STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151304	A. BUILDING -- B. WING	06/27/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.625. Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Emergency Preparedness survey, Rush Memorial Hospital was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 485.625. The facility has 25 certified beds. At the time of the survey, the census was 6. Quality Review completed on 07/06/23 The requirement at 42 CFR, Subpart 485.625 is NOT MET as evidenced by:	E 0000		
E 0041 Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carrie Tressler	CNO	07/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. 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, the following was noted for the facility's emergency and standby power systems: a. 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. b. the emergency generator identified as Generator #2 is diesel fuel fired and rated at 500 kW.	E 0041	A.) A). 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. B.) B.) 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 8/11/2023. C.) C) Monthly fuel quality reports are now being sent to director of maintenance, fuel company had incorrect mailing info for current director. D.) D) Preventative Maintenance has been updated to include the transfer time, at the time of the Emergency Generator-Monthly Test Log. E) E) 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 This will be monitored by the	08/11/2023

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	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. c. 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. d. 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"		Maintenance Director (attachement)	

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	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 Executive Officer, the Vice President of Nursing, the Maintenance Director, and the Project Manager during the exit conference. e. 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. 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.			

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. The facility was constructed at three different times. The original building built in 1949 is a three story, non sprinkled building with a basement with a renovation to the first floor, second floor and small basement addition in 1972 of Type I (332) construction and non sprinkled except the elevator shaft and dumb waiter shaft enclosures. In 1996, a two story addition to the north of the original building was constructed and is a two story, sprinkled addition with a basement of Type I (332) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building. Both buildings have a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detection in all patient sleeping rooms. The facility has a capacity of 25 and had a census of 6	K 0000		

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	at the time of this survey. All areas of the 1996 addition where patients have customary access were sprinklered. The facility has detached buildings providing facility services which were not sprinklered. Quality Review completed on 07/06/23			
K 0225 Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 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: (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)	K 0225	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. 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 co mpliance.**	08/18/2023

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	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.			
K 0324 Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.			

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	18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 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 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	K 0324	Koorsen Fire Protection has been contacted by the Maintenace Director. RMH will have updated contact info from previous maintenance director to new director. The maintenance director is now receiving the Kitchen fire suppression system inspections, as of 7/1/2023. Maintenace director will be responsible for maintaining compliance. (attachement)	08/01/2023

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	Executive Officer, the Vice President of Nursing, the Maintenance Director and the Project Manager during the exit conference.			
K 0353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 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.	K 0353	1) Updated contact information, current director is now receiving the proper documentation and inspection reports. 2) Maintenance has created a spreadsheet as part of their monthly preventative maintenance to check gauges and normal water supply pressure on wet sprinkler systems. And we have created another spreadsheet for weekly preventative maintenance to	07/20/2023

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	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. 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		inspect gauges and valves for proper function on dry sprinkler systems. (attachement) Director of Maintenance responsible for maintaining compliance.	

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	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 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			

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	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.			
K 0354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all patients in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures	K 0354	The Fire Watch plan for automatic sprinkler system impairment was updated by Safety officer to include notification of the alarm monitoring company, the building owner and the insurance carrier if the required automatic sprinkler system is out of-service for 10 hours or more in a 24- period. (See attachment) Compliance will be the responsibility of the safety officer	07/20/2023

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	that the impairment coordinator shall follow. This deficient practice could affect all patients, staff and visitors. Findings include: Based on review of "Fire Watch" documentation dated June 2023 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, the fire watch plan for sprinkler system impairment was incomplete. The fire watch policy for automatic sprinkler system impairment failed to also include notification of the alarm monitoring company, the building owner and the insurance carrier if the required automatic sprinkler system is out-of-service for 10 hours or more in a 24-hour period. Based on interview at the time of record review, the Vice President of Nursing agreed the fire watch plan for sprinkler system impairment was incomplete. 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.		and maintenance director.	
K 0372 Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING 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			

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	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of over 10 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 12 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 2:00 p.m. and 3:50 p.m., (1) a section of ceiling tile was missing in the smoke barrier drop ceiling in the basement Phone Room numbered A0060. And (2) fire barrier caulk had been knocked out in the ceiling and was missing in basement room #A00611. (3) Based on observations and interview	K 0372	(1) Upon notification of missing ceiling tile in the smoke barrier drop ceiling in the basement phone room numbered A0060, Information Systems Department member immediately placed the ceiling tile back into location on 6/26/23 at 2:30p.m. EST. Education was conducted in the IS Dept. staff meeting on 6/27/23. (2) The fire barrier caulk in room A00611 has been resealed on 6/30/2023 by the maintenance department (3) The floor penetration in the second floor IT closet has been properly sealed with fire barrier caulk, on 7/3/2023 by the maintenance department VP of IT is responsible for maintaining compliance	07/03/2023

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	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., in the 2nd floor "IT" Hall Closet there was a gang of wires penetrating through the concrete floor which were not sealed. 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.			
K 0712 Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 4 of 4 quarters. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on review of "Fire Drill Observer Checklist" documentation with the Vice President of	K 0712	1) Sta Maintenance Staff has been made aware by the Maintenance Director that Fire Drills need to have varying times; Fire Drill processes will be changed to meet requirements. 2) We have updated the Fire Drill Observer Checklist to include roles during the drill and names of all that participated. (see	07/03/2023

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	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, first shift fire drills conducted within the most recent twelve-month period on 07/28/22, 10/12/22, 01/11/23 and on 04/26/23 were conducted at, respectively, 1:45 p.m., 1:00 p.m., 2:00 p.m. and 1:00 p.m. Based on interview at the time of record review, the Vice President of Corporate Compliance stated the facility operates three shifts per day and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. 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 all staff who participated in quarterly fire drills on the first, second and third shifts for four of four quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all patients, staff, and visitors. Findings include: Based on review of "Fire Drill Observer Checklist" 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, documentation for first, second and third shift fire drills conducted		attachment 5) Maintenance Director is responsible for maintaining compliance.	

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	within the most recent twelve-month period did not include all staff who participated in the fire drill. Based on interview at the time of record review, the Vice President of Corporate Compliance stated the facility operates three shifts per day. Based on interview at the time of record review, the Project Manager stated each fire drill documents the name of the maintenance staff who conducted the drill but agreed documentation for all fire drills conducted within the most recent twelve-month period did not include all staff who participated in the fire drill. 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.			
K 0918 Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent			

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	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. 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.	K 0918	1.) 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. 2.) Generator 2 will have new PM created by 8/11/2023. PM to include annual load test for 30 minutes of not less than 50% of EPS nameplate kW rating. 3.) Monthly fuel quality reports are now being sent to director of maintenance, fuel company had incorrect mailing info for current director. 4.) Preventative Maintenance has been updated to include the transfer time, at the time of the Emergency Generator- Monthly Test Log. 5.) Preventative Maintenance has been updated for all three generators to include the cool	08/11/2023

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	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, 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. 2. 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		down time, and documented with the same information on both the Preventative Maintenance Checklist and the Emergency Generator-Monthly Test Log. Maintenance Director will be responsible for maintaining compliance.	

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	not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. 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. 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.			

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	3. 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. 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.			

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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. 4. 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			

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	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. 5. 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			

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	"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. 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.			
K 0920 Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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) assembles 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 power strips in the basement were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used as a substitute for fixed wiring. This deficient practice could affect up to 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 2:00 p.m. and 3:50 p.m., (1) in the basement Lab Reference room #A00498 a power strip was being used to power a dorm style refrigerator (high power draw equipment). And (2) 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., in the Med Staff area on the 3rd floor a power strip was being used to power a coffee machine (high power draw equipment). And (3) in the "Lean Project Facilitator" office a power strip was being used to power a dorm style refrigerator (high power draw equipment). 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.	K 0920	Power strip in the basement Lab Reference room #A00498 was being used to power a dorm style refrigerator. Power strip has been removed the dorm style refrigerator has been plugged directly in to a wall outlet. (2) Power strip in the Med Staff area on the red floor to power a coffee machine was removed on 6/25/23 and plugged directly into a wall outlet. (3) Power strip in the 'Lean Project Facilitator' office to power a dorm style refrigerator has been removed on 7/13/23. Refrigerator is plugged directly in to a wall outlet. Maintenace Director is responsible for maintaining compliance.	07/13/2023

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K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. Rush Memorial Hospital consists of the main hospital building (Building 01) and the RMH Walk-In Care Clinic (Building 02) which is a detached one story building with no basement. The RMH Walk-In Care Clinic commenced operation in 2017 and was determined to be of Type V(000) construction, was nonsprinklered and has a monitored fire alarm system with smoke detection in the corridor and in exam rooms. Building 02 was surveyed with Chapter 38, New Business Occupancies. The hospital has a capacity of 25 and had a census of 6 at the time of this survey. Quality Review completed on 07/06/23	K 0000		
K 0345	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 02	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 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. 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	K 0345	The cell repeater for 323 Conrad Harcourt Way was replaced on 06/30/2023by Securitas. This was tested by the Maintenace Director and cleared the deficiencies on the fire panel . The Maintenace director will be responsible for maintaining compliance. (attachement)	06/30/2023

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	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.			
K 0355 Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 5 staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., the portable fire extinguisher located in the Walk-In Care Building, near the Mechanical Room was mounted on the wall with the top of the extinguisher more than 5 feet above the floor. Based on interview at the time of observation, the Project Manager agreed the fire extinguisher was mounted with the top of	K 0355	The fire extinguisher at Walk-in Care Building has been lowered by the maintenance department to be in tolerance of the restricted height. Extinguisher was moved on 6/30/2023 by the maintenance department. Maintenance Director will be responsible for maintaining compliance	06/30/2023

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	the extinguisher appearing to be greater than five feet above the floor. 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.			
K 0363 Bldg. 02	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			

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	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. 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.			
	Based on observation and interview, the facility failed to ensure 1 of 1 corridor door in the Office of the Walk-In Care building had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., the Office corridor door in the Walk-in Care Building failed to self-close and latch positively into the door frame. 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.	K 0363	The latch that was not functioning at the Walk-In Care Building was replaced on 6/30/2023 by the Maintenace Department, latch functions properly . Maintenace Director is responsible for maintaining compliance.	06/30/2023
K 0000 Bldg. 03	A Life Safety Code Recertification Survey was	K 0000		

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	conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. Rush Memorial Hospital consists of the main hospital building (Building 01) and the Medical Office Building (Building 03) which is a detached two story building with a basement. The Medical Office Building commenced operation in 2006 and was determined to be of Type II(000) construction, was fully sprinklered and has a monitored fire alarm system with smoke detection in the corridor. Building 03 was surveyed with Chapter 39, Existing Business Occupancies. The hospital has a capacity of 25 and had a census of 6 at the time of this survey. Quality Review completed on 07/06/23			
K 0353 Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing 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			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 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. 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 "Sprinkler System	K 0353	1) No record of any repair completed. Maintenance reset panel upon completion of the inspection, the trouble code cleared on its own. 2) Inspections were completed, Koorsen Fire Protection did not have the correct email address to make sure those records were sent to the correct party. Contact info has been updated. DiDirector of Maintenance is responsible for maintaining compliance . F	07/20/2023

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	Inspection" documentation dated 07/20/22 for the Medical Office Building 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 sprinkler systems. The "Deficiencies" section of the 07/20/22 inspection report stated, "Panel Condition Deficiency Found 2nd floor MON T 1:2-37 wrong device on panel upon arrival". Based on interview at the time of record review, the Maintenance Director stated inspection contractor repair or replace documentation may have been e-mailed to the previous Maintenance Director's e-mail account for which he did not have access to but agreed repair or replace documentation on or after 07/20/22 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. 2. 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.			

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	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. Findings include: Based on review of the sprinkler system inspection contractor's "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 first quarter (January, February, March) 2023 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 first quarter 2023 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.			
K 0363 Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors			

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	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. 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.			

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	Based on observation and interview, the facility failed to ensure 1 of 1 corridor in the Medical Office Break Room would self-close, had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., the Break Room corridor door in the Medical Office Building adjacent to the stairwell entrance, equipped with a self-closing device, failed to self-close and latch positively into the door frame. 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.	K 0363	Door in the Medical Office Break Room was rubbing the floor, would not self-close. The door was removed, sanded down and reinstalled on 7/3/2023 by the Maintenace Department. Quarterly checks will be imitated in every department during quarterly safety checks. Door moves freely now and does self-close. Maintenace Director will be responsible for maintaining compliance.	07/03/2023
K 0920 Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens 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) assembles 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			

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	151304	A. BUILDING 03 B. WING	06/27/2023

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	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 Based on observation and interview, the facility failed to ensure 2 of over 30 rooms did not use multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., in the Medical Office Building (1) ENT's Physician's office and (2) Exam Room #7, multi-plug adaptors were in use powering equipment. Based on interview at the time of observation, the Project Manager and VP of Cooperate Compliance agreed multi-plug adaptors were being used. This finding was acknowledged at the time of discovery by the Project Manager and VP of Cooperate Compliance and again at the exit	K 0920	(1) Multi-plug adaptor was removed from ENTs Physician's Office in the Medical Office Building by maintenance staff (2) A member of the Information Systems Department has corrected the issue and has removed the multi-plug adaptor located on the IT equipment in Medical Office Building Exam room #7 on 7/10/23. A surge suppressor strip was used to replace. Education was conducted in the IS Dept. staff meeting on 7/10/23. Maintenace Director will be responsible for maintaining compliance	07/10/2023

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	conference with the Project Manager, VP of Nursing and CNO, Maintenance Director and CEO present on 06/27/23.			
K 0000 Bldg. 04	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. Rush Memorial Hospital consists of the main hospital building (Building 01) and the Medical Professional Building (Building 04) which is a detached one story building with no basement. The Medical Professional Building commenced operation in 2006 and was determined to be of Type II(000) construction, was not sprinklered and has a monitored fire alarm system with smoke detection in the corridor. Building 04 was surveyed with Chapter 39, Existing Business Occupancies. The hospital has a capacity of 25 and had a census of 6 at the time of this survey. Quality Review completed on 07/06/23	K 0000		

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K 0293 Bldg. 04	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to provide clear direction with exit signage in 1 of 3 exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 9 staff and patients. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., the side door exit in the Professional Office Building was marked with an appropriate exit sign as an Exit. However, confusion was created with an additional sign located in front of the door which stated the door was "NO EXIT." At the time of observation, the Project Manager and VP of Cooperate Compliance acknowledged the condition and described why the additional NO EXIT sign had been placed in	K 0293	The 'No Exit' sign in front of the door at the Professional Office Building was removed on 6/26/23 by the Maintenance Director. A new sign of 'Emergency Exit Only' has been placed on the physical door. Maintenance Director will by responsible for maintaining compliance.	06/27/2023

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	front of the door. 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.			
K 0345 Bldg. 04	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 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. Findings include: Based on review of the fire alarm system inspection contractor's "Inspection Summary" documentation dated 01/04/23 for the 201 Conrad Harcourt location with the Vice President of Corporate Compliance, the Vice President of	K 0345	Fire alarm system inspection noted device deficiencies on the fire panel at HCA 201 Conrad Harcourt Way, the Failure reason was due to a communication error. This was corrected by Johnson Control on 1/27/2023, a new cell repeater was installed. This cleared the trouble from the fire panel. (attachment) Compliance will be maintained by Director of Maintenance	07/20/2023

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	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: Reported 1 time out of 3 attempts to the maintenance shop needs trouble shot". Based on interview at the time of record review, the Maintenance Director stated inspection contractor repair documentation may have been e-mailed to the previous Maintenance Director's e-mail account for which he did not have access to but agreed repair documentation on or after 01/04/23 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.			
K 0920 Bldg. 04	NFPA 101 Electrical Equipment - Power Cords and Extens 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) assembles 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 power strips in the Private Office were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used as a substitute for fixed wiring. This deficient practice could affect up to 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., in the Professional Office Building, Private Office, a power strip was being used to power both a dorm style refrigerator and a microwave oven (high power draw equipment). 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.	K 0920	The power strip in the Professional Office Building, Private Office, being used to power both a dorm style refrigerator and a microwave oven has been removed. by Maintenace Department Items are now plugged directly into the wall. Maintenace Director will be responsible for maintaining compliance.	07/10/2023
K 0000 Bldg. 05	A Life Safety Code Recertification Survey was	K 0000		

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	conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. Rush Memorial Hospital consists of the main hospital building (Building 01) and RMH Pain Management (Building 05) which is a detached one story building with no basement. Building 05 is separated from the adjoining bank by a one hour fire barrier separation wall. The RMH Pain Management commenced operation in 2017 and was determined to be of Type II(000) construction, was not sprinklered and has a monitored fire alarm system with smoke detection in the corridor. Building 05 was surveyed with Chapter 38, New Business Occupancies. The hospital has a capacity of 25 and had a census of 6 at the time of this survey. Quality Review completed on 07/06/23			
K 0363 Bldg. 05	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	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. 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. Based on observation and interview, the facility failed to ensure 1 of over 8 corridor doors had no	K 0363	Door latch not functioning on the Lounge Area corridor in the Pain	06/30/2023

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	impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff. Findings include: Based on observations and interview during a tour of the facility with the Project Manager and VP of Cooperate Compliance on 06/26/23 between 9:45 a.m. and 1:50 p.m., the Lounge Area corridor door in the Pain Management Building failed to latch positively into the door frame. 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.		Management building was replaced on 6/30/2023 by the Maintenace Department and is functioning properly. Quarterly checks will be imitated in every department during quarterly safety checks. Maintenance Director is responsible for maintaining compliance.	
K 0000 Bldg. 06	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 485.623(c). Survey Date(s): 06/26/23 & 06/27/23 Facility Number: 005082 Provider Number: 151304 AIM Number: 100269820A At this Life Safety Code survey, Rush Memorial Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 485.623(c), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing	K 0000		

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	Health Care Occupancies. Rush Memorial Hospital consists of the main hospital building (Building 01) and RMH Pediatrics (Building 06) which is a detached one story building with no basement. The RMH Pediatrics commenced operation in 2013 and was determined to be of Type V(000) construction, fully sprinklered and has a monitored fire alarm system with smoke detection in the corridor. Building 06 was surveyed with Chapter 39, Existing Business Occupancies. The hospital has a capacity of 25 and had a census of 6 at the time of this survey. Quality Review completed on 07/06/23			
K 0353 Bldg. 06	NFPA 101 Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in	K 0353	The deficiencies that were found on the fire panel at 1339 N Cherry	08/17/2023

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	accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 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. 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 "Sprinkler System Inspection" documentation dated 07/20/22 for the 1339 North Cherry Street 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 1 dry sprinkler system. The "Deficiencies" section of the 07/20/22 inspection report stated "Panel Condition Deficiency Found Trouble TELCO Line 1". Based on interview at the time of record review, the Maintenance Director stated inspection contractor repair or replace documentation may have been e-mailed to the previous Maintenance Director's e-mail account for which he did not have access to but agreed repair or replace documentation on or after		St.on 7/20/2022 have been corrected by Koorsen . Service was requested and completed 8/17/2022. (attachment) Director of Maintenance will be responsible for maintaining compliance.	

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	07/20/22 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.			