STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151304	A. BUILDING 00 B. WING	06/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
C 0000 Bldg. 00	This visit was for a Critical Access Hospital re-certification survey. Facility Number: 005082 Survey Date: 6/19/2023 - 6/20/2023 QA: 7/7/23	C 0000		
C 0910 Bldg. 00	485.623 PHYSICAL PLANT AND ENVIRONMENT §485.623 Condition of Participation: Physical Plant and Environment 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 emergency generators was allowed a 5-minute cool down period after a load test for the most	C 0910	A) Koorsen Fire Protection has been contacted, we have updated contact info from previous director to current Maintenace Director. Current Director is receiving the Kitchen fire suppression system inspections, as of 7/1/2023 . 1) The kitchen fire suppression system had been inspected in April and October, The deficiency was not being able to produce those documents at the time of inspection. Director of Maintenace have attached a copy of the email where the contact information was changed to myself and the kitchen suppression system inspections will be attached as well. 2) A policy has been created and attached, that states these suppression systems need to be inspected biannually, in April and October. Additionally a calendar reminder has been entered into	08/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carrie Tressler	CNO	07/25/2023

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	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.		Director of Maintenace Calendar at the beginning of April and October to follow up with Koorsen Fire Protection that a date will be scheduled for the kitchen suppressions inspection. B) Generators 1 and 2 will have a new policy/procedure to be on a 3 year rotation to have a 4 hour continuous exercise. Generator #2, which was carrying load greater than 30%, has now been scheduled for an annual load bank test. This test will count toward the 36 month 4 hour continuous run exercise. 1) Director of Maintenance has scheduled annual load bank exercise to occur in July of each calendar year. 2) Calendar has been updated to ensure load bank test for Generator #2 will take place at the same time yearly, and can be used for the 36 month 4 hour continuous run test. C) Monthly fuel quality reports are now being sent to director of maintenance, fuel company had incorrect mailing info for current maintenance director. Generator #2 was found to be carrying load greater than 30% of load, this generator has now been scheduled for an annual load bank test. 1) A new policy was created by the Maintenance Director to define criteria of generators, stated by NFPA 99 and NFPA 110	

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			guidelines, which must have an annual load bank test. 2) A load bank test has been scheduled for Generator #2 to occur at 8 AM on July 26th, 2023. Future load bank tests have been added to the Maintenace Directors calendar to occur at same time in future years. D) Preventative Maintenance has been updated to include the transfer time, at the time of the Emergency Generator- Monthly Test Log. Related to the failure to ensure annual fuel quality test performed for generators. Director had submitted monthly fuel quality analysis, was not aware that an annual fuel test was required. 1) Policy created to educate the necessity of performing an annual fuel quality test, based off of the NFPA guidelines. 2) An annual Fuel Quality Test has been scheduled to take place July 27th, 2023. Yearly tests have been added to Director Calendar, will take place at same time yearly. E) Preventative Maintenance has been updated for all three generators to include the cool down time. Related to the failure to ensure documentation of transfer time. The preventative maintenance has been updated to include transfer time and cool down time. Maintenance techs will track time	

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			for each part of the PM. The project manager and the Director will verify metrics have been met with monthly reviews of the PM's. F) - Our plan of remediation includes: extending the current entrance to the banister to provide more room in the front of the network closet. Converting the doorway to the network closet to a solid wall with a 2 hour fire rating. The room itself will be encapsulated in a 2 hour rating. Relocate the entrance of this room to the hallway with an in-swing door. - An initiation device in the closet will be installed - The sleeve to run cables must be a 2 hour rated sleeve. It must be horizontal and go from the hallway directly into the network closet. It should not pass from the hallway, into the stairwell enclosure, and then into the network closet. G) The deficiencies that were found on the fire panel at 1339 N Cherry St.on 7/20/2022 have been corrected. Service was requested and completed 8/17/2022. Related to failure 1 of 1 fire alarm systems Maintained. 1) Director will continue to monitor monthly reports from vendor to verify deficiencies. Director or Maintenance is responsible for maintaining the compliance for all the above. Update:	

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C 0914 Bldg. 00	485.623(b) , 485.623(b)(1) MAINTENANCE 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; 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. Findings include: 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	C 0914	A) Koorsen Fire Protection has been contacted, we have updated contact info from previous director to current Maintenace Director. Current Director is now receiving the Kitchen fire suppression system inspections, as of 7/1/2023 1) The kitchen fire suppression system had been inspected in April and October, The deficiency was not being able to produce those documents at the time of inspection. I have attached a copy of the email where the contact information was changed to myself and the kitchen suppression system inspections will be attached as well. 2) A policy has been created and attached, that states these suppression systems need to be inspected biannually, in April and October. Additionally a calendar reminder has been entered into Directors Calendar at the beginning of April and October to follow up with Koorsen Fire Protection that a date will be scheduled for the kitchen	08/11/2023

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	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. 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. 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 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. Findings include: Based on record review with the Vice President of		suppressions inspection. B) Generators 1 and 2 will have a new policy/procedure to be on a 3 year rotation to have a 4 hour continuous exercise. The policy/procedure will be completed by 8/11/2023 by the Maintenance Director. Generator #2, which was carrying load greater than 30%, has now been scheduled for an annual load bank test. This test will count toward the 36 month 4 hour continuous run exercise. 1) Director has scheduled annual load bank exercise to occur in July of each calendar year. 2) Calendar has been updated to ensure load bank test for Generator #2 will take place at the same time yearly, and can be used for the 36 month 4 hour continuous run test. C) Generator 2 will be scheduled for an annual load bank test. Preventative Maintenance will be updated to include date of next annual load bank test. PM and Test will be scheduled by 8/11/2023by the Maintenance Director Generator #2 was found to be carrying load greater than 30% of load, this generator has now been scheduled for an annual load bank test. 1) A new policy was created to define criteria of generators, stated by NFPA 99 and NFPA 110	

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	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. 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. 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. 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: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS		guidelines, which must have an annual load bank test. 2) A load bank test has been scheduled for Generator #2 to occur at 8 AM on July 26th, 2023. Future load bank tests have been added to calendar to occur at same time in future years. D) Monthly fuel quality reports are now being sent to director of maintenance; fuel company had incorrect mailing info for current director. (attachment) Related to the failure to ensure annual fuel quality test performed for generators. Director had submitted monthly fuel quality analysis, was not aware that an annual fuel test was required. 1) Policy created to educate the necessity of performing an annual fuel quality test, based off of the NFPA guidelines. 2) An annual Fuel Quality Test has been scheduled to take place July 27th, 2023. Yearly tests have been added to Director Calendar, will take place at same time yearly. E) Preventative Maintenance has been updated to include the transfer time, at the time of the Emergency Generator- Monthly Test Log. (att Related to the failure to ensure documentation of transfer time. The preventative maintenance has been updated to include transfer time and cool down time. Maintenance techs will track time	

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	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. Findings include: 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. 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. 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. Based on record review and interview, the facility failed to ensure an annual fuel quality test was		for each part of the PM. The project manager and the Director will verify metrics have been met with monthly reviews of the PM's. F) Preventative Maintenance has been updated for all three generators to include the cool down time, and documented with the same information on both the Preventative Maintenance Checklist and the Emergency Generator-Monthly Test Log. Director of Maintenance is responsible for compliance.	

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	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. Findings include: 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, 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. These findings were reviewed with the Chief Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project			

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	Manager during the exit conference. 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. Findings include: 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 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. These findings were reviewed with the Chief			

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	Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference. 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. Findings include: 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"			

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	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. 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 0930 Bldg. 00	485.623(c), 485.623(c)(1)(i) LIFE SAFETY FROM FIRE §485.623(c) Standard: Life Safety From Fire (1) Except as otherwise provided in this section: (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.) (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. 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	C 0930	A). Our plan of remediation includes: extending the current entrance to the banister to provide more room in the front of the network closet. Converting the doorway to the network closet to a solid wall with a 2 hour fire rating. The room itself will be encapsulated in a 2 hour rating.	08/18/2023

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	are met: (1) The space shall be separated from the stair enclosure by the same fire resistance as the exit enclosure. (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. Findings include: 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 (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. 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. 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		Relocate the entrance of this room to the hallway with an in-swing door. - An initiation device in the closet will be installed. Goal will be to be completed in 30days, Due to getting parts in timely may have a further 60 day completion date of 10/20/2023 **Director of Maintenace is responsible for maintaining compliance.** B) Deficiency has been corrected. The cell repeater for WIC 323 Conrad Harcourt Way, was replaced on 06/30/2023. This cleared the deficiencies on the fire panel (see attachment 1) 1) Updated contact information, current director is now receiving the proper documentation and inspection reports. 2) Maintenance will create a spreadsheet by 8/4/2023 as part of their monthly preventative maintenance to check gauges and normal water supply pressure on wet sprinkler systems. And will create another spreadsheet by 8/4/2023 for weekly preventative maintenance to inspect gauges and valves for proper function on dry sprinkler systems	

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	151304	A. BUILDING 00 B. WING	06/20/2023

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	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. Findings include: 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 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. 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. 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			

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	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 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. Findings include: 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.			

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	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. 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 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. Findings include: 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			

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	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 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 0962 Bldg. 00	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL 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. 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	C 0962	1. Social Services consult to be placed in electronic medical record upon Swing Bed admission by admiting RN. Consult to be completed within 4 days of admission. If Social Services unavailable, psycho-social assessment to be completed by nursing staff/discharge planner (designee). a. Instructions for Psychosocial Assessment in	08/17/2023

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	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. 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. 5. Review of 5 Swing Bed patient medical records (Pts 26, 27, 28, 29 and 30) lacked documentation of Activity Program activities. 6. Review of 5 Swing Bed medical records (Pts 26, 27, 28, 29 and 30) lacked documentation of oral cavity assessment upon admission. 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.		electronic medical record: i. Open patient chart ii. Click on ad hoc iii. Click on Psychosocial Assessment-Adult iv. Complete assessment v. Click on green checkmark to save in chart b. Chart audits to be completed on each Swing Bed patient to monitor compliance of assessment completion. This will be performed by night nursing staff or designee. c. Psychosocial reassessment will be conducted as indicated by changes in patient's condition. Reassessment to be documented by social services or designee. 2. Activity Program will be directed by the Rush Memorial Hospital Therapy Department, specifically Occupational Therapy. The assessment will be completed within 48 hours of admission. If Occupational Therapist is unavailable, activity assessment to be completed by nursing staff (designee). a. Instructions for Activity Assessment in electronic medical record:	

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			i. Open patient chart ii. Click on ad hoc iii. Click on Activities of Daily Living Banner iv. Click on Activity Assessment v. Complete assessment vi. Click on green checkmark to save in chart b. Chart audits to be completed by nursing staff on each Swing Bed patient to monitor compliance of activity assessment completion. c. Activity reassessment will be conducted as indicated by changes in condition of the patient. Reassessment to be documented by Occupational Therapist or Nursing Staff designee. d. Activity Program Activities will vary based on individual's assessment results. Upon completion of activities, documentation will be placed in electronic medical record. Activities can be completed by nurse, volunteer, or activity designee. i. If patient is unable to perform activities, documentation will be placed in	

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S 0000 Bldg. 00			the electronic medical record. By nursing staff or designee e. Chart audits will be completed by nursing staff or designee on each Swing Bed patient to monitor compliance of performance of activities as well as documentation of completion. 3. Nursing Admission Assessment to include oral cavity assessment with 24 hours of admission. The assessment will be completed by nursing staff. a. Instructions for oral cavity documentation in electronic medical record: i. Open patient chart ii. Click on Interactive View Banner iii. Click on Adult Systems Assessment iv. Document under EENT subcategory-Mouth b. Chart audits to be completed by nursing staff or designee on each Swing Bed patient to monitor compliance of oral cavity/mouth assessment. Med Surgical Director will be responsible for maintaining compliance.	

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	This visit was for a hospital licensure survey. Facility Number: 005082 Survey Dates: 6/19/2023 - 6/20/2023 Rush Memorial Hospital, is in compliance with 410 IAC 15-1.1 Hospital Licensure Rules. QA: 7/7/23	S 0000		