STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155776	A. BUILDING -- B. WING	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHILL VILLAGE	1001 E SPRINGHILL DR TERRE HAUTE, IN 47802

(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: 09/12/22 Facility Number: 012188 Provider Number: 155776 AIM Number: 200958030 At this Emergency Preparedness survey, Springhill Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 99 certified beds. At the time of the survey, the census was 80. Quality Review completed on 09/13/22	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	
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: 09/12/22 Facility Number: 012188 Provider Number: 155776 AIM Number: 200958030 At this Life Safety Code survey, Springhill Village was found not in compliance with Requirements	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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. The facility was a one story building determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 99 and had a census of 80 at the time of this survey. All areas with customary access to residents were sprinklered. Two detached buildings used for nursing supply, storage, and maintenance storage were not sprinklered. Quality Review completed on 09/13/22			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			

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	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 17 residents and staff near room 303. Findings include: Based on a observation with the Maintenance Director on 09/12/22 during a tour of the facility between 12:15 p.m. and 1:10 p.m., an unsealed penetration was discovered in the smoke barrier wall above the drop ceiling near Resident Room 303. Four wires were running through the barrier wall that had been fire stopped in the past, but the fire stop had pulled away from the barrier. Based on interview at the time of observation, the Maintenance Director agreed the penetration was not sealed and stated that he believed this was done by surveillance camera contractors.	K 0372	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Room 303 and residents and staff in this location could have been impacted. Upon identification of fire wall penetration, facility maintenance corrected immediately. Contracted work is in the final stages of completion, this being part of their project. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. All facility residents and staff could be impacted. 2. Upon completion of contracted work the area will be visually inspected by facility maintenance to ensure all aspects of the job are complete. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? 1. Facility maintenance will visually inspect each area of contracted work ie..fire barriers are intact to code. This will be documented at the completion of contracted work. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	09/12/2022

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		quality assurance program will be put into place? 1. QAPI audit tool, Contracted Vendor Inspections, will be utilized with each fire barrier service provided. This document will be kept and presented in QAPI when applicable.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:	K 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Door was inspected on 7/14/22 by facility maintenance, overlooked separate binder where completed forms were located. Binder now labeled and with the Life Safety Binder. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. The facility has only 1 oxygen door in the facility requiring inspection. 2. The Door Inspection binder with this information was inadvertently overlooked when providing information to the surveyor. This binder has now been clearly labeled and will be made available to the surveyor upon his request. Providing the required documents with this POC. What measures	09/12/2022

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	(1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 10 residents and staff. Findings include: Based on record review and interview with the Maintenance Director on 09/12/22 between 9:40 a.m. and 12:05 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour of the facility with the Maintenance Director, the Oxygen Transfilling room has one fire door assembly. Based on interview at the time of records review		will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? 1. Binder now clearly labeled and will be provided with the Life Safety Code binder for future inspections at the time of the visit. 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? 1. This fire door to the oxygen room is inspected annually and is up to date, last inspection 7/14/22, documentation provided. This documentation is located in the Door Inspection Binder and marked when completed in the TELS system listed as O2 room in Fire Door Inspections. TELS is used as the Quality Assurance Compliance monitor and notifies at each and next intervals of inspections so we can remain compliant and always up to date on requirements. ED will monitor required door inspection compliance utilizing TELS for this annual requirement.	

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	and observation, the Maintenance Director stated the annual fire door inspection did not include the Oxygen Transfilling room and he would add it to the annual fire door inspection tasks. The finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			