emergency generator identified as Generator #2 is diesel fuel fired and rated at 500 kW.</p>	C 914		

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C 914	<p>Continued From page 5</p> <p>Monthly emergency generator load testing documentation for the most recent twelve-month period indicated no monthly test achieved not less than 30% (150 kW) of the EPS nameplate kW rating. Based on interview at the time of record review, the Project Manager agreed monthly load testing for Generator #2 did not achieve at least 30% load and agreed annual supplemental load testing documentation for the most recent twelve-month period was not available for review.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p> <p>Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's three diesel fuel fired emergency generators. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager from 10:00 a.m. to 4:30 p.m. on</p>	C 914		

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C 914	<p>Continued From page 6</p> <p>06/26/23, documentation of an annual fuel quality test for the facility's three diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Project Manager stated the facility has three diesel fuel fired emergency generators. Based on interview at the time of record review, the Maintenance Director stated contractor reports may have been e-mailed to the previous Maintenance Director's e-mail account for which he did not have access to but agreed documentation of an annual fuel quality test for each of the three-diesel fuel fired emergency generators was not available for review at the time of the survey.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p> <p>Based on record review and interview, the facility failed to ensure documentation of the transfer time to the alternate power source was within 10 seconds for monthly load tests conducted for 3 of 3 emergency generators for the most recent 12-month period. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Test Log" documentation with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, monthly load testing documentation for the facility's three diesel fuel fired emergency</p>	C 914		

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C 914	<p>Continued From page 7</p> <p>generators for the most recent twelve-month period was incomplete. The transfer time was not documented on "Emergency Generator-Monthly Test Log" documentation. Generator inspection and testing is also documented on "Preventive Maintenance Checklist" documentation where the run time duration was listed as "20 minutes" and where the "Transfer Time (Less than 10 seconds)" is checked "OK" but the day of each inspection or test on the "Preventive Maintenance Checklist" is not the same date as monthly load testing dates on "Emergency Generator-Monthly Test Log" documentation. Based on interview at the time of record review, the Maintenance Director and the Project Manager agreed the transfer time for monthly load testing documentation for each of the facility's three emergency generators was not available for review.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p> <p>Based on record review and interview, the facility failed to ensure 3 of 3 emergency generators was allowed a 5-minute cool down period after a load test for the most recent twelve-month period. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.5(4) requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p>	C 914		

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C 914	<p>Continued From page 8</p> <p>Based on review of "Emergency Generator-Monthly Test Log" documentation with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, monthly load testing documentation for the facility's three diesel fuel fired emergency generators for the most recent twelve-month period was incomplete. The cool down time was not documented on "Emergency Generator-Monthly Test Log" documentation. Generator inspection and testing is also documented on "Preventive Maintenance Checklist" documentation where the run time duration was listed as "20 minutes" and where the "Cool Down Time - (20 Minutes)" is checked "OK" but the day of each inspection or test on the "Preventive Maintenance Checklist" is not the same date as monthly load testing dates on "Emergency Generator-Monthly Test Log" documentation. Based on interview at the time of record review, the Maintenance Director and the Project Manager agreed the cool down time for monthly load testing documentation for each of the facility's three emergency generators was not available for review.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p>	C 914		
C 930	<p>LIFE SAFETY FROM FIRE CFR(s): 485.623(c), 485.623(c)(1)(i)</p> <p>§485.623(c) Standard: Life Safety From Fire</p>	C 930		8/18/23

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C 930	<p>Continued From page 9</p> <p>(1) Except as otherwise provided in this section:</p> <p>(i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)</p> <p>(ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure in 1 of 2 interior exit enclosures were not used for storage. LSC 7.2.2.5.3 states Enclosed, usable spaces within exit enclosures shall be prohibited, including under stairs, unless otherwise permitted by 7.2.2.5.3.2. which states enclosed, usable space shall be permitted under stairs, provided that both of the following criteria are met:</p> <p>(1) The space shall be separated from the stair enclosure by the same fire resistance as the exit enclosure.</p> <p>(2) Entrance to the enclosed, usable space shall not be from within the stair enclosure. This deficient practice could affect all residents, staff and visitors using the exit stairwell.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/27/23 between 9:20 a.m. and 11:50 a.m., the exit stairwell connecting the first floor (marked Not an Exit) and the second-floor surgery OR area</p>	C 930		

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C 930	<p>Continued From page 10</p> <p>(marked an Exit) contained an enclosed storage room under the stairs used as an "IT" storage room containing IT equipment, boxes and other material. The door to the aforementioned room opens into the exit enclosure. Based on interview at the time of observation, the Project Manager and VP of Cooperate Compliance confirmed the aforementioned exit enclosure was used for storage.</p> <p>This finding was acknowledged at the time of discovery by the Project Manager and VP of Cooperate Compliance and again at the exit conference with the Project Manager, VP of Nursing and CNO, Maintenance Director and CEO present on 06/27/23.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the fire alarm system inspection contractor's "Inspection Summary" documentation dated 01/04/23 for the 323 Conrad Harcourt location with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, deficiencies were</p>	C 930		

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C 930	<p>Continued From page 11</p> <p>noted for the facility's fire alarm system. The "Device Deficiencies" section of the 01/04/23 inspection report stated the fire panel failed testing due to "Failure Reason: Com fault 1 and 2 upon arrival". Review of "Proposal and Service Agreement" documentation dated 03/23/23 indicated the contractor provided a quote for fire alarm system repair. Based on interview at the time of record review, the Maintenance Director stated the facility approved the quote but the contractor is awaiting parts to arrive to complete the repair.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director and the Project Manager during the exit conference.</p> <p>1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, Section 5.2.5 requires that waterflow alarm</p>	C 930		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/27/2023
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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C 930	<p>Continued From page 12</p> <p>devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. Section 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all patients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the sprinkler system inspection contractor's "Inspection Report" and "Sprinkler System Inspection" documentation with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, sprinkler system inspection and testing documentation for the fourth quarter (October, November, December) 2022 was not available for review. Based on interview at the time of record review, the Project Manager agreed sprinkler system inspection and testing documentation for the fourth quarter (October, November, December) 2022 was not available for review.</p> <p>These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.</p> <p>2. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states</p>	C 930		

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C 930	<p>Continued From page 13</p> <p>gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry, preaction and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the sprinkler system inspection contractor's "Inspection Report" and "Sprinkler System Inspection" documentation with the Vice President of Corporate Compliance, the Vice President of Nursing, the Maintenance Director, and the Project Manager during record review from 10:00 a.m. to 4:30 p.m. on 06/26/23, sprinkler system gauges and valves were inspected by the contractor for two months of the most recent twelve-month period. Based on interview at the time of record review, the Project Manager stated facility maintenance staff do not perform additional sprinkler system gauge and valve inspections in addition to the contractor's quarterly inspections and agreed additional monthly sprinkler system gauge and valve inspection documentation for the most recent</p>	C 930		

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C 930	Continued From page 14  twelve-month period was not available for review.  These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference.	C 930		
C 962	GOVERNING BODY OR RESPONSIBLE INDIVIDUAL  CFR(s): 485.627(a)  The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.  This STANDARD is not met as evidenced by: Based on documentation review and interview, the governing body failed to ensure that 3 Swing Bed policies were implemented.  Findings Include:  1. Review of policy titled: Social Services (last approved 12/2022) indicated that a psycho-social assessment will be completed within 4 days of admission.  2. Review of policy titled: Activity Program (last approved 12/2022) indicated an on-going Activity Program will have a qualified professional direct the Activity Program.  3. Review of policy titled: Nursing Admission Assessment (last approved 12/2022) indicated that an oral cavity review would be assessed upon admission.	C 962		8/17/23

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C 962	<p>Continued From page 15</p> <p>4. Review of 5 Swing Bed medical records (Pts 26, 27, 28, 29 and 30) indicated 3 eligible patients (Pts 28, 29 and 30) lacked documentation of a social service psycho-social assessment.</p> <p>5. Review of 5 Swing Bed patient medical records (Pts 26, 27, 28, 29 and 30) lacked documentation of Activity Program activities.</p> <p>6. Review of 5 Swing Bed medical records (Pts 26, 27, 28, 29 and 30) lacked documentation of oral cavity assessment upon admission.</p> <p>7. Interview on 06/20/23 at 2:45 pm with S10 (Director of Medical Surgical) confirmed: no psycho-social assessments completed on 3 eligible patients (Pts 28, 29 and 30); medical records lacked documentation of an oral cavity assessment on 5 of 5 patients (Pts 26, 27, 28, 29 and 30); an lack of activity director/designee and activities on the medical record in 5 of 5 medical records (Pts 28, 29 and 30) reviewed.</p>	C 962		