STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155777	A. BUILDING -- B. WING	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

(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: 11/09/22 Facility Number: 012285 Provider Number: 155777 AIM Number: 201006770 At this Emergency Preparedness survey, Creasy Springs 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 71 certified beds. At the time of the survey, the census was 63. Quality Review completed on 11/17/22	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on November 9, 2022.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/09/22 Facility Number: 012285 Provider Number: 155777 AIM Number: 201006770 At this Life Safety Code survey, Creasy Springs Health Campus was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Rife	Executive Director	12/02/2022

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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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors spaces open to the corridors and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 63 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/17/22		survey visit with exit on November 9, 2022.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure the means of egress in 1 of 5 corridors was continuously maintained free of obstructions. This deficient practice could affect as many as 18 residents, 4 staff. and 2 visitors. Findings include:	K 0211	The Director of Plant Operations has removed all three drawer carts not on wheels from the corridors. The Director of Plant Operations was educated by Executive Director on K-211, NFPA 101,	11/23/2022

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	Based on observations made during a tour of the facility on 11/09/22 at 2:54 p.m. with the Director of Plant Operations (DPO) and the Facilities Management Support (FMS) person, there was a small three drawer cart immediately outside resident room #203. This cart was not on wheels and when it was noticed by the FMS person, he immediately opened the cart and placed the plastic wheels on the bottom of it. Based on an interview at the time of the observation, the (FMS) stated that many of these small drawer carts were brand new and that staff does not always remember to take the wheels out and mount them to the bottoms of them when they are placed in use. This deficiency was discussed at the exit conference with the DPO, the Supervising DPO, and the FMS person at the exit conference. 3.1-19(b)		2012 Means of Egress. Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/119.2.2 through 18/19.2.11, 18.2.1, 19.2.1, 7.1.10.1 The Director of Plant Operations will audit each corridor for obstructions to means of egress 1 X Daily X 30 days Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect over 18 residents, 4 staff and 2 visitors if needing to exit the facility.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen was installed in accordance with	K 0355	The Director of Plant Operations has relocated the 55-gallon trash that obstructed the K Class Fire	11/23/2022

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	NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect as many as 5 staff in the kitchen. Findings include: Based on observations made during a tour of the facility on 11/09/22 at 3:55 p.m. with the Director of Plant Operations (DPO) and the Facilities Management Support (FMS) person, the K Class portable fire extinguisher located in the kitchen was obstructed by a 55-gallon trash can. Based on interview at the time of observation, the FMS person acknowledged the fire extinguisher located in the kitchen was blocked and moved the 55-gallon trash container to another location in the kitchen. This deficiency was was discussed at the exit conference with the DPO, the Supervising DPO, and the FMS person at the exit conference. 3.1-19(b)		Extinguisher. The Director of Plant Operations and Kitchen staff were educated on Portable fire extinguishers, NFPA 101, Portable fire extinguishers are, selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10. The Director of Plant Operations will audit the K-Class fire extinguisher located in the kitchen for obstructions 1 X Daily x 4 weeks Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice would affect as many as 5 staff in the kitchen.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure all fire dampers within the facility were inspected and	K 0521	The Director of Plant Operations scheduled damper testing with contractor to be completed	11/23/2022

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	provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 11/09/22 at 2:14 p.m. with the Director of Plant Operations (DPO) and the Facilities Management Support (FMS) person, a current Fire / Smoke Damper Maintenance Record could not be located for review. The most recent damper testing that could be located was completed in 2016 and was well over the four-year requirement in NFPA 80. The lack of current four-year maintenance conducted on all the facility fire and smoke dampers within the facility		11/14/22. The Director of Plant Operations was educated by the Executive Director on NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years. The Director of Plant Operations will review results of the damper testing with the Executive Director. Results of this review will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors within the facility.	

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	was acknowledged by the DPO and the FMS person during record review. The DPO then stepped out of the conference room and returned a short time later to state that the testing had been scheduled and would be completed within the next week. It was noted during a tour of the facility that numerous air inlets and outlets had stickers showing that the dampers were located therein and had been inspected in 2016. This deficiency was discussed at the exit conference with the DPO, the Supervising DPO, and the FMS person on 11/09/22 at 5:16 p.m. 3.1-19(b)			