DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 155764 B. WING 08/24/2023 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 conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/24/23 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 54. Quality Review completed on 08/28/23 K 0000 Bldg. 02 A Life Safety Code Recertification and State K 0000 Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/24/23 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Lakeithia Webb

Executive Director

09/15/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>02</u> 155764 B. WING			(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLI		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from I National Fire Prot Life Safety Code Health Care Occu Spring Mill Health nursing facility of in 2007 that is atta living building of was built in 1998. separated from the 2-hour rated fire w is fully sprinklered detection located is the corridors and is protected by a 150 The facility has a certified for Medii the census was 54 Quality Review co	d, 42 CFR Subpart 483.90(a), Fire, and the 2012 edition of the ection Association (NFPA) 101, (LSC), Chapter 19, Existing pancies and 410 IAC 16.2. In Campus is a two-story skilled Type II (111) construction built inched to a two-story assisted Type V (111) construction that The skilled nursing facility is e assisted living building by a wall. The skilled nursing building d and has supervised smoke In the corridors, spaces open to In resident rooms. The facility is D-kW diesel generator.			
K 0100 SS=E Bldg. 02	Section 18.1 and that are not addr K-tags, but are d along with the ap NFPA standard on Form CMS-29 Based on observat	ments - Other RKS section any LSC I 19.1 General Requirements essed by the provided eficient. This information, oplicable Life Safety Code or citation, should be included 567. ion and interview, the facility	K 0100	K100- NFPA 101 General	09/08/202
	smoke barrier doo	latching hardware on 1 of 5 rs in the facility. LSC 4.6.12.3 ife safety features obvious to		Requirements The facility requests paper	

R MEDICARE & MEDIC	DR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039		
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	È É		DNSTRUCTION	. ,	
	155764	B. WI	B. WING		08/24/2023	
PROVIDER OR SLIPPLIER STREET ADDRESS, CITY, STATE, ZIP COD						
MILL HEALTH CA	MPUS					
SUMMARY	STATEMENT OF DEFICIENCIE		ID		T	(X5)
			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETIO
REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	DATE
	uired by the Code, shall be			compliance for this citation.		
-				•••••••••••••••••		
practice could affe	et approximately 10 residents			This Plan of Correction is the		
and staff.				center's credible allegation of		
				_		
Findings include:				, .		
_				Preparation and/or execution of	of	
Based on observati	on with the Administrator and					
VP of Regional Op	erations on 08/24/23 between					
U .				ų.		
doors on the second floor near the elevator was provided with latching hardware but fa						
	latching hardware but failed to			_		
	e					
				-		
-				-		
-				federal and state law.		
-				1)Immediate actions taken fo	r	
and VP of Regiona conference.	l Operations during the exit			those residents identified:		
				 Second floor smoke bar 	rier	
3.1-19(b)				doors adjusted and tested for		
				proper function of latching		
				hardware.		
				2) How the facility identified		
				other residents.		
				 Visitors, staff, and 		
				residents that reside at the fac	ility	
				have the potential to be affected	ed	
				by the alleged deficient practic	e.	
				1) Measures put into place	e/	
				System changes:		
				· The Maintenance Direct	or	
				or Designee will inspect smoke	e	
				barrier doors weekly for one m	onth	
	AT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIED MILL HEALTH CAI SUMMARY (EACH DEFICIEN REGULATORY OI the public if not rec either maintained o practice could affec and staff. Findings include: Based on observati VP of Regional Op 12:30 p.m. and 1:3. doors on the second was provided with latch when tested. I of observation, the agreed the smoke d latching devices, bu latching when tested The finding was rec and VP of Regional conference.	AT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER 155764 PROVIDER OR SUPPLIER IDENTIFICATION NUMBER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Administrator and VP of Regional Operations on 08/24/23 between 12:30 p.m. and 1:35 p.m., the set of smoke barrier doors on the second floor near the elevator room was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the VP of Regional Operations agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and VP of Regional Operations during the exit conference.	TO OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MI OF CORRECTION DENTIFICATION NUMBER X2) MI A. BU 155764 NUMARY PROVIDER OR SUPPLIER MILL HEALTH CAMPUS NUMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Administrator and VP of Regional Operations on 08/24/23 between 12:30 p.m. and 1:35 p.m., the set of smoke barrier doors on the second floor near the elevator room was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the VP of Regional Operations agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and VP of Regional Operations during the exit conference.	TO F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CC OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING IS5764 B. WING PROVIDER OR SUPPLIER STREET 101 W MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE ID SUMMARY STATEMENT OF DEFICIENCIE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Administrator and VP of Regional Operations on 08/24/23 between 12:30 p.m. and 1:35 p.m., the set of smoke barrier doors on the second floor near the elevator room was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the VP of Regional Operations agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and VP of Regional Operations during the exit conference. Conference.	AT OF DEFICIENCIES N1) PROVIDERSUPPLIER/CLIA N2) MULTIPLE CONSTRUCTION DECORRECTION DESTIFICATION NUMBER N2) MULTIPLE CONSTRUCTION DESTIFICATION NUMBER NUMA D PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE D PROVIDERS TEAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TGG Compliance for this clistion. The public if not required by the Code, shall be cither maintained or removed. This deficient practice could affect approximately 10 residents and staff. D Preparation and/or execution of this plan of correction does no constitute admission or agreed by the grovisions of agreed the smoke doors were equipped with latching hardware but failed to latch when tested. Preparation and/or execution of the facts alleged or conclusions set forth in the statement of those residents identified: 12:30 pr. and 1:35 pr., the set of smoke barrier and VP of Regional Operations during the exit conference. Second floor smoke barrier and the doors did not properly latching when tested. 3.1-19(b) The finding was reviewed with the Administrator and VP of Regional Operations during the exit conference. Second floor smoke bar doors adjusted and tested for proper function of latching hardware. 3.1-19(b) Stot operations during the exit conference. Second flo	AT OF DEFICIENCIES N1) PROVIDERSUPPLIER CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SI COMMER De CORRECTION IDENTIFICATION NUMBER X2) MULTIPLE CONSTRUCTION X3) DATE SI COMMER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE 08/24/2 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE 08/24/2 MILL HEALTH CAMPUS STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE 08/24/2 SUMMARY STATEMENT OF DEFICIENCIE ID PREPIX Comments and or consensation in the approximately 10 residents and staff. Findings include: ID PREPIX Compliance for this citation. This Plan of Correction of the approximately 10 residents and staff. Findings include: ID Preparation and/or execution of this prepared and/or execution of this plan of correction of dese not 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 execution of the statement of deficiencies. The plan of correction shoce barrier doors do not nerview at the time of observation, the VP of Regional Operations during the exit conference. 1) Immediate actions taken for those residents identified: 3.1-19(b) Staff, and residents that reside at the facility have the potonial tob eaflected by the alleged deficient practice. Vis

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED
		155764	B. WING		08/24/2023
	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	
				87TH AVE	
SPRING	MILL HEALTH CA	MPUS	MERRI	ILLVILLE, IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
IAG	REGULATORIO	R ESC IDENTIFITING INFORMATION	IAG	and monthly thereafter to ens	
				the latching hardware is work	
				properly and will document it	-
				the Preventative Maintenanc	e
				Worksheet. The Maintenance	9
				Director will be re-educated of	
				Preventative Maintenance Pr	-
				by the Administrator designer 9/7/23.	ру
				• The Maintenance Dire	ctor
				is responsible for compliance	
				4)How the corrective action will be monitored:	s
				• The Administrator will	
				review the Preventative	
				Maintenance Worksheets monthly.	
				• The results of these au	ıdits
				will be reviewed in Quality	ion C
				Assurance Meeting monthly to months or until 100% complia	
				is achieved. The QA Commi	
				will identify any trends or pat	
				and make recommendations	
				revise the plan of correction a indicated.	as
				5)Date of compliance: 9/8/2	3
)225	NFPA 101				
S=E	-	nokeproof Enclosures			
ldg. 02	-	nokeproof Enclosures			
		nokeproof enclosures used			
		cordance with 7.2. 4, 19.2.2.3, 19.2.2.4, 7.2			

Event ID: M3HU21 Facility ID: 010739

If continuation sheet Page 4 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERV	VICES
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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	r í	JILDING NG	02	(X3) DATE SURVEY COMPLETED 08/24/2023
	PROVIDER OR SUPPLIE			101 W	address, city, state, zip cod 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETIO DATE
	Based on observat failed to ensure 1 of were in accordance 7.2.1.5.10 requires on a door leaf to b device that has an and is readily oper conditions. This d approximately 10 Findings include: Based on observat facility with the A Operations betwee 08/24/23, the door exit door near the did not completely testing three times of observation, the agreed that the stat the frame and ack	ion and interview, the facility of 4 stairway enclosure doors e with 7.2. LSC Section a latch or other fastening device e provided with a releasing obvious method of operation ated under all lighting efficient practice affects residents and staff. ion during the tour of the dministrator and VP of Regional in 12:30 p.m. and 1:35 p.m. on for the second floor stairwell elevator was self-closing, but a latch into the frame after . Based on interview at the time is VP of Regional Operations inwell door did not latch into nowledged the deficiency. cussed with the VP of Regional dministrator at exit conference.	K 02		 K225- NFPA 101 Stairways as Smokeproof Enclosures 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 constitute admission or agreened 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: The Second-floor stairw door was adjusted to ensure proper closure. 2) How the facility identified other residents: 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: 	nd 09/08/202 of t ment he et

	R MEDICARE & MEDI		-			MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLIE MILL HEALTH CA		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO	N 3F	(X5)
TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) • The Maintenance Dir		COMPLETION DATE
				or Designee will inspect sta doors weekly for one month monthly thereafter to ensure compliance. The Maintenan Director will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated Preventative Maintenance F by the Administrator /design 9/7/23. • The Maintenance Dir is responsible for compliance 4)How the corrective action will be monitored: • The Administrator will review the Preventative Maintenance Worksheets monthly. • The results of these a will be reviewed in Quality Assurance Meeting monthly months or until 100% comp is achieved. The QA Comm will identify any trends or pa and make recommendation revise the plan of correction indicated. 5)Date of compliance: 9/8 /	and ance ance be ce on the Program hee by ector ce. ns I audits for 6 liance hittee atterns s to as	
< 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm Syste Maintenance Fire Alarm Syste	-				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF COR	DEFICIENCIES RRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		02	COMPLETED 08/24/2023	
NAME OF PROVID				101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410		
	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	
A fire in ac com Natio Natio Recci and 9.6.7 Base faile main 9.6.1 teste 70, N Natio 14.2 malf pract Find Base and V betw syste fire a locat inspo being inter Adm is sci on g	ccordance wi plying with the onal Electric onal Fire Ala ords of syste testing are re- 1.3, 9.6.1.5, I ed on record re- d to ensure 1 of that and mainta National Electronic onal Fire Alar .1.2.2 requires a functions shall tice could affee lings include: ed on record re- VP of Regiona- den in the build ected due to the g able to locat view at the tim- inistrator state heduled to be etting the two lings were discover VP of Regiona- den the build ected due to the g able to locat view at the tim- inistrator state heduled to be etting the two lings were discover VP of Regiona-	em is tested and maintained th an approved program he requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. m acceptance, maintenance eadily available. NFPA 70, NFPA 72 eview and interview, the facility of 1 fire alarm systems was ordance with LSC 9.6.1.3. LSC ire alarm system to be installed, and in accordance with NFPA tical Code and NFPA 72, m Code. NFPA 72, Section that system defects and be corrected. This deficient ct all occupants. eview with the Administrator al Operations on 08/24/23 h. and 1:35 p.m., the last fire dated 06/14/23 by the facility's ndicated two duct detectors are ding. The two devices were not is inspection company not is the devices. Based on the of record review, the ed that the fire alarm company out at the facility and will work devices inspected or tested. mussed with the Administrator al Operations at exit conference.	K	0345	 K345 NFPA 101 Fire Alarm System- Testing and Maintenance 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 constitute admission or agreeme 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: The two duct detectors were inspected on 9/7/23. 2) How the facility identified other residents: 		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	ΞY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155764	B. WING		08/24/2023	
NAME OF	PROVIDER OR SUPPLIE	P	STREE	T ADDRESS, CITY, STATE, ZIP	COD	
				V 87TH AVE		
SPRING	G MILL HEALTH CA	MPUS	MERF	RILLVILLE, IN 46410		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	APPROPRIATE	IPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	I	DATE
				· Staff, and resid	ents that	
				reside at the facility ha		
				potential to be affecte		
				alleged deficient prac	-	
				3) Measures put into	nlace/	
				System changes:		
				· The Maintenan	ce Director	
				will be re-educated or	n the	
				Preventative Maintena	ance Program	
				by the Administrator /	designee by	
				9/7/23.		
				• The Maintenan		
				is responsible for com	ipliance.	
				4)How the corrective will be monitored:	actions	
				• The Administra		
				review the Preventativ		
				Maintenance Worksho for compliance.		
				· The results of t	hese audits	
				will be reviewed in Qu	uality	
				Assurance Meeting m	-	
				months or until 100%		
				is achieved. The QA		
				will identify any trends		
				and make recommend revise the plan of corr		
				indicated.		
				5)Date of compliance	e: 9/8/23	
0353	NFPA 101	Maintanayaa ay d				
SS=F	Sprinkler System	 Maintenance and Testing 				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	0NSTRUCTION 02	X3) DATE SURVEY COMPLETED 08/24/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record of facility failed to pro other evidence the s had been inspected LSC 4.6.12.1 requir system required for maintained in accor for the Inspection, T Water-Based Fire P 4.3.1 requires record inspections, tests, and components and sha authority having jur requires that records performed (e.g., inst the organization that results, and the date waterflow alarm det	supply source RKS information on non-required or partial r system.	K 0353	K353 NFPA 101 Sprinkler System- Maintenance and Testing 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 constitute admission or agreen by the provider of the truth of th 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	nent he

NAME OF PI SPRING I (X4) ID	OF CORRECTION	IDENTIFICATION NUMBER	A DUILDING	00	COMPLETED	
SPRING I	155764		A. BUILDING <u>02</u> B. WING		08/24/2023	
(X4) ID	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
	MILL HEALTH CA	MPUS		/ 87TH AVE RILLVILLE, IN 46410		
	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY 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	
	-	5, 5.3.3.1 requires the mechanical		federal and state law.		
		evices including, but not limited				
	-	ngs, shall be tested quarterly.		1)Immediate actions taken for	r	
	-	ne-type and pressure		those residents identified:		
	switch-type waterf	low alarm devices shall be				
	tested semiannually	y. This deficient practice could		Sprinkler Quarterly		
	affect all residents,	, staff, and visitors in the		inspections is current and in		
	facility.			compliance.		
				• The 5-year inspection fo	r	
	Findings include:			the Internal Pipe is scheduled	to	
				be completed on October 12th	and	
	Based on review of the quarterly sprinkler system			October 13, 2023.		
	inspection records	with the Administrator and VP		2) How the facility identified		
	-	tions on 08/24/23 between 10:11		other residents:		
		n., there was no quarterly				
	-	spection report available for		· Staff, Visitors, and		
		(April, May, and June) of 2023.		residents that reside at the fac	ility	
		w at the time of record review,		have the potential to be affected	•	
	-	l Operations stated that the		by the alleged deficient practic		
	-	had conducted two types of				
		ginning of July 2023 which		3) Measures put into place/		
		onducted in lieu of a second		System changes:		
		but was unable to provide				
		a sprinkler inspection during		· The Maintenance Direct	tor	
	the second quarter			or Designee will complete mor		
	and percent quarter			visual inspection of Sprinkler	lany	
	Findings were disc	ussed with the VP of Regional		Heads and monthly inspection	of	
		lministrator at exit conference.		the wet pipe system to include		
	r unu / K			gauges and valves. Inspection		
	3.1-19(b)			will document it on the	-	
	(*)			Preventative Maintenance		
	2. Based on record	review, observation, and		Worksheet. The Maintenance		
		ity failed to maintain 1 of 1		Director will be re-educated or		
		accordance with 19.3.5.3.		Preventative Maintenance Pro		
		lition, 14.2.1 states except as		by the Administrator /designee	•	
		.1 and 14.2.1.4 an inspection of		8/23/23.	· ~ j	
		line conditions shall be				
		years by opening a flushing		· The Maintenance Direct	tor	
		nd of one main and by		is responsible for compliance.		
		er toward the end of one branch				

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023			
	NAME OF PROVIDER OR SUPPLIER		PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE						
SPRING	MILL HEALTH CA	MPUS		MERRI	LLVILLE, IN 46410				
(X4) ID	4) ID SUMMAR	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	'N	(X5)		
PREFIX	[×]	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE PRIATE	COMPLETION		
TAG	TAG REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	of foreign organic	e of inspecting for the presence and inorganic material. This could affect all occupants.			4)How the corrective action will be monitored:	ons			
	Findings include:				The Administrator wi review the Preventative Maintenance Worksheets	II			
		view with the Administrator Il Operations on 08/24/23			monthly.				
	between 10:11 a.m Annual report date Healthcare portion floor and pump roc inspection. The iter the inspection. Bas tour of the facility p.m. with the Adm Operations, a tag le indicated the last in completed 01/2018 of record review an Regional Operation the deficiency and pipe inspection wa Findings were disc and VP of Regional	a. and 12:28 p.m., the Sprinkler d 07/06/23 stated that the of the building of the second om were due for an internal pipe m was listed as a deficiency of ed on observation during a between 12:30 p.m. and 1:35 inistrator and VP of Regional ocated on the sprinkler riser internal pipe inspection was 8. Based on interview at the time and observation, the VP of ns stated they were unaware of was unaware if the internal s completed or not. ussed with the Administrator al Operations at exit conference.			 The results of these will be reviewed in Quality Assurance Meeting monthly months or until 100% comp is achieved. The QA Comr will identify any trends or pa and make recommendation revise the plan of correction indicated. 5)Date of compliance: 10/ 	y for 6 liance nittee atterns s to n as			
. 0918 SS=C Bldg. 02	Electrical System System Maintena The generator or source and assoc of supplying servi 10-second criterio monthly test, a pr annually confirm	s - Essential Electric Syste s - Essential Electric ince and Testing other alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUILDING B. WING	construction <u>02</u>	(X3) DATE SURVEY COMPLETED 08/24/2023
	PROVIDER OR SUPPLII MILL HEALTH CA		101 V	t address, city, state, zip cod V 87TH AVE RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	switches are per NFPA 110. Generator sets a exercised under year in 20-40 da once every 36 m Scheduled test u a complete simu automatic or mai loads, and are co personnel. Maint energy power so accordance with circuit breakers a program for perio components is e manufacturer rec of maintenance a and readily avail and circuits are n and separate fro Minimizing the p emergency powe consideration for 6.4.4, 6.5.4, 6.6. NFPA 111, 700. 1. Based on record facility failed to en generators was all period after a load 2012 NFPA 99 rec generator serving to be in accordance for Emergency an Chapter 8. NFPA Shutdown require minutes shall be p the Emergency Por	e generator and transfer formed in accordance with are inspected weekly, load 30 minutes 12 times a y intervals, and exercised bonths for 4 continuous hours. Inder load conditions include lated cold start and nual transfer of all EES onducted by competent tenance and testing of stored purces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and a odically exercising the stablished according to quirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, m normal power circuits. ossibility of damage of the er source is a design new installations. 4 (NFPA 99), NFPA 110, 10 (NFPA 70) d review and interview, the nsure 1 of 1 emergency owed a 5 minute cool down It test. Chapter 6.4.4.1.1.4(a) of quires monthly testing of the the emergency electrical system the with NFPA 110, the Standard d Standby Powers Systems, 110, 6.2.10 Time Delay on Engine is that a minimum time delay of 5 rovided for unloaded running of ower Supply (EPS) prior to elay provides additional engine	К 0918	K918 NFPA 101 Electrical Systems- Essential Electric System 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 no	of

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER				02	COMPLETED			
		155764	B. WIN	G	08/24		1/2023	
JAME OF	PROVIDER OR SUPPLIE		<u> </u>	STREET .	ADDRESS, CITY, STATE, ZIP COD			
					87TH AVE			
SPRING	6 MILL HEALTH CA	MPUS		MERRI	LLVILLE, IN 46410			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		DR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		me delay shall not be required			constitute admission or agree			
		or less) air-cooled prime movers.			by the provider of the truth of t			
	-	ctice could affect all residents,			facts alleged or conclusions se	et		
	as well as staff and			forth in the statement of				
				deficiencies. The plan of				
	Findings include:			correction is prepared and/or				
					executed solely because it is			
	Based on record re			required by the provisions of				
	-	al Operations on 08/24/23			federal and state law.			
		n. and 12:28 p.m., the Generator						
	Checklist form do			1)Immediate actions taken for	or			
	-	at least 30 minutes under load,			those residents identified:			
	however, there wa	s no documentation on the form						
	-	enerator had a cool down time			 The Generator Load Ba 	ink		
	following its load	test. Based on interview at the			Test checklist form was updat	ed		
	time of record revi	iew, the VP of Regional			to include recording of cool do	wn		
	Operations stated	that the forms used are			time, load percentage and tran	nsfer		
	templates from the	e company who does servicing			time to the alternate power			
	for the generator.	They further stated that they			source.			
		under load weekly and						
	confirmed cooldov	wn times have not been			2) How the facility identified			
	recorded on the sh	eets provided and those were			other residents:			
	the only generator	sheets available during record						
	review.				 Staff, and residents that 	t		
					reside at the facility have the			
	This finding was r	eviewed with the Administrator			potential to be affected by the			
	and VP of Region	al Operations at the exit			alleged deficient practice.			
	conference.							
					3) Measures put into place/			
	3.1-19(b)				System changes:			
		l review and interview, the						
	-	xercise the generator for 12 of 12			The Maintenance Direc	tor		
		e requirements of NFPA 110,			or Designee will complete			
	2010 Edition, the			Generator weekly inspection a				
		ystems, Chapter 8.4.2. Section			monthly 30 minutes under load			
		generator sets in service shall			testing and will document on t	he		
	be exercised at lea			Preventative Maintenance				
		ng one of the following			Worksheet. The Maintenance	;		
	methods:				Director will be re-educated or	n the		
	(1) Loading that m	naintains the minimum exhaust			Preventative Maintenance Pro	ogram		

Event ID:

M3HU21 Facility ID: 010739

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AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP COE 87TH AVE ILLVILLE, IN 46410)	-1
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETIC DATE
	gas temperatures a manufacturer (2) Under operatin not less than 30 per Power Supply) nat Section 8.4.2.3 stat installations that d 8.4.2 shall be exer EPSS (Emergency shall be exercised loads at not less that nameplate kW ratif and at not less that nameplate kW ratif total test duration of hours. This deficie occupants. Findings include: Based on review of documentation with Operations and Act 12:28 p.m. on 08/2 show the actual load powered generator on interview at the Regional Operation runs under load wo provided at the tim the load percentag This finding was r and VP of Regional conference. 3.1-19(b) 3. Based on record facility failed to do	s recommended by the g temperature conditions and at rcent of the EPS (Emergency meplate kW rating. tes diesel-powered EPS o not meet the requirements of cised monthly with the available Power Supply System) load and annually with supplemental an 50 percent of the EPS ng for 30 continuous minutes a 75 percent of the EPS ng for 1 continuous hour for a of not less than 1.5 continuous ent practice could affect all f generator load testing th the VP of Regional luministrator from 10:11 a.m. to 24/23, the load information to ad percentage for the diesel was not documented. Based e time of record review, the VP of ns stated that the generator eekly, however documentation ne of the survey did not show		by the Administrator /des 9/7/23. The Maintenance I is responsible for complia 4)How the corrective ac will be monitored: The Administrator review the Preventative Maintenance worksheets The results of these will be reviewed in Qualit Assurance Meeting mont months or until 100% cor is achieved. The QA Cor will identify any trends or and make recommendati revise the plan of correct indicated. 5)Date of compliance: \$	Director ance. tions will monthly. audits y thly for 6 mpliance mmittee patterns ons to ion as	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		x1) provider/supplier/clia identification number 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLI		101 V	t address, city, state, zii V 87TH AVE RILLVILLE, IN 46410	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	alternate power su service within 10	12 months to ensure the apply was capable of supplying seconds. This deficient practice sidents, staff and visitors.				
	Findings include:					
	a.m. and 12:28 p.1 Operations and A Checklist docume reviewed and lack power to emergen the time of record Operations indica under load on a w on the Generator of survey. She furthe transfer times wer only documentation	eview on 08/24/23 between 10:11 m. with the VP of Regional dministrator, the Generator ntation over the past year was ted the transfer time from normal cy power Based on interview at review, the VP of Regional ted that the generator runs eekly basis and is documented Checklist sheets provided at the er acknowledged that the e missing and stated that's the on available at record review. cussed with the VP of Regional dministrator at exit conference.				
K 0920	3.1-19(b) NFPA 101					
SS=E Bldg. 02	Electrical Equipr Extens Electrical Equipr Extension Cords Power strips in a used for compor patient-care-rela (PCREE) assem assembled by qui the conditions of the patient care non-PCREE (e.g.	nent - Power Cords and nent - Power Cords and patient care vicinity are only tents of movable ted electrical equipment bles that have been ualified personnel and meet 10.2.3.6. Power strips in vicinity may not be used for g., personal electronics), rm care resident rooms that				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLI		101 W	f address, city, state, zip cod / 87TH AVE RILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE	
	meet UL 1363A for non-PCREE (outside of vicini non-patient care other UL standa used with genera- cords are not us wiring of a struct temporarily are r completion of the installed and me 10.2.3.6 (NFPA (NFPA 70), 590. Based on observa failed to ensure 1 not used multi-plu fixed wiring. LSC and equipment sh 70, National Elect Edition, Article 44 specifically permi shall not be used a a structure. This d approximately 2 s residents. Findings include: Based on observa Operations and A between 12:30 p.1 Services Office co powering equipm time of observatio Operations agreed use.	EE. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms ty) meet UL 1363. In rooms, power strips meet rds. All power strips are al precautions. Extension ed as a substitute for fixed ure. Extension cords used removed immediately upon e purpose for which it was ets the conditions of 10.2.4. 99), 10.2.4 (NFPA 99), 400-8 3(D) (NFPA 70), TIA 12-5 tion and interview, the facility of 1 Social Services office did ag adaptors as a substitute for e 9.1.2 requires electrical wiring all be in accordance with NFPA trical Code. NFPA 70, 2011 00.8 requires that, unless tted, flexible cords and cables as a substitute for fixed wiring of deficient practice affects taff and an unknown number of the with the VP of Regional dministrator on 08/24/23 n. and 1:35 p.m., the Social ontained a multi-plug adaptor ent. Based on interview at the on, the VP of Regional d a multi-plug adaptor was in	К 0920	 K920 NFPA 101 Electrical Equipment- Power Cords and Extension Cords 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 constitute admission or agreen by the provider of the truth of th 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: 	of hent he t	

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE		
SPRING	MILL HEALTH CA	MPUS	MERR	ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETIC DATE	
	3.1-19(b)			• The Multi-plug adaptor v removed from the Social Servi Office.		
				2) How the facility identified other residents:		
				• 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:		
				• The Maintenance Direct or Designee will complete visu weekly inspection audit tool to ensure multi-plug adaptor are in use.	al	
				• IDT will be re-educated the use of power cords and extension cords and multi-plug adaptors.		
				• The Maintenance Direct will be re-educated on the Preventative Maintenance Pro by the Administrator /designee 9/7/23.	gram	
				• The Maintenance Direct is responsible for compliance.	or	
				4)How the corrective actions will be monitored:		
				• The Administrator will review the Preventative		

PARTMENT OF HEALTH AND HUN NTERS FOR MEDICARE & MEDICA	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 <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023	
NAME OF PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410		
PREFIX (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 APPROPR DEFICIENCY) Maintenance worksheets mo • The results of these at will be reviewed in Quality Assurance Meeting monthly months or until 100% compli- is achieved. The QA Commi will identify any trends or pat and make recommendations revise the plan of correction a indicated. 5)Date of compliance: 9/8/2	INTE DATE DATE	

M3HU21 Facility ID: 010739

If continuation sheet

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