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	04/26/2021

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: 04/26/2021 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 53 certified beds. At the time of the survey, the census was 46. Quality Review completed on 04/28/21	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: 04/26/2021 Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890	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 agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a	

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

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	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 is has a capacity of 53. All 53 beds are certified for Medicare and 10 beds are dually certified for Medicaid. At the time of the survey, the census was 46. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/28/21		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 0222 SS=D Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following			

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	special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised			

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	automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	The facility failed to ensure the delayed egress locking arrangements were installed in accordance with LSC Section 19.2.2.2.4 in 1 of 7 exits. Section 19.2.2.2.4 states that doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted. Section 19.2.2.2.4 (2) states that delayed-egress locks complying with 7.2.1.6.1 shall be permitted. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.	K 0222	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?** The sensor on the Exit Door in the 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**	05/05/2021

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	(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect staff and up to 5 residents in the therapy gym. 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 12:35 p.m., when the 15 second delayed egress doors were pushed in the Therapy Gym, the irreversible process to release the lock was not initiated. This was confirmed by Property Manager #2 and Director of Maintenance when they tested the door at the time of the observation. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		**will the facility take or will alter to ensure that the problem will not recur?** Maintenance staff was educated on the need for exit doors to alarm and open properly. A onetime audit was performed by maintenance to assure no other doors in facility had this deficient practice. **4. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Copy of the audits will be reviewed at QA meetings. All deficient practices will be corrected as they occur. Maintenance Director/Designee will inspect all exit doors 2 x a week for 3 months to ensure proper functionality. **5. By what date the systemic changes will be completed?** Systemic changes will be completed by May 5, 2021	
K 0232 SS=E Bldg. 02	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width			

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	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 2208. At the time of observation, the Director of Maintenance agreed that the wheels had been removed from the isolation cart.	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 measures will the facility take or will alter to ensure that the problem will not recur?** Maintenance Staff was educated on the need for isolation bins to have wheels properly installed. A onetime audit was performed by maintenance to assure no other isolation bins in facility had this	05/05/2021

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	This deficient practice was reviewed with the Administrator at the time of exit. 3.1-19(b)		deficient practice. **4. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Copy of the audits will be reviewed at QA meetings. All deficient practices will be corrected as they occur. Maintenance Director/Designee will inspect all isolation bins 2 x a week for 3 months to ensure proper functionality. **5. By what date the systemic changes will be completed?** Systemic changes will be completed by May 5, 2021	