STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING **02** B. WING _____	**06/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	**101 W 87TH AVE** **MERRILLVILLE, IN 46410**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code and Pre-Occupancy Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Bed Addition: (Medicare/Medicaid affected rooms already licensed/certified) Eleven beds added to the facility license: One (1) T18/19 bed added, to rooms 2200, 2201, 2203, 2204, 2205, 2206, 2207, 2208, 2211, 2213, & 2215. This brings the skilled nursing certified bed count to 64 from 53. Survey Date: 06/16/2022 Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890 At this Life Safety Code Pre-Occupancy survey, Spring Mill Health Campus was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), 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 and 410 IAC 16.2. Spring Mill Health Campus is a two story skilled nursing facility of Type II (111) construction built in 2007 that is attached to a two story assisted living building of Type V (111) construction that was built in 1998. The skilled nursing facility is separated from the assisted living building by a 2-hour rated fire wall. The skilled nursing building is fully sprinklered and has supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING **02** B. WING _____	**06/16/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 is protected by a 150 kW diesel generator. The facility is has a capacity of 64. All 64 beds are certified for Medicare and 21 beds are dually certified for Medicaid. At the time of the survey, the census was 59. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/17/22	K 000		