Lakeithia Webb

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

09/15/2023

AND PLAN OF CORRECTION IDENTIFICATION NUMB		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY  COMPLETED  08/24/2023	
	PROVIDER OR SUPPLIER		101 W 8	ADDRESS, CITY, STATE, ZIP COD 37TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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	
E 0000						
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 08/24/23		E 0000			
	Facility Number: 08/24 Facility Number: 0 Provider Number: 2008	10739 155674				
	Mill Health Campus Emergency Prepare	Preparedness survey, Spring s was found in compliance with dness Requirements for caid Participating Providers FR 483.73				
	the survey, the cens					
K 0000	Quality Review con	npleted on 08/28/23				
DI-I 00						
Bldg. 02	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000			
	Survey Date: 08/24	/23				
	Facility Number: 0 Provider Number: 1 AIM Number: 2008	155674				
		Code survey, Spring Mill found not in compliance with				
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE	

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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**Executive Director** 

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SU COMPLE 08/24/2	TED
	PROVIDER OR SUPPLIEF		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	Life Safety from Find National Fire Protect Life Safety Code (In Health Care Occupations). Spring Mill Health nursing facility of Time 2007 that is attact living building of Time was built in 1998. The separated from the 2-hour rated fire was is fully sprinklered detection located in the corridors and in protected by a 150-th facility has a carefified for Medical certified for Medical the census was 54.	articipation in 42 CFR Subpart 483.90(a), re, and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Campus is a two-story skilled Type II (111) construction built hed to a two-story assisted the skilled nursing facility is assisted living building by a ll. The skilled nursing building and has supervised smoke the corridors, spaces open to resident rooms. The facility is kW diesel generator.  Apacity of 64. All 64 beds are are and 10 (21) beds are dually and the time of the survey,				
K 0100 SS=E Bldg. 02	Section 18.1 and that are not addre K-tags, but are de along with the app	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, slicable Life Safety Code or tation, should be included				
	Based on observation failed to maintain la smoke barrier doors	on and interview, the facility atching hardware on 1 of 5 in the facility. LSC 4.6.12.3 in the facility features obvious to	K 0100	K100- NFPA 101 General Requirements  The facility requests paper		09/08/2023
	requires existing III	c sarcty reatures obvious to	I	The facility requests paper	l	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/24/2023	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD V 87TH AVE	
SPRING	MILL HEALTH CAN	//PUS	MERRILLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
		uired by the Code, shall be		compliance for this citation	
		removed. This deficient tapproximately 10 residents		This Plan of Commontion is the	
	and staff.	t approximately 10 residents		This Plan of Correction is the center's credible allegation o	
				compliance.	
	Findings include:			Preparation and/or execution	n of
	Based on observation	on with the Administrator and		this plan of correction does n	
		erations on 08/24/23 between		constitute admission or agree	
	_	p.m., the set of smoke barrier		by the provider of the truth of	
	doors on the second floor near the elevator room was provided with latching hardware but failed to			facts alleged or conclusions a forth in the statement of	sei
	latch when tested. Based on interview at the time			deficiencies. The plan of	
		VP of Regional Operations		correction is prepared and/or	
	-	oors were equipped with		executed solely because it is	
	latching devices, but latching when tested	t the doors did not properly		required by the provisions of federal and state law.	
	latening when tester	.i.		rederal and state law.	
	_	riewed with the Administrator		1)Immediate actions taken t	for
	and VP of Regional conference.	Operations during the exit		those residents identified:	
	conference.			Second floor smoke ba	arrier
	3.1-19(b)			doors adjusted and tested for	r
				proper function of latching	
				hardware.	
				2) How the facility identified	ı
				other residents:	
				· Visitors, staff, and	
				residents that reside at the fa	-
				have the potential to be affect	
				by the alleged deficient pract	ice.
				1) Measures put into place	ce/
				System changes:	
				· The Maintenance Dire	ctor
				or Designee will inspect smo	ke
				barrier doors weekly for one	month

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE S COMPLE 08/24/2	ETED
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
				and monthly thereafter to the latching hardware is we properly and will document the Preventative Maintena Worksheet. The Maintena Director will be re-educated Preventative Maintenance by the Administrator design 9/7/23.  The Maintenance Discreptive act will be monitored:  The Administrator will be monitored:  The Administrator will be monitored:  The Administrator will be review the Preventative Maintenance Worksheets monthly.  The results of these will be reviewed in Quality Assurance Meeting month months or until 100% continuents	vorking nt it on ance ance ed on the e Program gnee by  Director ince.  tions  will  e audits y hly for 6 npliance mmittee patterns ons to on as	
K 0225 SS=E Bldg. 02	Stairways and Sm Stairways and Sm as exits are in acc	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2. , 19.2.2.3, 19.2.2.4, 7.2				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	failed to ensure 1 or	on and interview, the facility f 4 stairway enclosure doors with 7.2. LSC Section	K 0	225	K225- NFPA 101 Stairways at Smokeproof Enclosures	nd	09/08/2023
	7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation				The facility requests paper compliance for this citation.		
	and is readily opera	ted under all lighting ficient practice affects			This Plan of Correction is the center's credible allegation of compliance.		
	Findings include:				Preparation and/or execution of this plan of correction does no		
	Based on observation during the tour of the facility with the Administrator and VP of Regional Operations between 12:30 p.m. and 1:35 p.m. on				constitute admission or agreed by the provider of the truth of t facts alleged or conclusions so	the	
	exit door near the edid not completely	for the second floor stairwell levator was self-closing, but latch into the frame after			forth in the statement of deficiencies. The plan of correction is prepared and/or		
	of observation, the agreed that the stair	Based on interview at the time VP of Regional Operations well door did not latch into owledged the deficiency.			executed solely because it is required by the provisions of federal and state law.		
	Findings were discu	ussed with the VP of Regional ministrator at exit conference.			1)Immediate actions taken for those residents identified:	or	
	3.1-19(b)	ininistrator at Carl Conference.			<ul> <li>The Second-floor stairw door was adjusted to ensure proper closure.</li> </ul>	rell	
					2) How the facility identified other residents:		
					<ul> <li>Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.</li> </ul>		
					3) Measures put into place/ System changes:		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY  COMPLETED  08/24/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECCTION (X5) OULD BE PPROPRIATE COMPLETION DATE	
				or Designee will inspect doors weekly for one monthly thereafter to er compliance. The Maint Director will document of Preventative Maintenar Worksheet. The Maintenar Worksheet. The Maintenar by the Administrator /de 9/7/23.  The Maintenance is responsible for compaire will be monitored:  The Administrator will be monitored:	t stairwell conth and nsure cenance con the nce chance ated on the nce Program esignee by ce Director liance.  actions  or will cets  cese audits lity nthly for 6 compliance committee cor patterns ations to ction as	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm Syster Maintenance Fire Alarm Syster					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
		155764	B. WING 08/24/2023			2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
	Maintenance A fire alarm syster in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record reversiled to ensure 1 of maintained in accord 9.6.1.3 requires a firested, and maintained 70, National Electric National Fire Alarm 14.2.1.2.2 requires a malfunctions shall be practice could affect Findings include:  Based on record reversile and VP of Regional between 12:30 p.m. system inspection of fire alarm vendor in located in the building inspected due to the being able to locate interview at the time Administrator stated is scheduled to be on getting the two definings were discontinuous findings were discontinuous firms and the firms of the firms o	m is tested and maintained in an approved program e requirements of NFPA 70, Code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available.  FPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems was edance with LSC 9.6.1.3. LSC are alarm system to be installed, and in accordance with NFPA cal Code and NFPA 72, in Code. NFPA 72, Section that system defects and be corrected. This deficient	K 0	345	K345 NFPA 101 Fire Alarm System- Testing and Maintenance  The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for those residents identified:  The two duct detectors were inspected on 9/7/23.  2) How the facility identified other residents:	of ot ment the et	09/08/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/24/2023
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5)  COMPLETION  DATE
				Staff, and residents the reside at the facility have the potential to be affected by the alleged deficient practice.	;
				3) Measures put into place/ System changes:	,
				The Maintenance Directivity will be re-educated on the Preventative Maintenance P by the Administrator /designers/7/23.	rogram
				· The Maintenance Dire is responsible for compliance	
				4)How the corrective action will be monitored:	ns
				The Administrator will review the Preventative Maintenance Worksheets me for compliance.	onthly
				The results of these a will be reviewed in Quality Assurance Meeting monthly months or until 100% compli is achieved. The QA Comm will identify any trends or pat and make recommendations revise the plan of correction indicated.	for 6 ance ittee tterns
K 0353	NFPA 101			5)Date of compliance: 9/8/2	23
SS=F		- Maintenance and Testing			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155764 B. WING 08/24/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS 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 Bldg. 02 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 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 1. Based on record review and interview, the K 0353 09/08/2023 K353 NFPA 101 Sprinkler facility failed to provide written documentation or System- Maintenance and other evidence the sprinkler system components **Testing** had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or The facility requests paper system required for compliance with this Code be compliance for this citation. maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly This Plan of Correction is the maintained in accordance with NFPA 25, Standard center's credible allegation of for the Inspection, Testing, and Maintenance of compliance. Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all Preparation and/or execution of inspections, tests, and maintenance of the system this plan of correction does not components and shall be made available to the constitute admission or agreement authority having jurisdiction upon request. 4.3.2 by the provider of the truth of the requires that records shall indicate the procedure facts alleged or conclusions set performed (e.g., inspection, test, or maintenance), forth in the statement of the organization that performed the work, the deficiencies. The plan of results, and the date. NFPA 25, 5.2.5 requires that correction is prepared and/or waterflow alarm devices shall be inspected executed solely because it is quarterly to verify they are free of physical required by the provisions of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	(X3) DATE SURVEY COMPLETED 08/24/2023	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1	, 5.3.3.1 requires the mechanical		federal and state law.		
		evices including, but not limited				
	_	ngs, shall be tested quarterly.		1)Immediate actions taken for	•	
	-	ne-type and pressure		those residents identified:		
		low alarm devices shall be				
	1	y. This deficient practice could		· Sprinkler Quarterly		
	· ·	staff, and visitors in the		inspections is current and in		
	facility.			compliance.		
				The 5-year inspection for		
	Findings include:			the Internal Pipe is scheduled t		
	l			be completed on October 12th	and	
	Based on review of the quarterly sprinkler system inspection records with the Administrator and VP			October 13, 2023.		
				2) How the facility identified		
		ions on 08/24/23 between 10:11		other residents:		
	_	., there was no quarterly				
		spection report available for		Staff, Visitors, and		
	_	(April, May, and June) of 2023.		residents that reside at the facil	-	
	-	w at the time of record review,		have the potential to be affecte		
	_	Operations stated that the		by the alleged deficient practice	Э.	
		had conducted two types of				
		inning of July 2023 which		3) Measures put into place/		
		inducted in lieu of a second		System changes:		
		but was unable to provide		The Maintenan D'		
	the second quarter	sprinkler inspection during		The Maintenance Director		
	the second quarter	01 2023		or Designee will complete mon	tniy	
	Eindings wone dies	useed with the VD of Decional		visual inspection of Sprinkler	-f	
	_	ussed with the VP of Regional Iministrator at exit conference.		Heads and monthly inspection	OI	
	Operations and Ad	immistrator at exit conference.		the wet pipe system to include gauges and valves. Inspections		
	3.1-19(b)			will document it on the		
	3.1-19(0)			Preventative Maintenance		
	2 Based on record	review, observation, and		Worksheet. The Maintenance		
		ity failed to maintain 1 of 1		Director will be re-educated on	the	
		accordance with 19.3.5.3.		Preventative Maintenance Prog		
		ition, 14.2.1 states except as		by the Administrator /designee		
		.1 and 14.2.1.4 an inspection of		8/23/23.	ы	
		line conditions shall be		0/23/23.		
		years by opening a flushing		The Maintenance Director	or	
		nd of one main and by		is responsible for compliance.	וי	
	Connection at the ci	na or one main and by	1	I is responsible for compliance.	i	

removing a sprinkler toward the end of one branch

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 02 COMPLETI			
		155764	B. W	ING		08/24/	2023
NAME OF D	DOWNED OF CURRINE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		of inspecting for the presence			4)How the corrective actions		
		nd inorganic material. This			will be monitored:		
	deficient practice could affect all occupants.  Findings include:				The Administration will		
					The Administrator will review the Preventative		
		view with the Administrator			Maintenance Worksheets monthly.		
	and VP of Regional Operations on 08/24/23 between 10:11 a.m. and 12:28 p.m., the Sprinkler						
					The results of these aud	dits	
	•	1 07/06/23 stated that the			will be reviewed in Quality		
	_	of the building of the second m were due for an internal pipe			Assurance Meeting monthly fo		
		n was listed as a deficiency of			months or until 100% compliants achieved. The QA Committee		
	-	ed on observation during a			will identify any trends or patte		
	-	petween 12:30 p.m. and 1:35			and make recommendations to		
	-	nistrator and VP of Regional			revise the plan of correction as		
	-	cated on the sprinkler riser			indicated.	•	
		ternal pipe inspection was			maioatoa.		
		Based on interview at the time			5)Date of compliance: 10/20	23	
	-	d observation, the VP of			0,5 at 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		
		s stated they were unaware of					
		was unaware if the internal					
	pipe inspection was						
	Eindings 4'	roand with the Administration					
	-	ssed with the Administrator  Operations at exit conference.					
		1					
	3.1-19(b)						
K 0918	NFPA 101						
SS=C		s - Essential Electric Syste					
Bldg. 02		s - Essential Electric					
	System Maintenar						
		other alternate power					
	_	iated equipment is capable					
		ce within 10 seconds. If the					
	10-second criterio	n is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm tl	his capability for the life					
	safety and critical	branches. Maintenance					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED				
		155764	B. Wl	NG	08/24/2023		
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	FRO VIDER OR SUFFLIER				87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(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
	1	generator and transfer					
		ormed in accordance with					
	NFPA 110.						
		e inspected weekly,					
		oad 30 minutes 12 times a					
	1 -	intervals, and exercised					
	I	onths for 4 continuous hours. Inder load conditions include					
	a complete simula						
	•	ual transfer of all EES					
		nducted by competent					
	· ·						
	personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in						
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate from	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency power	source is a design					
	consideration for i						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		review and interview, the	K 0	918	K918 NFPA 101 Electrical		09/08/2023
		sure 1 of 1 emergency			Systems- Essential Electric		
	_	wed a 5 minute cool down			System		
	_	test. Chapter 6.4.4.1.1.4(a) of					
	_	uires monthly testing of the			The facility requests paper		
		ne emergency electrical system with NFPA 110, the Standard			compliance for this citation.		
		· ·			This Plan of Correction is the		
		Standby Powers Systems, 10, 6.2.10 Time Delay on Engine			This Plan of Correction is the		
	_	that a minimum time delay of 5			center's credible allegation of		
	_	ovided for unloaded running of			compliance.		
	•	ver Supply (EPS) prior to			Preparation and/or execution of	of.	
		ay provides additional engine			this plan of correction does no		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	02	COMPL	ETED
		155764	B. W			08/24/	
				OWN PROT	ADDRESS SITE OF THE STREET	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SDDIVIO	MILL HEALTH CAI	MBUS			87TH AVE LLVILLE, IN 46410		
SPRING	WILL DEALID CAL	WIF U3		IVIERKII	LLVILLE, IIN 404 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne delay shall not be required			constitute admission or agree		
	· ·	r less) air-cooled prime movers.			by the provider of the truth of		
	This deficient practice could affect all residents,				facts alleged or conclusions s	set	
	as well as staff and	visitors in the facility.			forth in the statement of		
					deficiencies. The plan of		
	Findings include:				correction is prepared and/or		
					executed solely because it is		
		view with the Administrator			required by the provisions of		
	_	ol Operations on 08/24/23			federal and state law.		
	between 10:11 a.m. and 12:28 p.m., the Generator				<u> </u>		
	Checklist form documented the generator was				1)Immediate actions taken for	or	
	tested weekly for at least 30 minutes under load,				those residents identified:		
	however, there was no documentation on the form						
		nerator had a cool down time			The Generator Load Ba		
	-	est. Based on interview at the			Test checklist form was upda		
		ew, the VP of Regional			to include recording of cool do		
	-	hat the forms used are			time, load percentage and transfer		
	-	company who does servicing			time to the alternate power		
	-	They further stated that they			source.		
	-	under load weekly and					
		vn times have not been			2) How the facility identified		
		eets provided and those were			other residents:		
	, ,	sheets available during record			04-# 1 :1 :1 :1		
	review.				Staff, and residents the	ΙŢ	
	This finding	rejourned with the Administrator			reside at the facility have the		
		eviewed with the Administrator			potential to be affected by the	)	
	_	l Operations at the exit			alleged deficient practice.		
	conference.				2) Magaziros mutinto placat		
	3.1-19(b)				3) Measures put into place/		
	( )	review and interview, the			System changes:		
		ercise the generator for 12 of 12			The Maintenance Direct	etor	
	•	requirements of NFPA 110,			or Designee will complete	AUI	
		Standard for Emergency and			Generator weekly inspection	and	
		ystems, Chapter 8.4.2. Section			monthly 30 minutes under loa		
		generator sets in service shall			testing and will document on		
		st once monthly, for a minimum			Preventative Maintenance	u I <del>C</del>	
		g one of the following			Worksheet. The Maintenance	2	
	methods:	is one of the following			Director will be re-educated o		
		aintains the minimum exhaust					
	(1) Loauing mat in	annams the minimulii exhaust	1		Preventative Maintenance Pro	ograni	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE A. BUILDING B. WING	construction 02	(X3) DATE SURVEY  COMPLETED  08/24/2023				
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			101 V	STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	(X5)  E COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	manufacturer	recommended by the		by the Administrator /designor/ 9/7/23.	ee by			
		temperature conditions and at cent of the EPS (Emergency		The Maintenance Dire	otor			
	Power Supply) nam			is responsible for compliance				
		es diesel-powered EPS		is responsible for compliance	J.			
		not meet the requirements of		4)How the corrective action	ns			
		ised monthly with the available		will be monitored:				
		Power Supply System) load and						
		nnually with supplemental		· The Administrator will				
		n 50 percent of the EPS		review the Preventative				
	_	g for 30 continuous minutes		Maintenance worksheets mo	onthly.			
	and at not less than 75 percent of the EPS							
	nameplate kW rating for 1 continuous hour for a			The results of these au	dits			
	total test duration of not less than 1.5 continuous hours. This deficient practice could affect all			will be reviewed in Quality	for 6			
	occupants.	it practice could affect an		Assurance Meeting monthly months or until 100% compli				
	occupants.			is achieved. The QA Comm				
	Findings include:			will identify any trends or pat				
	Ü			and make recommendations				
	Based on review of	generator load testing		revise the plan of correction				
	documentation with the VP of Regional			indicated.				
	Operations and Adr	ninistrator from 10:11 a.m. to						
	_	4/23, the load information to		5)Date of compliance: 9/8/2	23			
		d percentage for the diesel						
		was not documented. Based						
		time of record review, the VP of						
		s stated that the generator						
		ekly, however documentation						
	the load percentage	e of the survey did not show						
	me man percentage	s ioi cauli ioau.						
	This finding was re	viewed with the Administrator						
		Operations at the exit						
	conference.	1						
	3.1-19(b)							
		review and interview, the						
	-	cument the transfer time to the						
	alternate power sou	rce on the monthly load tests						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764			A. BUILDING B. WING	02		LETED L/2023		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			101 W 8	STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI  TAG DEFICIENCY)		BE	(X5) COMPLETION DATE		
	alternate power supply service within 10 service within 10 service could affect all residence.  Findings include:  Based on record revial. Address and 12:28 p.m. Operations and Adn Checklist document reviewed and lacked power to emergency the time of record rec	iew on 08/24/23 between 10:11 with the VP of Regional ministrator, the Generator ation over the past year was the transfer time from normal v power Based on interview at eview, the VP of Regional dithat the generator runs ekly basis and is documented the ekklist sheets provided at the acknowledged that the available at record review.  In the transfer time from normal v power based on interview at eview, the VP of Regional dithat the generator runs ekly basis and is documented the ekklist sheets provided at the acknowledged that the missing and stated that's the available at record review.  In the transfer time from normal v power based on interview at eview, the VP of Regional ministrator at exit conference.						
K 0920 SS=E Bldg. 02	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care vic non-PCREE (e.g.,	d electrical equipment						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			î ´	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL		
		155764	B. W	ING		08/24/	2023
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	BROWNERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	do not use PCRE meet UL 1363A o for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on observation failed to ensure 1 on the used multi-plug fixed wiring. LSC 9 and equipment shal 70, National Electrically permitt shall not be used as a structure. This deapproximately 2 staresidents.  Findings include:  Based on observation Operations and Adult between 12:30 p.m. Services Office compowering equipment ime of observation Operations agreed a use.  Findings were discussed.	E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms e) meet UL 1363. In coms, power strips meet ls. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. e), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility f 1 Social Services office did gadaptors as a substitute for e).1.2 requires electrical wiring l be in accordance with NFPA fical Code. NFPA 70, 2011 e).8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ficient practice affects eff and an unknown number of en with the VP of Regional ministrator on 08/24/23 and 1:35 p.m., the Social stained a multi-plug adaptor ent. Based on interview at the ent, the VP of Regional ministrator at exit conference.	K 0	920	K920 NFPA 101 Electrical Equipment- Power Cords and Extension Cords  The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for those residents identified:	of It ment the et	09/08/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUILDING <u>02</u> COM		(X3) DATE SURVEY COMPLETED 08/24/2023				
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	-			
SPRING MILL HEALTH CAMPUS			101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	· The Multi-plug adaptor				
	3.1-19(b)			removed from the Social Service.	rices			
				2) How the facility identified other residents:				
				Staff, and residents that reside at the facility have the potential to be affected by the				
				alleged deficient practice.  3) Measures put into place/				
				System changes:				
				The Maintenance Director Designee will complete vis weekly inspection audit tool to ensure multi-plug adaptor are in use.	ual o			
				IDT will be re-educated the use of power cords and extension cords and multi-plu adaptors.				
				The Maintenance Direct will be re-educated on the Preventative Maintenance Proby the Administrator /designe 9/7/23.	ogram			
				The Maintenance Directis responsible for compliance				
				4)How the corrective actions will be monitored:	S			
				The Administrator will review the Preventative				

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/24/2023		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE 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 (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPI		(X5) COMPLETION DATE
					Maintenance worksheets moning of these aud will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliar is achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as indicated.  5) Date of compliance: 9/8/23	dits or 6 nce ee erns o	

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