PRINTED: 08/17/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPL	ETED
		155764	B. WING		08/02/	2022
NAME OF	PROVIDER OR SUPPLIEI		STREET	T ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF	PROVIDER OR SUPPLIE	K.		/ 87TH AVE		
SPRING	MILL HEALTH CAI	MPUS	MERF	RILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
E 0000						
Bldg	A E		F 0000	This when of a supertion shall a		
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.		E 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation		
	Survey Date: 08/02	8/02/22 of the plan of corrections does not				
				constitute an admission of or		
	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			agreement with the facts and		
				conclusions set forth in this su	•	
				report Our plan of correction is	S	
				prepared and executed as a means to continuously improv	,,	
				the quality of care and to com		
				with all applicable state and	۳۰,	
				federal regulatory requiremen	ts	
	and Suppliers, 42 C	CFR 483.73		The facility respectfully reques	st	
				paper compliance Thank you	for	
		certified beds. At the time of		your consideration,		
	the survey, the cens	sus was 62.		Paspostfully		
	Quality Review con	mpleted on 08/04/22		Respectfully,		
	Quality Review con	impleted on 00/04/22				
				Kevin Mehay		
				Executive Director		
				Spring Mill Health Campus		
				317-525-3537		
K 0000						
Bldg. 02						
	-	e Recertification and State	K 0000	This plan of correction shall se	erve	
	-	vas conducted by the Indiana		as this facilities' credible alleg	ation	
	_	Ith in accordance with 42 CFR		of compliance Preparation,		
	483.90(a).		1	submission, and implementati	on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Survey Date: 08/02/22

TITLE

constitute an admission of or

submission, and implementation of the plan of corrections does not

(X6) DATE

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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
		155764	B. W	B. WING		08/02/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890				agreement with the facts and		
				conclusions set forth in this survey report Our plan of correction is		-	
						6	
					prepared and executed as a		
					means to continuously improv		
	I -	Code survey, Spring Mill			the quality of care and to com	ply	
	_	s found not in compliance with			with all applicable state and		
	Requirements for P	-			federal regulatory requirement		
		, 42 CFR Subpart 483.90(a),			The facility respectfully reques		
	1	re, and the 2012 edition of the			paper compliance Thank you	IOF	
	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				your consideration,		
					Respectfully,		
	Treatur Care Occupancies and 410 IAC 10.2.				Respectionly,		
	Spring Mill Health Campus is a two-story skilled						
	nursing facility of Type II (111) construction built						
		hed to a two-story assisted					
		ype V (111) construction that			Kevin Mehay		
		The skilled nursing facility is			Executive Director		
		assisted living building by a			Spring Mill Health Campus		
		ıll. The skilled nursing building			317-525-3537		
		and has supervised smoke					
	detection located in	the corridors, spaces open to					
	the corridors and in	resident rooms. The facility is					
	protected by a 150-1	kW diesel generator.					
	The facility has a ca	apacity of 64. All 64 beds are					
	certified for Medicare and 10 (21) beds are dually						
	certified for Medica	aid. At the time of the survey,					
	the census was 62.						
	Quality Review con	npleted on 08/04/22					
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 02	Hazardous Areas						
		are protected by a fire					
		our fire resistance rating					
	1	rated doors) or an					
automatic fire extinguishing system in							

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CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED
		155764	B. WING		08/02/2022
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
	TAG REGULATORY OR LSC IDENTIFYING		TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
	accordance with 8 approved automation is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 galf. Combustible Sto (over 50 square feg. Laboratories (if Hazard - see K322 Based on observation failed to ensure the hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazard - see K322 Based on observation failed to ensure the hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazard - see K322 Based on observation failed to ensure the hazardous areas, sur rooms over 50 square for some over 50 square for some over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 square feg. Laboratories (if Hazardous areas, sur rooms over 50 squ	a.7.1 or 19.3.5.9. When the tic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) mance, and Paint Shops from sexceeding 64 In Rooms lons) orage Rooms/Spaces set) classified as Severe 2) on and interview, the facility corridor door to 3 of 7 ch as combustible storage re feet, soiled linen rooms, and provided with self-closing	K 0321	K321 NFPA 101 HAZARDOU 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 this plan of correction does not this plan of correction do	S 08/03/2022
	r manigs include:			this plan of correction does no	ν

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Event ID:

KBDU21

Facility ID: 010739

If continuation sheet

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155764 B. WING 08/02/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE constitute admission or agreement Based on observations on made during a tour of by the provider of the truth of the the facility on 08/02/22 from 09:15 a.m. to 10:40 facts alleged or conclusions set p.m., the following was noted: forth in the statement of a) the facility Administrators office contained deficiencies. The plan of large amounts of personal protective equipment. correction is prepared and/or (PPE) Numerous boxes of gloves, gowns, masks, executed solely because it is and Covid-19 testing kits were contained on 2 required by the provisions of metal shelves were stored therein. This office federal and state law. measured approximately 360 square feet in size and the door to the corridor did not contain a Immediate actions taken self-closing device on it. for those residents identified: b) the Soiled linen room down from the center nurses' station had a self-closing devise installed Administrator and DON on it. This door, when tested on three separate office PPE supplies were occasions, did not fully close or latch into the relocated to appropriate door frame. This door was adjusted and fix prior to combustible storage room with my exiting of the facility. self- closing mechanism. c) the Director of Health Services office contained Soiled linen room door large amounts of personal protective equipment. inspected and adjusted to ensure (PPE) Numerous boxes of gloves, gowns, masks, proper closure. This was observed and Covid-19 testing kits were contained on 2 by surveyor before official survey metal shelves were stored therein. This office measured approximately 360 square feet in size and the door to the corridor did not contain a 2) How the facility identified self-closing device on it. other residents: Based on interview at the time of each observation, the Maintenance Director, the facility Visitors, staff, and Administrator, and the Senior facility Director residents that reside at the facility agreed that the aforementioned rooms containing have the potential to be affected PPE were hazardous rooms greater than 50 square by the alleged deficient practice. feet in size and needed to have self-closing devices installed on the corridor doors. During the 3) Measures put into place/ exit conference with the facility Administrator, the System changes: Senior facility Administrator, and the Maintenance Director on 08/02/22 at 1:30 p.m., no Director of Nursing or additional information or evidence could be designee will complete weekly

3.1-19(b)

provided contrary to this deficient finding.

of PPE supplies.

audit for four weeks, then monthly thereafter to ensure proper storage

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>02</u> COMPLETED	COMPLETED	
155764 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		
SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET	ON	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		
· 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:		
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		
revise the plan of correction as indicated.		

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