STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155852	A. BUILDING -- B. WING	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON SPRINGS HEALTH CAMPUS	871 PACER DRIVE NW CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/20/2024 Facility Number: 013702 Provider Number: 155852 AIM Number: 300018569 At this Emergency Preparedness survey, Harrison Springs Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 58 certified beds. At the time of the survey, the census was 46. The requirement at 42 CFR, Subpart 483.73 is MET as evidenced by: Quality Review completed on 03/21/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/20/2024 Facility Number: 013702 Provider Number: 155852 AIM Number: 300018569	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ryan Morton	Executive Director	04/02/2024

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.

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	At this Life Safety Code survey, Harrison Springs Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 58 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered. Quality Review completed on 03/21/24			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story			

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	non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on observation and interview, the facility failed to maintain the building construction type in 1 of 1 Soiled Linen Holding rooms in the 200 hall. This deficient practice could affect staff. Findings include: Based on observations during a tour of the facility on 03/20/2024 between 12:30 p.m. and 2:04 p.m. with the Director of Plant Services and Facilities Management Support, a 1/4 inch penetration was located in the soiled linen holding room in the 200 hallway around metal piping. Based on interview at the time of observation, the Director of Plant Services agreed there was a penetration in the wall	K 0161	K 161 Building Construction Type and Height 1. Director of Plant Operations repaired ¼ inch fire penetration located in 200 hall soiled linen closet. 3-21-24 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that all penetrations into the building structure must have an approved firestop penetration	03/21/2024

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	and provided the measurement. This finding was reviewed with the Executive Director, Director of Plant Services, and Facilities Management Support at the exit conference. 3.1-19(b)		system per tag K161. 4. As a quality measure, the Director of Plant Operations will ensure any penetration into the building structure will be inspected in house. DPO will also monitor any outside contractors that initiate work at the facility. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators	K 0345	K 345 Fire Alarm System – Testing and Maintenance 1. Director of Plant Operations is now utilizing visual semi-annual fire alarm system audit inspection form. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that all fire system-related equipment is to be visually	04/02/2024

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	c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review with the Director of Plant Services on 03/20/2024 between 9:15 a.m. and 12:30 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Director of Plant Services stated he did not know the location of the paperwork for the visual semi-annual inspection of the fire alarm system. This finding was reviewed with the Executive Director, Director of Plant Services, and Facilities Management Support at the exit conference. 3.1-19(b)		inspected semi-annually in house per tag K345. Education was provided by Life Safety surveyor. 3-20-24 4. As a quality measure, the Director of Plant Operations will ensure that all fire system-related equipment will be visually inspected semi-annually. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to ensure 2 of 6 sprinkler heads under the Health Care carport and 1 of 1 sprinkler head outside at the emergency exit near room 111 covered with rust/corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect any resident, staff, or visitor while under the front porch/car port overhang. Findings include: Based on observations during a tour of the facility on 03/20/2024 between 12:30 p.m. and 3:04 p.m. with the Director of Plant Services and Facilities Management Support, two corroded sprinkler heads were located under the Health Care carport and one corroded sprinkler head was located on the outside of emergency exit near room 111. Based on interview at the time of observations, the Director of Plant Services agreed the sprinkler heads were corroded.	K 0353	K 353 Sprinkler System – Maintenance and Testing 1. The Director of Plant Operations contacted our fire sprinkler contractor to come and replace three corroded fire sprinkler heads found during our Life Safety survey. Contractor to replace three corroded fire sprinkler heads 4-10-24. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that all fire sprinkler heads shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage per tag K353. If any sprinkler head meets the mentioned criteria they shall be replaced with a new sprinkler head in a timely manner. 4. As a quality measure, the Director of Plant Operations will ensure that all fire sprinkler heads are visually inspected both in house and by a qualified fire sprinkler contractor at least quarterly. Any findings will be reviewed at least quarterly and	04/10/2024

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	This finding was reviewed with the Executive Director, Director of Plant Services, and Facilities Management Support at the exit conference. 3.1-19(b)		ongoing in the campus Quality Assurance Performance Improvement meetings.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments			

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	there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 resident sleeping room door for room 301 could close completely and latch into the door frame. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observation during a tour of the facility on 03/20/2024 between 12:30 p.m. and 2:04 p.m. with the Director of Plant Services and Facilities Management Support, the door to room 301 would not latch into the door frame. Based on interview at the time of the observation, the Director of Plant Services agreed the door to room 301 would not latch into the door frame. This finding was reviewed with the Executive Director, Director of Plant Services, and Facilities Management Support at the exit conference. 3.1-19(b)	K 0363	K 363 Corridor- Doors 1. The Director of Plant Operations adjusted and repaired resident sleeping room door for room 301. The door located at room 301 now closes and latches as it should. 3-21-24 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that all resident sleeping room doors must completely close and latch to the door frame per code K363. 4. As a quality measure, the Director of Plant Operations will ensure that all resident sleeping room doors close and latch to door frames. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	03/21/2024
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to			

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	another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/tranfilling location was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect all residents, staff and visitors while in the smoke compartment. Findings include: Based on observation with the Director of Plant Services and Facilities Management Support during a tour of the facility on 03/20/2024 from 12:30 p.m. to 2:04 p.m., the oxygen storage/tranfilling room had four liquid oxygen containers and seven E cylinders. Based on interview at the time of observation, the Director of Plant Services was able to enter the room and close the door, but agreed it was not possible to transfill in the room with the door closed. This finding was reviewed with the Executive Director, Director of Plant Services, and Facilities Management Support at the exit conference.	K 0927	K 927 Gas Equipment – Transfilling Cylinders 1. The Director of Plant Operations removed one large oxygen container located in the oxygen room to accommodate safe transfilling by facility clinical staff. 3-21-24 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that there is adequate space in the Oxygen room to safely transfill with the door closed per code K927. 4. As a measure of ongoing compliance, the DPO/Designee will complete routine daily rounds to ensure that the Oxygen room has adequate space for clinical staff to safely transfill cylinders while the door is closed.	03/21/2024

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	3.1-19(b)			