STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/29/24 Facility Number: 010613 Provider Number: 155659 AIM Number: 200221040 At this Emergency Preparedness survey, Sellersburg Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 90. Quality Review completed on 10/30/24	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: 10/29/24 Facility Number: 010613 Provider Number: 155659 AIM Number: 200221040 At this Life Safety Code survey, Sellersburg	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Jackson	Administrator	11/11/2024

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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	Healthcare Center 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms with a battery backup that alarm at the central nurse's station. The facility has 15 total vent unit beds in the 400 Hall. The facility has a capacity of 110 and had a census of 90 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached garage used for storage which is not sprinkled. Quality Review completed on 10/30/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and Interview, the facility failed to ensure 1 of over 7 delayed egress locking arrangements was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:	K 0222	**K 222** **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 State of Deficiencies. The Plan of**	11/15/2024

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	(a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 8 staff. Findings include: Based on observation and interview with the Maintenance Director (MD) on 10/29/24 during a tour of the facility between 11:30 a.m. and 1:35 p.m., the kitchen exit door was equipped with a 15 second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the MD tried 3 times to activate the delay egress. The MD stated the delayed egress is not working, however it was working when he checked it recently but now will need to be repaired. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		**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 Life Safety Annual Survey conducted on October 29th, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents were not harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Maintenance repaired kitchen door with 15 second egress restored. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Executive Director held in	

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			service with maintenance and kitchen staff to inform maintenance of any issues with exit doors in kitchen or dining room. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/designee will test all doors with an egress 5 days a weeks x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 months and compliance is maintained to ensure delayed egress is maintained appropriately. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 6 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature.	K 0351	**K 351** **Preparation or execution of this plan of correction does not constitute admission or**	11/15/2024

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	NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 4 residents in two smoke compartments. Findings include: Based on observation and interview with the Maintenance Director (MD) on 10/29/24 during a tour of the facility between 11:30 a.m. and 1:35 p.m., in (1) the nurses' supply closet 1 of 4 sprinkler heads had gaps where the sprinkler meets the ceiling. And (2) in the Medical Records Office 1 of 4 sprinkler heads were missing escutcheons creating a gap around where the sprinkler head and ceiling meet. The MD a greed there were gaps around the sprinkler heads. These findings were reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		**agreement of provider of the truth of the facts alleged or conclusions set forth on the State 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 Life Safety Annual Survey conducted on October 29th, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents were not harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** This deficiency could affect residents in the identified smoke compartments. The sprinkler/ceiling gaps identified	

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			were repaired. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Maintenance Director/Designee will review and validate quarterly inspections of contractors in facility. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/designee will inspect all sprinklers 5 days a weeks x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 months and compliance is maintained to appropriate ceiling construction around sprinklers. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on record review, observation and interview; the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 57 of 57 resident sleeping rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on interview with the Maintenance Director and Executive Director during record review from 9:15 a.m. to 11:30 a.m. on 10/29/24, the facility historically has applied for an annual Life Safety Code waiver with IDOH for using the egress corridor as a return air system. A waiver for this current year will be sought following the survey. Based on interview at the time of record review, the Maintenance Director stated corrections to the HVAC system to not use the egress corridor as a return air system have not been made and a waiver would be sought. Based on observations with the Maintenance Director during a tour of the facility, all 57 resident sleeping rooms in the facility were using the egress corridor as a return air system. In addition to the wall mounted PTAC in each resident sleeping room, a ceiling mounted	K 0521	**K521** **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 State 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 Annual Life Safety Survey conducted on October 29th, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the**	11/15/2024

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	HVAC supply vent was noted in each room with the HVAC return air located in the central atrium housing the nurse's station and support rooms. Based on interview at the time of the observations, the Maintenance Director agreed all 57 resident sleeping rooms are using the egress corridor for the return air system. These findings were reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice:** The deficiency would not affect the health or safety of residents/patients in the facility. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** **It is the practice of this facility that all HVAC systems comply with NFPA 90A at all times. Sellersburg Healthcare Center would like to request a waiver of K521 NFPA 90A life safety code standard as this Deficiency would not affect the health and safety of the patients/residents here in our facility based on the following:** 1 We are fully sprinkled facility meeting the Type V (111) minimum. In addition, we have fast response sprinkler heads installed throughout the facility; we have quarterly inspections by licensed sprinkler contractors of the fire protection sprinkler system to ensure proper operation. 2 We are fully monitored by a Smart Fire Alarm System, with smoke and heat detectors in all hallways tied to fire alarm system. In addition, all resident rooms are hardwired with smoke detectors, with battery back up tied into the fire alarm system at the nurses station.	

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			3 We have HVAC fan shut down circuits that are inspected for proper operation by licensed fire alarm and HVAC contractors. 4 Our fire alarm and tie in HVAC circuits are inspected quarterly for proper operation by licensed fire alarm and HVAC contractors. 5 We are inspected by the local fire department on their time table at least annually for compliance with all NFPA Fire Regulations. 6 We conduct fire drills as required (1 drill per shift per month, per quarter) and in addition we conduct fire drills on all three shifts monthly at different times, for competency, and to ensure compliance with RACE procedures. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/designee will continue to ensure all practices in Step 3 are continued. Please see attached letter and Waiver form. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any	

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			patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 6 staff and residents. Findings include: Based on observation and interview with the Maintenance Director (MD) on 10/29/24 during a tour of the facility between 11:30 a.m. and 1:35 p.m., in the Central Nurses Station a power strip was plugged into and was supplied power by another power strip. Based on interview at the time of observation, the Maintenance Director agreed the two powerstrips were daisy chained together. This finding was reviewed with the Maintenance Director and Executive Director during the exit	K 0920	**K920** **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 State 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 Life Safety Annual Survey conducted on October 29th, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to**	11/15/2024

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	conference. 3.1-19(b)		**respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents were not harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** 2/2 Daisy chains were removed from facility. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** All staff were educated that power cord daisy chains cannot be used as a substitute for fixed wiring. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/designee will inspect nurses' station 5 days a weeks x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks for no less than 3 months and compliance is maintained to	

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			ensure “Fire Prevention, Discovery & Announcement Policy.” The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	