DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
	155764	B. WING	04/26/2021			

26/2021 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 DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 This plan of correction shall serve conducted by the Indiana Department of Health in as this facilities' credible allegation accordance with 42 CFR 483.73. of compliance Preparation, submission, and implementation Survey Date: 04/26/2021 of the plan of corrections does not constitute an admission of or Facility Number: 010739 agreement with the facts and Provider Number: 155674 conclusions set forth in this survey AIM Number: 200856890 report Our plan of correction is prepared and executed as a At this Emergency Preparedness survey, Spring means to continuously improve Mill Health Campus was found in compliance with the quality of care and to comply Emergency Preparedness Requirements for with all applicable state and Medicare and Medicaid Participating Providers federal regulatory requirements and Suppliers, 42 CFR 483.73 The facility respectfully request paper compliance Thank you for The facility has 53 certified beds. At the time of your consideration, the survey, the census was 46. Respectfully, Quality Review completed on 04/28/21 Kevin Mehay **Executive Director** Spring Mill Health Campus 317-525-3537 K 0000 Bldg. 02 A Life Safety Code Recertification and State K 0000 This plan of correction shall serve Licensure Survey was conducted by the Indiana as this facilities' credible allegation Department of Health in accordance with 42 CFR of compliance Preparation, 483.90(a). submission, and implementation of the plan of corrections does not Survey Date: 04/26/2021 constitute an admission of or agreement with the facts and Facility Number: 010739 conclusions set forth in this survey Provider Number: 155674 report Our plan of correction is AIM Number: 200856890 prepared and executed as a

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

TITLE

(X6) DATE

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		JILDING	02	COMPL 04/26/	ETED	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Health Campus was Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupated Spring Mill Health Care Occupated Spring Mill Health Car	A2 CFR Subpart 483.90(a), re, and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Campus is a two story skilled type II (111) construction built thed to a two story assisted type V (111) construction that The skilled nursing facility is assisted living building by a ll. The skilled nursing building and has supervised smoke the corridors, spaces open to resident rooms. The facility 0 kW diesel generator. capacity of 53. All 53 beds are re and 10 beds are dually id. At the time of the survey,		means to continuously improve the quality of care and to compare with all applicable state and federal regulatory requirement. The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	oly s st	
K 0222 SS=D Bldg. 02	be equipped with a requires the use of	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following				

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPLETED	
155764		B. WI	B. WING			04/26/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					B7TH AVE		
SPRING MILL HEALTH CAMPUS				LLVILLE, IN 46410			
OI INING	E HEALIH OAN			WIET VI VII	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	special locking arr	•					
		S OR SECURITY THREAT					
	LOCKING						
	-	king arrangements for the					
	-	eeds of the patient are					
	-	cking device shall be					
		door and provisions shall					
		apid removal of occupants					
	_ ·	l of locks; keying of all					
	-	ied by staff at all times; or e means available to the					
	staff at all times.	e means available to the					
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	.2.2.0, 19.2.2.2.3.1,					
	SPECIAL NEEDS	I OCKING					
	ARRANGEMENT						
	_	king arrangements for the					
	-	e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					
	-	at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
	•	by a complete smoke					
		(or is constantly monitored					
	_	ration within the locked					
	space); and both t	the sprinkler and detection					
		iged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
	Approved, listed d	lelayed-egress locking					
	systems installed in accordance with						
	7.2.1.6.1 shall be	permitted on door					
	assemblies servin	g low and ordinary hazard					
	contents in building	igs protected throughout by					
	an approved, supe	ervised automatic fire					
	detection system or an approved, supervised						

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l f		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			_ 			COMPL	
155764		B. WING 04/26/2021				2021	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			101 W 8	ADDRESS, CITY, STATE, ZIP COD 37TH AVE LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervi system. 18.2.2.2.4, 19.2.2. The facility failed to locking arrangemen with LSC Section 1 19.2.2.2.4 states that means of egress shad or lock that requires the egress side, unless side, unless complying with LSC 7.2.1.6.1(3) state that the lock in the seconds, or 30 secon authority having jurns a force to the releas under all of the follow. The force shall recontinuously applie (c) The initiation of	COLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall C.2.4 BY EXIT ACCESS NGEMENTS It access door locking in C.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an sed automatic sprinkler C.2.4 De ensure the delayed egress atts were installed in accordance 9.2.2.2.4 in 1 of 7 exits. Section at doors within a required all not be equipped with a latch as the use of a tool or key from ass otherwise permitted. C.2.1.6.1 shall be permitted. Attes an irreversible process shall the direction of egress within 15 ands where approved by the arisdiction, upon application of the device required in 7.2.1.5.10	K 02	222	Life Safety Plan of Correction 1. What corrective action(will be accomplished for thoresidents found to have been affected by the deficient practice? The sensor on the Exit Door in therapy gym was adjusted now operates properly. 2. How will facility identify other residents who have the potential to be affected by the same alleged deficient practice? This deficient practice has the potential to affect everyone. 3. What corrective measures.	se n the w	05/05/2021

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	COME	E SURVEY PLETED 6/2021	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE	
TAG	(d) Once the lock happlication of force relocking shall be be deficient practice or residents in the there. Findings include: During a tour of the Administrator, Direct Corporate Facilities #1, and Property M 12:35 p.m., when the doors were pushed irreversible process initiated. This was a Manager #2 and Dithey tested the door observation.	as been released by the to the releasing device, by manual means only. This could affect staff and up to 5 rapy gym. The facility with the factor of Maintenance, The Director, Property Manager fanager #2 on 04/26/2021 at fine 15 second delayed egress fin the Therapy Gym, the for release the lock was not confirmed by Property frector of Maintenance when for at the time of the	TAG	will the facility take or alter to ensure that the problem will not recur. Maintenance staff was on the need for exit do and open properly. A onetime audit was permaintenance to assure doors in facility had this practice. 4. What quality assembler plans will be implement monitor facility performensure corrections are achieved and permanel. Copy of the audits will at QA meetings. All define practices will be correct occur. Maintenance Director/E will inspect all exit door week for 3 months to exproper functionality. 5. By what date the changes will be completed by May 5, 2.	educated ors to alarm erformed by no other sideficient urance nted to mance to eent? be reviewed ficient ted as they Designee so 2 x a noure e systemic leted?	DATE	
K 0232 SS=E Bldg. 02	NFPA 101 Aisle, Corridor, or Aisle, Corridor or	•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, 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	
TAU	2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to protect 1 of 3 corridors in accordance with LSC Section 19.2.3.4(4). LSC 19.2.3.4(4) states that projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect staff and up to 10 residents in the smoke compartment. Findings include: During a tour of the facility with the Administrator, Director of Maintenance, Corporate Facilities Director, Property Manager #1, and Property Manager #2 on 04/26/2021 at 12:50 p.m., a non-wheeled isolation cart was located in the corridor outside of Resident Room	K 0232	Life Safety Plan of Correction 1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice? Wheels were installed on the Isolation Bin. 2. How will facility identify other residents who have the potential to be affected by the same alleged deficient practice? This deficient practice has the potential to affect everyone. 3. What corrective measure will the facility take or will alter to ensure that the problem will not recur? Maintenance Staff was educate on the need for isolation bins to have wheels properly installed.	05/05/2021) e	
	2208. At the time of observation, the Director of Maintenance agreed that the wheels had been removed from the isolation cart.		A onetime audit was performed maintenance to assure no othe isolation bins in facility had this	r	

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

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/26/2021			
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ice was reviewed with the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) deficient practice. 4. What quality assurance plans will be implemented to monitor facility performance ensure corrections are achieved and permanent? Copy of the audits will be revie at QA meetings. All deficient practices will be corrected as a occur. Maintenance Director/Designe will inspect all isolation bins 2 week for 3 months to ensure proper functionality. 5. By what date the system changes will be completed? Systemic changes will be completed? Systemic changes will be completed by May 5, 2021	ewed hey ee x a	(X5) COMPLETION DATE
			l				

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