

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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K020000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/21/13</p> <p>Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This fully sprinklered facility located on one wing on the first and second floors of a two story building, plus the first floor of a 2007 wing addition, were determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in all resident</p>	K020000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>rooms, in corridors and in spaces open to the corridors. The facility has the capacity for 58 and had a census of 46 at the time of this survey.</p> <p>All areas accessible to residents and areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/26/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings through the smoke barrier walls and ceilings in 2 of 6 smoke compartments were maintained to provide the smoke resistance of the smoke barrier. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling including interstitial spaces. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, be protected so that the space between the penetrating item and the smoke barrier shall be filled with an approved material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient</p>	K020025	<p>K 025 It is the intent of this facility to ensure that openings through the smoke barrier walls and ceilings are maintained to provide the smoke resistance of the smoke barrier. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The penetration was sealed. The wall was repaired. The penetration was sealed. The escutcheon was replaced and the ceiling was sealed. The penetration was sealed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents in the area of a firewall with an open smoke barrier could be affected. The Director of Plant Operations/designee will monitor these repairs to assure compliance. What measures will be put into place or what systemic changes will be made to ensure</p>	12/06/2013			

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	<p>could affect visitors, staff, and 10 or more residents in the smoke compartment adjacent to the facility services area and the second floor center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/21/13 between 12:20 p.m. and 4:00 p.m., unsealed penetrations were found:</p> <ul style="list-style-type: none"> a. In the elevator equipment room, measuring one half and three fourths inch around two conduits through the ceiling; b. In the corridor wall near the housekeeping storage room measuring three fourths inch by six inches; c. In the kitchen where wires penetrating the ceiling and wall gapped one inch; d. Behind dryers in the laundry where the escutcheon was missing from a sprinkler head and and a ceiling conduit penetration left a half inch gap; e. In the second floor soiled utility room where two conduits left half inch gaps into the attic space above the ceiling. <p>The maintenance director acknowledged at the time of observations, the penetrations had not been properly sealed.</p>		<p>that the deficient practice does not recur: The Director of Plant Operations has visually inspected all fire wall areas for open penetrations and sealed any open areas. The DPO/designee will monitor any future work/repairs made in a firewall area to assure no open smoke penetrations are created. The DPO/designee will repair any open areas and report those findings to the Executive Director/designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Any findings of non-compliance will be reported to the Executive Director/designee. These findings and the corrective action will be reported to the Quality Assurance Committee for review. Date systemic changes will be completed by 12/6/2013.</p>				

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	3.1-19(b)			

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K020029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 doors to hazardous areas, such as a storage rooms larger than 50 square feet, closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, and 4 or more staff in the facility services smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/21/13 at 1:20 p.m., the corridor door to the 144 square foot central nursing supply office and storage room could not self close and latch into the door frame because the self closer had been dismantled. The room was equipped with six foot shelving units filled with plastic, paper and cardboard wrapped supplies. The maintenance director said at the time of observation, he was unaware the self closer had been</p>	K020029	K 029 It is the intent of this facility to ensure doors to storage rooms larger than 50 square feet close automatically or upon activation of the fire alarm system. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The closure to the central nursing supply office was repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any residents in the surrounding area could be affected by this alleged deficient practice. The Director of Plant Operations/designee will assure that any area larger than 50 square feet established for temporary/permanent storage is equipped with an automatic closure. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DPO/designee will include storage area door closures in their routine monthly door inspections. How the corrective action(s) will be	12/06/2013			

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	disconnected. 3.1-19(b)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Any findings of door closure non-compliance will be reported to the Executive Director/designee. Any findings of non-compliance and the corrective action will be reported to the monthly Quality Assurance Committee for review. Date systemic changes will be completed by 12/06/2013.		

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K020038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/21/13 between 12:30 p.m. and 4:00 p.m., all eight emergency exit doors for the first and second floors were equipped with electromagnetic locks which released after fifteen seconds but lacked the proper signage. The maintenance director acknowledged at the time of observations, the doors released after 15 seconds but the signs were missing.</p>	K020038	<p>K 038 It is the intent of this facility to ensure that doors equipped with electromagnetic locks have approved signage placed adjacent to the lock. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Signs have been installed on all doors missing approved signage. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential of being affected by the alleged deficient practice. The Director of Plant Operations/designee will monitor all doors monthly to assure that proper signage is in place on doors equipped with electromagnetic locks. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DPO/designee will include proper signage is in place on doors with electromagnetic locks in the routine monthly door inspections. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>	12/06/2013			

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	3.1-15(b)		Any findings of non-compliance will be reported to the Executive Director/designee. These findings and the corrective actions will be submitted to the monthly Quality Assurance Committee for review. Date systemic changes will be completed by 12/06/2013.		

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K020051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 1 of 4 first floor smoke compartments, was properly separated from a wall. LSC Chapter 9 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.4.3.1 requires spot type smoke detectors shall be located on the ceiling not less than four inches from a sidewall to the near edge. This deficient practice could affect visitors, staff, and 10 or more residents in the first floor smoke compartment near the entrance.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K020051	<p>K 051 It is the intent of this facility to ensure that smoke detectors connected to the fire alarm system are properly separated from walls. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The smoke detector in room 3100 has been moved to meet compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Residents on the 3000 Hall have the potential to be affected by this alleged deficient practice. All rooms on the 3000 Hall were inspected to assure all smoke detectors were in</p>	12/06/2013			

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	<p>maintenance director on 11/21/13 at 1:05 p.m., the ceiling mounted smoke detector installed in resident room 3100 was located two inches from the meeting edge of the wall and ceiling. The maintenance director acknowledged at the time of observation, the smoke detector was closer than the minimum distance required from the wall.</p> <p>3.1-19(b)</p>		<p>compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Director of Plant Operations/designee will do visual observations for smoke detector compliance during regular room preventive maintenance checks. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Any concerns of non-compliance will be reported to the Executive Director/designee. Any concerns and their corrective action will be presented to the monthly Quality Assurance Committee meeting for review. Date systemic changes will be completed by 12/06/2013.</p>		

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K020076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure a resident room in 1 of 6 smoke compartments used to store oxygen was separated by construction with a one hour fire resistance rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects staff, visitors and 10 or more residents on the second floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/21/13 at 2:15 p.m., one liquid oxygen container (181 L capacity) was observed with a nasal cannula attached in resident room 2213. The resident's caregiver said at the time of</p>	K020076	K 076 It is the intent of this facility to ensure that oxygen is not stored in areas not designated for oxygen storage. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The liquid oxygen container was removed from room 2213. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any resident who is not on routine oxygen use with an oxygen container stored in that room has the potential of being affected by this alleged deficient practice. An audit of residents on PRN oxygen will be completed to assure no oxygen containers are stored in the resident room. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses and Department Managers were	12/06/2013

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	<p>observation, the oxygen was not in use but the resident had it available if he should need it. The charge nurse was interviewed on 11/21/13 at 2:25 p.m. She said the resident had not required oxygen since a return from the hospital "a month ago". She acknowledged the tank was being stored in the room. The door separating the room from the corridor was rated for 20 minutes.</p> <p>3.1-19(b)</p>		<p>in-serviced on observing resident rooms for oxygen containers being stored in resident rooms. Nurses/Department Managers will report any oxygen containers located in resident rooms and not in use to the Director of Nursing/designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Any report of non-compliance will be reported to the Executive Director/designee and reported to the monthly Quality Assurance Committee for review. Date systemic changes will be completed by 12/06/2013.</p>		

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K020144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the emergency generator equipment with the maintenance director on 11/21/132 at 2:30 p.m., a remote emergency shut off device was not found. The maintenance supervisor said at the time of observation, there was no remote emergency shut off for the generator.</p> <p>3.1-19(b)</p>	K020144	<p>K 144 It is the intent of this facility to ensure that emergency generators are equipped with a remote manual stop. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: A remote manual stop has been installed on the noted emergency generator. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents of the main building could be affected by this alleged deficient practice. A remote manual stop has been installed on the noted emergency generator. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: This facility maintains two emergency generators. Emergency remote shut offs are now installed on both generators. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: This facility emergency generators are inspected and tested semi-annually. This test</p>	12/06/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			will include the testing of the manual remote shut offs. Any non-compliance concerns will be reported to the Executive Director/designee and reviewed at the monthly Quality Assurance Committee meeting. Date systemic changes will be completed by 12/06/2013.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
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K020147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/21/13 at 2:00 p.m., an extension cord was piggybacked to a power strip to supply power to office equipment in the MDS office. The maintenance director said at the time of observation, the arrangement had not been approved for use.</p> <p>3.1-19(b)</p>	K020147	<p>K 147 It is the intent of this facility to ensure that flexible cords are not used as a substitute for fixed wiring. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The cords have been removed from office on the 100 hall. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents in this area could be affected by this alleged deficient practice. All rooms have been inspected to assure no other flexible cords are in use. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff has been in-serviced on the importance of not using extension cords as a replacement for fixed wiring. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Department supervisors are assigned rooms to monitor during week days and any areas of non-compliance will be reported to the Executive Director/designee in the daily</p>	12/06/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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			morning stand up meetings. Any findings of non-compliance and the corrective action will be presented to the monthly Quality Assurance meeting for review. Date systemic changes will be completed by 12/06/2013.	