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	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 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(s): 09/12/22 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 102. Quality Review completed on 09/15/22	E 0000	Sellersburg Healthcare Center September 30, 2022 Brenda Buroker, Director Long Term Care Indiana State Department of Health 2 North Meridian St. Indianapolis, In 46204-3006 Dear Ms. Buroker, Enclosed you will find the plan of correction for the Life Safety Survey, conducted on August 30, 2022. The facility requests that this plan of correction be accepted as our compliance. Facility would like to request a desk review (paper compliance) in lieu of Post Survey Revisit. Please see attachments regarding plan of corrections and the facilities request for a waiver to K-521. If you should have any further questions, you may reach me at 812-246-4272 or jidirbas@chs-corp.com Respectfully, Monica Dirbas Executive Director	

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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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(s): 09/12/22 Facility Number: 010613 Provider Number: 155659 AIM Number: 200221040 At this Life Safety Code survey, Sellersburg 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 a capacity of 110 and had a census of 102 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 09/15/22	K 0000	Sellersburg Healthcare Center September 30, 2022 Brenda Buroker, Director Long Term Care Indiana State Department of Health 2 North Meridian St. Indianapolis, In 46204-3006 Dear Ms. Buroker, Enclosed you will find the plan of correction for the Life Safety Survey, conducted on August 30, 2022. The facility requests that this plan of correction be accepted as our compliance. Facility would like to request a desk review (paper compliance) in lieu of Post Survey Revisit. Please see attachments regarding plan of corrections and the facilities request for a waiver to K-521. If you should have any further questions, you may reach me at 812-246-4272 or jidirbas@chs-corp.com Respectfully, Monica Dirbas Executive Director	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation was available to show that all resident rooms, plus 4 other smoke detectors (2 in Physical Therapy and 2 in Medical Records) were sensitivity tested within the past 24 months. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal	K 0300	K-300 What corrective action for the residents found to be affected by the deficient practice- 1. Maintenance Director completed a 100% audit of all smoke detectors in the facility including those found in resident rooms, physical therapy and medical records. All smoke detectors have passed a functionally test and are working properly Corrective action taken for those resident having the potential to be affected by the same practice- 2. All smoke detectors in the resident rooms, physical therapy and in medical records will be sensitivity tested by facility contracted fire system provider. Measure/systemic changes put into place to ensure the deficient practice does not recur- 3. All smoke detectors will be placed on a routine sensitivity testing and completed according	10/03/2022

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	at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 09/12/22 between 9:30 a.m. and 11:45 a.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all resident rooms, plus the Physical Therapy and Medical Records room smoke detectors for the past 24 month period. Based on observations between 11:45 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, it was determined smoke detectors in all resident rooms, plus Physical Therapy and Medical Records are hard wired to a panel at the Nurses' Station with battery back up. These smoke detectors are not connected to the fire alarm system but to a separate panel at the Nurses' Station to notify staff if activated. The Maintenance Director removed a resident room smoke detector and there was information on the back of the detector to show a sensitivity range. Based on interview at the time of observation, the Maintenance Director confirmed the detector removed from the resident room had a sensitivity range and acknowledged there was no record available for sensitivity testing for other smoke detectors of this type.		to the requirements listed in the NFPA 72, National Fire Alarm Code, 2010 Edition. Corrective actions to be monitored to ensure the deficient practice 4. Sensitivity testing for facility smoke detectors for resident rooms, physical therapy and medical records department has been added to the facility preventative maintenance program. Maintenance Director/ED will monitor compliance through facility preventative maintenance program. Maintenance Director has been educated on the requirements regarding sensitivity testing for smoke detectors.	

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=B Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 Based on observation and interview, the facility failed to ensure sprinkler heads at 1 of 2 outdoor porch overhangs covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting	K 0353	Note: Sprinkler heads have been measured and ordered. K-353 What corrective action for the residents found to be affected by the deficient practice- 1. No residents were found to be affected by the deficient practice. It was identified that 1 of 2 outdoor porch overhangs had sprinkle heads that were found to have corrosion.	09/30/2022

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	unless painted by the sprinkler manufacturer. This deficient practice could affect residents, staff, and visitors sitting on the south patio. Findings include: Based on observations on 09/12/22 between 11:45 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, there were three sprinkler heads under the overhang at the south patio covered with corrosion. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler heads were covered with corrosion at the south patio. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		Corrective action taken for those resident having the potential to be affected by the same deficient practice- 2. Maintenance director completed a 100% audit on all facility sprinkler heads. No other sprinkler heads were found to have corrosion. Facility will replace sprinkler heads that were found to have corrosion noted. Measure/system changes put into place to ensure the deficient practice does not recur- 3. Maintenance Director has been educated on the monitoring of facility sprinkler heads. Maintenance Director/designee will ensure the preventative maintenance program is completed per facility policy Corrective action to be monitored to ensure the deficient practice will not recur- 4. Administrator/Designee will ensure outdoor sprinkler heads are checked semi-annually x1 year and then quarterly thereafter to ensure no corrosion is noted.	
K 0521 SS=C Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as	K 0521	K-521	09/30/2022

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	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 observations on 09/12/22 between 11:45 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, 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 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 stated the facility has an existing Life Safety Code waiver for all 57 resident sleeping rooms and agreed the egress corridors were being used for the return air system. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		It is the practice of this center to assure 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 adversely affect the health and safety of the patients/residents here in our facility based on the following. 1. We are a 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 contractor 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 batter back-up tied into spate alarm system at the nurse’s station. 3. We have HVAC fan shut down circuits tied into the fires alarm system to shut units down upon activation, in addition we have fires dampers installed in main trunk lines to seal off supply and return ductwork to prevent the transmission of smoke. 4. Our fire alarm and tie in HVAC circuits are inspected quarterly for proper operation by	

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			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. 7. We conduct annual fire extinguisher hands on training.	