STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING -- B. WING	08/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/02/22 Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890 At this Emergency Preparedness survey, Spring Mill Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 62. Quality Review completed on 08/04/22	E 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/02/22	K 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or	

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

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	Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890 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 483.90(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 is protected by a 150-kW diesel generator. The facility has a capacity of 64. All 64 beds are certified for Medicare and 10 (21) beds are dually certified for Medicaid. At the time of the survey, the census was 62. Quality Review completed on 08/04/22		agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 3 of 7 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect 18 residents, 4 staff and 2 visitors. Findings include:	K 0321	K321 NFPA 101 HAZARDOUS AREAS- ENCLOSURE **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/03/2022

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	Based on observations on made during a tour of the facility on 08/02/22 from 09:15 a.m. to 10:40 p.m., the following was noted: a) the facility Administrators office contained large amounts of personal protective equipment. (PPE) Numerous boxes of gloves, gowns, masks, and Covid-19 testing kits were contained on 2 metal shelves were stored therein. This office measured approximately 360 square feet in size and the door to the corridor did not contain a self-closing device on it. b) the Soiled linen room down from the center nurses' station had a self-closing devise installed on it. This door, when tested on three separate occasions, did not fully close or latch into the door frame. This door was adjusted and fix prior to my exiting of the facility. c) the Director of Health Services office contained large amounts of personal protective equipment. (PPE) Numerous boxes of gloves, gowns, masks, and Covid-19 testing kits were contained on 2 metal shelves were stored therein. This office measured approximately 360 square feet in size and the door to the corridor did not contain a self-closing device on it. Based on interview at the time of each observation, the Maintenance Director, the facility Administrator, and the Senior facility Director agreed that the aforementioned rooms containing PPE were hazardous rooms greater than 50 square feet in size and needed to have self-closing devices installed on the corridor doors. During the exit conference with the facility Administrator, the Senior facility Administrator, and the Maintenance Director on 08/02/22 at 1:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · Administrator and DON office PPE supplies were relocated to appropriate combustible storage room with self- closing mechanism. · Soiled linen room door inspected and adjusted to ensure proper closure. This was observed by surveyor before official survey exit. **2) How the facility identified other residents:** · Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Director of Nursing or designee will complete weekly audit for four weeks, then monthly thereafter to ensure proper storage of PPE supplies.	

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			· The Maintenance Director or Designee will inspect doors monthly and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/3/22. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 8/3/22**	