CENTERS FOI	R MEDICARE & MEDIC		_		ONID NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		154020	B. WING		01/30/2025	
	PROVIDER OR SUPPLIEF		8555 T	ADDRESS, CITY, STATE, ZIP COD AFT ST ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	· · ·	
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
A 0000						
Bldg. 00	This visit was for a Recertification survers of Survey: 1 and 1/31/2025  QA: 2/4/2025	rey.	A 0000			
A 0700	482.41					
Bldg. 00	and maintained to patient, and to pro and treatment and	be constructed, arranged, ensure the safety of the byide facilities for diagnosis d for special hospital ate to the needs of the	A 0700	To correct the outlined	02/29/2025	
	Dagad on absorpation	on managed marriages and	A 0700	To correct the outlined	02/28/2025	
		on, record review, and		deficiencies the following		
	1	ty failed to ensure non-hospital eptacles in 16 of 16 sleeping		actions were taken:		
	~	at least annually; failed to		grade receptacles were installed	ed in	
		e written record of monthly		all 16 sleeping rooms.	EU III	
	_	ng for 6 of 12 months; failed		Emergency Power/Generator		
		instructed in the use of the		load testing – The Director of		
		appression system in 1 of 1		Facilities conducted training w		
		rovide an approved method for		all maintenance personnel to	14.1	
		ppliances to where they were		review the step-by-step		
		ood extinguishing equipment		procedures for conducting the		
		istalled for 1 of 1 kitchen hood		weekly inspection and monthly	,	
		ms; failed to maintain 1 of 1		load testing of the generator.		
		ng system in accordance with		Additionally, the documentatio	n	
		for Ventilation and Fire		and recording procedures were	<b>I</b>	
		nercial Cooking Operations;		also reviewed with all responsi		

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

TITLE

(X6) DATE

Rachel Bakaitis VP of Accreditation & Quality 03/18/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		154020	B. W	ING		01/30/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R		8555 TA			
REGION	AL MENTAL HEAL <sup>-</sup>	TH CENTER			LLVILLE, IN 46410		
TEGIOIV	TE WENT TE TIET			WENT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f 1 electric fire pump was			members.		
		for 12 of 12 months over the			Fire Suppression System		
		ance with NFPA 25; failed to			Training – The Director of		
	-	system inspections in			Facilities conducted training w	ith	
		FPA 25; failed to conduct fire			all kitchen, maintenance,		
		1 of 4 quarters and 2 shifts for 2			housekeeping and security sta		
	of 4 quarters.				on the procedures for manuall	-	
					activating the fire suppression		
					system in the kitchen. Trainin	-	
	Findings Include:				included an overview of the fir	е	
		ect of these systemic problems			extinguishing devices in the		
		ity's inability to ensure it had			kitchen (fire extinguisher, fire		
		emic plan of correction to			blanket, dry-chemical fire		
	-	therefore failing to ensure the			suppression system in range l		
		health care in a safe			and fire sprinkler system), as v		
	environment.				as actions to take in case of a	fire	
					in the kitchen which included		
					manual activation of the range		
					hood suppression system and		
					evacuation of the space.		
					Fire Suppression Manual		
					Activation Device – The fire		
					suppression contractor comple	ea	
					the relocation of the manual		
					activation device for the range		
					hood fire suppression system	ω	
					lower the device to 46 inches	, the	
					above finish floor. Additionally		
					contractor realigned the spray		
					nozzles for the system above	ıı ı <del>C</del>	
					gas range to ensure they are positioned correctly.		
					Method of Returning Cooking	<b>a</b>	
					Appliances – Yellow duct tape	_	
					was placed on the floor in fron		
					the range in the kitchen and	l OI	
					training conducted with kitcher	n	
					staff so they know to replace t		
					range in the proper location af		
					cleaning or moving the range.		
					l organing of moving the range.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 154020	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/30/2025		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  8555 TAFT ST  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE OR ACTION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
IAU	REGULATORY OF	R LSC IDENTIFYING INFORMATION	IAG	Fire Pump Inspections – The Director of Facilities conducted training with responsible maintenance staff in the procedures for conducting and recording the monthly fire pum test.  Kitchen Extinguishing System The Director of Facilities conducted training with responsible maintenance staff the procedures for conducted a recording weekly sprinkler gau and valve inspections.  Sprinkler System Inspections The fire sprinkler service comp conducted a visual inspection all sprinkler heads throughout facility. They identified that the only area in the building with quick-response sprinkler heads was in Pod – B where the FQH is located. The FQHC was bui out in 2016/2017 and the date stamp on the sprinkler heads show the heads to be from 201 Consequently the 20-year sprinkler head inspection is du 2037. Additionally, the contract took standard response sprinkler heads to be sent to the lab to conduct the 50-year sprinkler hispection.  Fire Drills – The deficiency was previously identified during our internal audit process and subsequently reported to the Corporate Safety and Risk Committee. In response, the	p m - in and ge s - pany of the e s HC illt if. e in ctor ler head		

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Event ID:

JRWJ11

Facility ID: 005184

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Director of Facilities has

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PRINTED: 03/25/2025

EPARTMENT OF HEALTH AND HUN	FORM APPROVED					
ENTERS FOR MEDICARE & MEDICA	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 <u>00</u>	COMPLETED			
	154020	B. WING	01/30/2025			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER		8555 TAFT ST				
DECIONAL MENTAL HEALT	TH CENTED	MEDDILLVILLE IN 46410	MEDDILLVILLE IN 46440			

REGION	AL MENTAL HEALTH CENTER	MERR	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	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE				
			developed a Corrective Action Plan to address this issue and is actively implementing the plan to ensure ongoing compliance.  How the deficiencies will be prevented from reoccurring:  Electrical Systems – the completed invoice and specification sheets for the hospital grade outlets have been retained for audit and/or documentation purposes.  Emergency Power/Generator load testing – Both the weekly inspection and monthly generator load testing was inputted into our Computerized Maintenance Management Software (CMMS) as a Monthly PM to ensure future monthly tests are completed correctly and on time.  Fire Suppression System  Training – A review of these procedures will be conducted with appropriate staff during the quarterly fire drills. The Facility Manager will be responsible for training of any new staff throughout the year as necessary.  Fire Suppression Manual  Activation Device – device lowered to 46" above the finished floor which now meets regulation; completed invoice/documentation retained for records.  Method of Returning Cooking  Appliances – A permanent line to be painted on the kitchen floor.  The Facility Manager will be responsible for training of any new				

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Event ID:

JRWJ11 Facility ID: 005184

If continuation sheet

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

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 154020		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 01/30/2025					
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
REGION	AL MENTAL HEALT	TH CENTER	8555 TAFT ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX		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 APPROPRIA	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	staff throughout the year as	DATE		
				necessary.  Fire Pump Inspections – A			
				monthly PM was created and			
				added to our CMMS program ensure compliance moving	to		
				forward.			
				Kitchen Extinguishing Syste			
				A weekly PM was created and added to our CMMS program			
				ensure compliance moving			
				forward.			
				Sprinkler System Inspection A PM was created in our CMM			
				program to ensure that require			
				testing of these heads are			
				completed in 2036. Additional	lly,		
				the contractor took standard			
				response sprinkler heads to b	е		
				sent to the lab to conduct the 50-year sprinkler head inspec	tion		
				Documentation for the 50-yr	don.		
				sprinkler head inspection will	be		
				retained and a PM was create	ed for		
				2035 to ensure that follow on			
				10-year sprinkler heads are to	ested		
				as required.  Fire Drills – A comprehensive			
				schedule for the completion o			
				fire drills has been formulated			
				the Director of Facilities.			
				Furthermore, automatic remin			
				have been set up in Smartshe and the Director of Facilities	eet		
				examines these reports to cor	nfirm		
				that the drills have been			
				completed. Additionally, over	sight		
				is provided by the Corporate			
				Safety Committee.			

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Event ID:

JRWJ11 Facility ID: 005184

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 154020	(X2) MULTIPLE C A. BUILDING B. WING		
	PROVIDER OR SUPPLIE		8555 T	ADDRESS, CITY, STATE, ZIP COD TAFT ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
				Person Responsible – Direct Facilities	or of
A 0701	482.41(a)	OF PUNCHOAL PLANT			
Bldg. 00	The condition of to overall hospital endeveloped and m	OF PHYSICAL PLANT the physical plant and the nvironment must be aintained in such a manner d well-being of patients are			
	Based on observati interview; the facil grade electrical recomms were tested Health Care Faciliti 6.3.4.1.3 states rechospital-grade, at plocations where de anesthesia is admir intervals not excee Section 6.3.2.2, Re Rooms requires the receptacle shall be The continuity of the electrical receptacl polarity of the hot each electrical receptacl receptacles) shall be ounces); and failed record of monthly 12 months. Chapte requires monthly the emergency electrical receptacles with N Emergency and States. NFPA 110 8.4.2 sets shall be exercise.	ity failed to ensure non-hospital reptacles in 16 of 16 sleeping at least annually. NFPA 99, ries Code 2012 Edition, Section reptacles not listed as patient bed locations and in rep sedation or general ristered, shall be tested at ding 12 months. Additionally, receptacle Testing in Patient Care rephysical integrity of each confirmed by visual inspection. The grounding circuit in each reshall be verified. Correct and neutral connections in reptacle shall be confirmed; and the grounding blade of each re (except locking-type repeated to the standard for an accordance of the generator load testing for 6 of re 6.4.4.1.1.4(a) of 2012 NFPA 99 resting of the generator serving retrical system to be in FPA 110, the Standard for andby Powers Systems, Chapter red at least once a month with a load for 30 minutes or until the	A 0701	To correct the outlined deficiencies the following actions were taken:  Electrical Systems – hospital grade receptacles were install all 16 sleeping rooms.  Emergency Power/Generator load testing – The Director of Facilities conducted training wall maintenance personnel to review the step-by-step procedures for conducting the weekly inspection and monthly load testing of the generator. Additionally, the documentation and recording procedures were also reviewed with all responsimembers.  How the deficiencies will be prevented from reoccurring:  Electrical Systems – the completed invoice and specification sheets for the hospital grade outlets have be retained for audit and/or documentation purposes.  Emergency Power/Generator load testing – Both the weeklinspection and monthly generator load testing was inputted into	red in redith  y on re sible  een r y ator

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Event ID:

JRWJ11 Facility ID: 005184

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 154020		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 01/30/2025			ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 8555 TAFT ST 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE	
	stabilized. Chapter written record of in exercising period, a be regularly mainta	and the oil pressure have 6.4.4.2 of NFPA 99 requires a spection, performance, and repairs for the generator to ined and available for athority having jurisdiction.		Computerized Maintenance Management Software (CMM a Monthly PM to ensure future monthly tests are completed correctly and on time. Person Responsible – Direct Facilities	e		
	Facilities on 01/28/ the facility's 16 slee non-hospital-grade on records review of 1:53 p.m., no annua for non-hospital gra been conducted. Th aware of the require grade electrical record not have documenta Based on record rev Facilities on 01/28/ documentation for t incomplete. Docum for July 2024 throug completed and lack under load, and load from the documenta under load during th interview at the tim of Facilities agreed information was do maintenance technic	on with the Director of 2025 from 1:57 p.m. to 4:30 p.m., eping rooms contained electrical receptacles. Based on 01/28/2025 from 9:45 a.m. to all electrical receptacle testing and electrical receptacles had be Director of Facilities was not ement to test non-hospital eptacles and stated they diduction of any inspection. Wiew with the Director of 2025 from 9:45 a.m. to 1:53 p.m., the monthly load tests were dentation for monthly load tests gly December 2024 was not ed Transfer time, time rand dipercentage. It was not clear action if the generator was run hose months. Based on an electron of any inspection and electron and stated a new cian had started to perform the the time the information was					
A 0709	482.41(b) LIFE SAFETY FR	OM FIRE					
Bldg. 00	Life Safety from F						

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Based on observation, record review, and

Event ID:

JRWJ11

A 0709

Facility ID: 005184

To correct the outlined

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02/28/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		154020	B. WI	NG		01/30/	2025
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DECION	A. NACNITAL LICAL	THEENTED		8555 TA			
REGION	AL MENTAL HEAL	IH CENTER		MEKKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interview, the facili	ty failed to ensure staff were			deficiencies the following		
	instructed in the use	e of the UL 300 hood fire			actions were taken:		
	suppression system	in 1 of 1 kitchen. NFPA 96,			Fire Suppression System		
	Standard for Ventil	ation Control and Fire			Training - The Director of		
	Protection of Comn	nercial Cooking Operations,			Facilities conducted training w	ith	
	Section 10.5.7 state	es instruction shall be provided			all kitchen, maintenance,		
	to employees regard	ding the proper use of portable			housekeeping and security sta	ıff	
	fire extinguishers as	nd the manual activation of			on the procedures for manuall	y	
	fire-extinguishing e	equipment. Section 11.1.4 states			activating the fire suppression		
	instructions for mar	nually operating the fire			system in the kitchen. Training	g	
	extinguishing system	m shall be posted			included an overview of the fire	е	
	conspicuously in th	e kitchen and shall be			extinguishing devices in the		
	reviewed with empl	loyees by management. This			kitchen (fire extinguisher, fire		
	deficient practice co	ould affect kitchen staff only;			blanket, dry-chemical fire		
	failed to provide an	approved method for			suppression system in range h	nood	
	returning cooking a	ppliances to where they were			and fire sprinkler system), as v	vell	
	when the kitchen ho	ood extinguishing equipment			as actions to take in case of a	fire	
	was designed and in	nstalled for 1 of 1 kitchen hood			in the kitchen which included		
	extinguishing system	ms. NFPA 96 Standard for			manual activation of the range		
		and Fire Protection of			hood suppression system and		
	Commercial Cookii	ng Operations Section 2011			evacuation of the space.		
		1.2.2*Cooking appliances			Fire Suppression Manual		
		shall not be moved, modified,			Activation Device – The fire		
		out prior re-evaluation of the			suppression contractor comple	eted	
		ystem by the system installer			the relocation of the manual		
		unless otherwise allowed by			activation device for the range		
	_	re extinguishing system.			hood fire suppression system	to	
		e fire-extinguishing system			lower the device to 46 inches		
	_	evaluation where the cooking			above finish floor. Additionally	, the	
		ed for the purposes of			contractor realigned the spray		
		eaning, provided the			nozzles for the system above	the	
		rned to approved design			gas range to ensure they are		
	*	oking operations, and any			positioned correctly.		
		xtinguishing system nozzles			Method of Returning Cooking	_	
		iances are reconnected in			Appliances – Yellow duct tape		
		e manufacturer's listed design			was placed on the floor in fron	t of	
		.1.2.3.1 An approved method			the range in the kitchen and		
	-	nat will ensure that the			training conducted with kitcher		
		ed to an approved design			staff so they know to replace t		
	location; failed to n	naintain 1 of 1 kitchen			range in the proper location af	ter	

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Event ID: JRWJ11 Facility ID: 005184

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETI	ED
		154020	B. W	ING		01/30/20	25
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	2			AFT ST		
BECION	A. NACNITAL LICAL	TH CENTED					
REGION	AL MENTAL HEAL	IN CENTER		MEKKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	extinguishing system	m in accordance with NFPA			cleaning or moving the range.		
	96, Standard for Ve	ntilation and Fire Protection of			Fire Pump Inspections - The	:	
	Commercial Cookii	ng Operations, Section 10.5.1			Director of Facilities conducte	d	
	states A readily acc	essible means for manual			training with responsible		
	activation shall be l	ocated between 42 in. and 48			maintenance staff in the		
	in. above the floor,	be accessible in the event of a			procedures for conducting and	b	
	fire, be located in a	path of egress, and clearly			recording the monthly fire pun	np	
	identify the hazard	protected. Additionally, NFPA			test.		
		de, 4.6.12.3 states that existing			Kitchen Extinguishing Syste	m –	
	life safety features of	obvious to the public, if not			The Director of Facilities		
	required by the code	e, shall be either maintained or			conducted training with		
	removed; failed to e	ensure 1 of 1 electric fire pump			responsible maintenance staff	fin	
	was inspected mont	thly for 12 of 12 months over			the procedures for conducted	and	
	the past year in acco	ordance with NFPA 25. NFPA			recording weekly sprinkler gau	uge	
		ne Standard for the Inspection,			and valve inspections.		
	_	enance of Water-Based Fire			Sprinkler System Inspection	s –	
		, 8-3.1.2 requires electric			The fire sprinkler service com	pany	
	_	umps shall be operated			conducted a visual inspection	of	
		locument sprinkler system			all sprinkler heads throughout	the	
	_	dance with NFPA 25. NFPA			facility. They identified that th	е	
		Inspection, Testing, and			only area in the building with		
		ter-Based Fire Protection			quick-response sprinkler head	ls	
	1 -	ion, Section 5.2.4.2 states			was in Pod B where the FQH0	C is	
		sprinkler systems shall be			located. The FQHC was built	out	
	1 -	ensure that normal air and			in 2016/2017 and the date sta	-	
	_	being maintained. Section			on the sprinkler heads show the	ne	
	5.1.2 states valves a	-			heads to be from 2017.		
		e inspected, tested, and			Consequently the 20-year		
		dance with Chapter 13.			sprinkler head inspection is du		
		tes Table 13.1.1.2 shall be			2037. Additionally, the contra		
	_	on, testing and maintenance of			took standard response sprink	der	
		onents and trim. Section 4.3.1			heads to be sent to the lab to		
		be made for all inspections,			conduct the 50-year sprinkler	head	
		nce of the system and its			inspection.		
		all be made available to the			Fire Drills - The deficiency wa		
		risdiction upon request; failed			previously identified during ou	r	
	_	ocumentation or other			internal audit process and		
	_	response sprinkler heads were			subsequently reported to the		
		fter 20 years. LSC 4.6.12.1			Corporate Safety and Risk		
	requires any device	, equipment or system required			Committee. In response, the		

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JRWJ11 Facility ID: 005184

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		154020	B. W	ING		01/30/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t		8555 TA			
REGION	AL MENTAL HEAL	TH CENTER			LLVILLE, IN 46410		
I LOION	AL MILINIAL HLAL			IVILIXIXII	LL VILLE, IIN 70710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	•	this code be maintained in			Director of Facilities has		
		plicable NFPA requirements.			developed a Corrective Action	Plan	
		hall be properly maintained in			to address this issue and is		
		FPA 25, Standard for the			actively implementing the plan	ı to	
		, and Maintenance of			ensure ongoing compliance.		
		rotection Systems. NFPA 25,			How the deficiencies will be		
		ds shall be made for all			prevented from reoccurring:		
	_	nd maintenance of the system			Fire Suppression System		
		all be made available to the			Training – A review of these	***	
	, ,	risdiction upon request. 4.3.2			procedures will be conducted	with	
	_	s shall indicate the procedure			appropriate staff during the		
		pection, test, or maintenance),			quarterly fire drills. The Facilit	-	
	_ ~	at performed the work, the			Manager will be responsible fo	or	
	· ·	e. NFPA 25, 5.3.1.1.1.3			training of any new staff		
	l -	tured using fast-response			throughout the year as necess	sary.	
		been in service for 20 years			Fire Suppression Manual		
	_	r representative samples shall			Activation Device – device		
		etested at 10-year intervals;			lowered to 46" above the finish		
		re drills on 1 shift for 1 of 4			floor which now meets regulat		
	_	s for 2 of 4 quarters. LSC			completed invoice/documenta	tion	
		s shall be conducted quarterly			retained for records.		
		iliarize facility personnel			Method of Returning Cooking	_	
	,	intenance engineers, and			Appliances – A permanent lin		
	1	) with the signals and			be painted on the kitchen floor	•.	
	1 -	equired under varied			The Facility Manager will be		
	conditions.				responsible for training of any	new	
			1		staff throughout the year as		
					necessary.		
					Fire Pump Inspections – A		
	Findings include:		1		monthly PM was created and	to.	
	rindings include:				added to our CMMS program	ເບ	
	Rosed on observation	on and interview with the	1		ensure compliance moving		
		es on 01/28/2025 from 1:57 p.m.			forward.	m	
		-	1		Kitchen Extinguishing Syste		
	_	chen was provided with a UL ession system. Based on			A weekly PM was created and		
	* *	•			added to our CMMS program	เด	
		ur of the kitchen, the Kitchen			ensure compliance moving		
		ed what she would do if there			forward.	_	
		derneath the hood. She stated			Sprinkler System Inspection		
	a list of things she v	would do but failed to mention	1		A PM was created in our CMM	15	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/30/2025 154020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **8555 TAFT ST** REGIONAL MENTAL HEALTH CENTER MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE activating the fire suppression system. When she program to ensure that required was asked if she knew what the pipes with nozzles testing of these heads are above the stove were, she was aware that it was completed in 2036. Additionally, the contractor took standard the fire suppression system but was not familiar with the location of the pull station to activate the response sprinkler heads to be system. Based on interview the Director of sent to the lab to conduct the Facilities acknowledged the kitchen staff needed 50-year sprinkler head inspection. required training. Documentation for the 50-yr sprinkler head inspection will be Based on observation and interview with the retained and a PM was created for Director of Facilities on 01/28/2025 from 1:57 p.m. 2035 to ensure that follow on to 4:30 p.m., cooking appliances including a gas 10-year sprinkler heads are tested burner stove were located under the hood in 1 of 1 as required. kitchen were not provided with an approved Fire Drills - A comprehensive method that would ensure that the appliances schedule for the completion of all were returned to an approved design location fire drills has been formulated by after they had been moved for maintenance and the Director of Facilities. cleaning. Based on interview with the Furthermore, automatic reminders Maintenance Director, he was not aware of any have been set up in Smartsheet method or procedure in place. and the Director of Facilities examines these reports to confirm Based on observation and interview with the that the drills have been Director of Facilities on 01/28/2025 from 1:57 p.m. completed. Additionally, oversight to 4:30 p.m., the ANSUL "Remote Pull Station" is provided by the Corporate was mounted 59 1/2 inches above the floor as Safety Committee. measured with the surveyor's tape measure. Based on interview at time of observation, the Director of Person Responsible – Director of Facilities acknowledged the measurement and **Facilities** stated he believed it should be "grand-fathered". Based on observation with the Director of Facilities on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the sprinkler riser room, had an electric motor driven fire pump in operation for the sprinkler system. Based on an interview with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., the facility failed to provide documentation of monthly inspections of the electric motor driven fire pump. Documentation of quarterly sprinkler system inspections indicated the vendor

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		154020	B. W	ING		01/30/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R		8555 TA			
REGION	AL MENTAL HEAL	TH CENTER			LLVILLE, IN 46410		
TREGION	,			WILLY	LEVILLE, IIV 40410		
(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 APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rterly inspections, included					
	_	ectric motor driven fire pump;					
		nentation of inspections was					
	_	2 months including January					
		uary 2024, April 2024, May 2024,					
	November 2024.	2024, October 2024 or					
	November 2024.						
	Based on record res	view with the Director of					
		2025 from 9:45 a.m. to 1:53 p.m.,					
		provided indicating					
		tlers but did not include what					
		ekly sprinkler gauge inspection					
	documentation for 52 of 52 weeks was not						
	available for review	v. In addition, inspection					
	documentation for a	all sprinkler system control					
	valves was also not	available for review. Based					
	on observation on 0	01/28/2025 from 1:57 p.m. to					
	4:30 p.m., the facili	ty had a wet and a dry-sprinkler					
	system. Based on ir	nterview with the Director of					
		wledged the documents that					
	_	not show that valve or gauge					
	inspections had bee	en completed.					
		view with the Director of					
		2025 from 9:45 a.m. to 1:53 p.m.,					
		ne sprinkler system failed to					
		sprinkler heads were last ed. Based on observation on					
		57 p.m. to 4:30 p.m., the facility					
		nse and fast-response					
	_	sed on interview the Director					
		the building was built in 1977					
		e when the sprinklers were last					
	tested or replaced.	and optimized were rade					
	a replaced.						
	Based on record rev	view with the Director of					
	Facilities on 01/28/	2025 from 9:45 a.m. to 1:53 p.m.,					
		document fire drills conducted					
		he first quarter of 2024, the					
	I		1				

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

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 154020	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/30/2025	
NAME OF PROVIDER OR SUPPLIER REGIONAL MENTAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  8555 TAFT ST  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  second and third shifts of the second quarter of  2024 and the second and third shifts of the third quarter of 2024. Based on interview at the time of record review, the Director of Facilities stated the facility was aware that fire drills had not been conducted on each shift for each quarter. The facility had documented a plan to ensure fire drills were completed when required.		PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

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