

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2014
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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K020000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/18/14</p> <p>Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Spring Mill Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This fully sprinklered facility located on one wing on the first and second floors of a two story building, plus the first floor of a 2007 wing addition, were determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K020000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. This facility asks that this Plan of Correction and its supporting documentation be considered for desk review for compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>open to the corridors and hard wired detectors in resident sleeping rooms. The facility has a capacity of 54 and had a census of 41 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors leading into hazardous areas such as the kitchen would close and latch into the door frame. This deficient practice could affect 4 or more residents in the main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/18/14 at 1:10 p.m. with the Maintenance Supervisor, the door leading into the kitchen from the main dining room would not close and latch into its door frame. Based on interview on 03/18/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen door would not completely close and latch into the door frame.</p> <p>3.1-19(b)</p>	K020029	<p>K 029 It is the intent of this facility to ensure doors to storage rooms larger than 50 square feet close automatically or upon activation of the fire alarm system. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i> The door leading into the kitchen was repaired allowing for proper closure and latching of door. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i> Any residents in the surrounding area could be affected by this alleged deficient practice. The Director of Plant Operations/designee will assure that doors into hazardous areas close and latch properly. A monthly inspection of fire/smoke doors will be completed with any areas of non-compliance repaired immediately and reported to the Executive Director/designee. <i>What measures will be put into</i></p>	04/10/2014
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			<p><i>place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>Director of Plant Operations (DPO) will complete monthly inspection of doors that open into hazardous areas will be completed and any areas of non-compliance will be repaired immediately and reported to the Executive Director/designee. DPO will report findings to QAA monthly for 3 months. QAA will monitor for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor for 3 months or until 100% compliance is meet.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</i></p> <p>The Director of Plant Operations/designee and/or the Executive Director/designee will report any findings of non-compliance to the monthly Quality Assurance Committee for review. QAA will monitor for 90 days or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed by: 4/10/2014</i></p>	

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K020045 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting in 1 of 9 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any of the 41 residents including visitors and staff if they were required to evacuate out the north exit in an emergency and any of the single bulb outside light fixtures failed would leave the area in darkness.</p> <p>Findings include:</p> <p>Based on observation on 03/18/14 at 2:45 p.m. with the Maintenance Supervisor there was an exit light on generator back up located outside the north exit next to resident room 3100 which had a single bulb fixture only. Based on interview on 03/18/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor the aforementioned exit light was a single bulb fixture only.</p>	K020045	<p>K 045</p> <p>It is the intent of this facility to ensure that lighting in exit means of egress are arranged so the failure of any single lighting fixture does not leave the area in darkness.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i></p> <p>The light fixture at the north exit area near resident room 3100 has been replaced with a 2 bulb fixture.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i></p> <p>Residents exiting the north exit near Resident room 3100 have the potential of being affected by the alleged deficient practice. The Director of Plant Operations/designee has replaced this fixture with a 2 bulb fixture.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>The Director of Plant Operations/designee will continue to monitor all exit lights to assure</p>	04/10/2014
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			<p>approved fixtures in proper working order are in place monthly. Any findings of non-compliance will be corrected and reported to the Executive Director/designee. Director of Plant Operations or designee will report findings to QAA monthly for 90 days. QAA will monitor for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor for 90 days or until 100% compliance is obtained</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</i></p> <p>Any findings of non-compliance will be reported to the Executive Director/designee. These findings and the corrective actions will be submitted to the monthly Quality Assurance Committee for review. QAA will monitor for 90 days or until 100% compliance is obtained. Date systemic changes will be completed by: 4/10/2014</p>		

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K020056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers" states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 14 residents as well as staff or visitors adjacent to the service hall.</p> <p>Findings include:</p> <p>Based on observation on 03/18/14 at 1:40 p.m. with the Maintenance Supervisor, the two sprinkler heads located in the laundry wash room on Service Hall were</p>	K020056	<p>K 056 It is the intent of this facility to ensure that automatic sprinklers are spaced not less than 6 feet on center. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i> One sprinkler head in the laundry room was removed by the facility contracted vendor to meet the spacing requirements of automatic sprinkler heads. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</i> All residents have the potential of being affected by the alleged deficient practice. The Director of Plant Operations/designee will inspect all sprinkled rooms on this</p>	04/10/2014

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	measured to be five feet apart. Based on interview on 03/18/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the two sprinkler heads were less than six feet apart. 3.1-19(b)		<p>campus for compliance and the contracted vendor will return the facility to compliance.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>The DPO/designee will assure that all rooms have sprinkler heads that meet the spacing requirements of not less than 6 feet on the center. Any areas of non-compliance will be corrected by the contracted vendor for compliance. DPO or designee will audit 5 sprinkler heads per week to ensure that space requirement will be meet. DPO or designee will report findings to QAA monthly for 3 months. QAA will monitor for any trends and make recommendations to the Plan of Correction (POC) as needed. QAA will monitor for 3 months or until 100% compliance is obtained.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</i></p> <p>Any findings of non-compliance will be reported to the Executive Director/designee. These findings and the corrective actions will be submitted to the monthly Quality Assurance Committee for review. QAA will monitor monthly for 3 months or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed by: 4/10/2014</i></p>		