STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING -- B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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: 03/14/23 Facility Number: 005954 Provider Number: 155767 AIM Number: 201068810 At this Emergency Preparedness survey, Springhurst 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 74 certified beds. At the time of the survey, the census was 55. Quality Review completed on 03/16/23	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 3/14/2023.	
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: 03/14/23 Facility Number: 005954 Provider Number: 155767 AIM Number: 201068810 At this Life Safety Code survey, Springhurst	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marshall Hopkins	Executive Director	03/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	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 was 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. The healthcare portion of the facility has a capacity of 74 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 03/16/23		noncompliance cited during the survey visit with exit on 3/14/2023.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of	K 0232	**K232 – Aisle, Corridor or Ramp Width** **Immediate Intervention** Based upon observations the during survey the benches located at the town square were re	03/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect 30 residents, staff and visitors exiting through the facilities town square area. Findings: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., the town square area contained 4 bench seats extending into the corridor approximately 24 inches. The aforementioned wooden benches		attached to hook and eye system in place. Another bench was removed entirely as not to intervene with corridor width as this practice could affect 30 residents, staff and visitors exiting through town square to meet deficiency K232. **Exhibit A – Photo** **Exhibit B – Photo** **Compliance Date** **3/14/2023** The Director of Plant Operations was educated by Regional Support on K232 Aisle, corridor, and ramps as it pertains to NFPA 101 19.2.3.4, exceptions 1-5, 19.2.3.4, 19.2.3.5 **Exhibit C – In-service** The Director of Plant Operations will verify attachment of benches weekly x3 months. **Exhibit D – Audit Tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	were free standing, not affixed to the wall or floor. There were hook and eye mechanisms designed to secure the benches to the center area, however the benches were not securely attached. The Plant Operations Director stated that the benches had been removed during Christmas to allow for decorations, and apparently not been reinstalled properly. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)			
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies	K 0341	**K341- Fire Alarm System – Installation** **Immediate intervention** The fire panel was locked with the appropriate key and was placed	03/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., the fire alarm control panel (FACP) door, located in a high traffic area accessible to residents was not locked. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)		behind the nurse's station in its original location that could affect all occupants to meet deficiency K341. **Exhibit – E** **Compliance Date 3/21/2023** The Director of plant operations was educated by Regional Support on K341 Fire Alarm System Installation as it pertains to NFPA 70, National Electric code and NFPA72 National Fire alarm code referencing sections 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 and Signaling code section 10.10.1, 10.10.3: 10.10.7. **Exhibit C – In-service** The Director of Plant Operations will visually inspect the fire panel weekly x3 months to ensure fire panel is locked and key is made available in the event it is needed. **Exhibit F – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	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 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	Based on observation and interview, the facility failed to ensure all corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., the left door as part of a set of double corridor doors to the Sunroom area was propped open with a large, wheeled scale. The aforementioned doors were designed to be held open with a magnetic holder linked to the facilities fire alarm system. Based on interview at the time of observation, the Plant Operations Director acknowledged the aforementioned corridor door would not close unless the wheeled scale was first moved. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)	K 0363	**K363 – Corridor – Doors** **Immediate intervention** Removed wheeled scale away from the doors that would have prevented keeping closed, had no impediment to closing, latching and would resist the passage of smoke that could affect 15 residents to meet K363 deficiency. **Exhibit G – Photo** **Compliance date** **3/21/2023** The Director of Plant Operations was educated by Regional Support on K363 corridor – doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertains NFPA 101 in compliance with 7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.3, 42 CFR parts 403,418,460,482,483 and 485. Exhibit C – In-service The Director of Plant Operations or assigned party will visually inspect the corridor doors weekly. Exhibit H – Audit tool Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team	03/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
			determines substantial compliance has been achieved.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 20 residents in two smoke compartments. Finding include: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., the smoke barrier doors separating the dining area	K 0374	**K374 – Subdivision of building Spaces – Smoke barriers** **Immediate intervention** Ordered and installed an astragal to close the opening leaving only the minimum clearance necessary for proper operation that could affect 20 residents in two compartments to meet deficiency K374. **Exhibit I – Photo** **Compliance date** **3/21/2023** The Director of Plant Operations was educated by Regional Support on K374 smoke barrier	03/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	from the business office area had a 3/8-inch gap between the doors near the top and middle when closed, and a ½ inch gap near the bottom when closed as measured by the surveyor and the Facilities Support Manager. Based upon interview at the time of observation the Facilities Support Manager stated he believed the minimum gap allowable was 3/8th of an inch. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)		doors would restrict the movement of smoke for at least 20 minutes as it pertains to NFPA 101 2012 19.3.7.6, 19.3.7.8, 19.3.7.9 in Compliance with LSC Section 8.5.4, LSC 8.5.4.1 **Exhibit C – Inservice** The Director of plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit J – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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. This deficient practice could affect up to 3 residents and 2 staff in the Salon. Findings include: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., in the Salon two power strips were being used to power hair dryers (high power draw equipment). The aforementioned power strips were part of an apparatus designed to hold cosmetologically equipment. During the interview the Facilities Support Manager stated that the power strips had UL listings and appeared to be manufactured for use with hair dryers and curling irons. The surveyor stated that while the power strip device	K 0920	**K920 Electrical equipment – Power cords and extension cords** **Immediate Intervention** Removed the apparatus from the salon with the unapproved power strip attached and plugged device directly into the wall. Thus, removing the substitute for fixed wiring that could affect up to 3 residents and two staff members in the salon. **Exhibit K - Photo** **Compliance Date** **3/14/2023** Director of plant operations was educated by Regional Support on K920 NFPA101 10.2.3.6 Power strips in the patient care vicinity may not be used for non-PCREE(e.g., personal electronics), except in long-term	03/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	appears to be designed specifically for cosmetologically use, that would not mean it was allowable in a health care / LTC facility. A high amp draw appliance (such as a hair dryer) cannot be plugged into any type power strip or multiplug adaptor in a LTC environment. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)		care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. As it pertains to 10.2.4, 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70 - 2011), 590.3 (D) (NFPA70), TIA 12-5. **Exhibit C – In-service** The Director of Plant Operations and Executive Director will verify non approved devices are not in use once per week X 3 months followed by once per month X 3. **Exhibit L – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
	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 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is currently occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 03/14/23 between 11:30 a.m. and 1:45 p.m., the liquid oxygen storage/transfer room did not have a posted sign indicating the distinction between when transferring of liquid oxygen occurs and is not occurring in this location. Based on interview at the time of observation, the Plant Operations Director and the Facilities Support Manager stated the provided sign indicates that trans-filling of liquid oxygen is always occurring inside the room and does not distinguish between when it is and when it is not occurring. This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities Support Manager each present. 3.1-19(b)	K 0927	**K 927 Gas Equipment – Transfilling Cylinders** **Immediate Intervention** Signage that was missing indicating transfilling is currently occurring and area in use or open was ordered and will be installed once it arrives to the campus to prevent the practice that could affect 20 residents in one smoke compartment to meet deficiency K 927. **Compliance Date** **3/27/2023** The Director of Plant Operations was educated by Regional Support on K 927 Gas Equipment – Transfilling Cylinders in accordance with CGA P2.5, Transfilling to liquid oxygen containers or to portable containers over 50 PSI in compliance under 11.5.2.3.1 (NFPA 99), 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99). **Exhibit C – In-service** The Director of plant Operations will visually inspect signage of Hazardous areas to ensure appropriate indicators are present. This will be completed weekly x3	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 01 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

(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
			months then monthly thereafter. **Exhibit M – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	