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	09/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/13/23 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 101. Quality Review completed on 09/18/23	E 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 10-2-2023. We respectfully request a desk review in lieu of a post survey Revisit.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/13/23 Facility Number: 010613 Provider Number: 155659 AIM Number: 200221040 At this Life Safety Code survey, Sellersburg	K 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 10-2-2023. We respectfully	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Duhaime	Interim Administrator	10/10/2023

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 101 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 09/18/23		request a desk review in lieu of a post survey Revisit.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			

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	Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 09/13/23, the time of day for the fire alarm control panel at the center nurse's station was incorrect. The display read the time of day as 5:02 p.m. at 1:45 p.m. Based on interview at the time of the observations, the Maintenance Director agreed the main fire alarm control panel for the facility did not display the correct time of day. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0345	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 10-2-2023. We respectfully request a desk review in lieu of a post survey Revisit. It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **K345** Fire Alarm System – Testing and Maintenance **·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The maintenance director corrected the time on the fire alarm control panel at the center nurse's station at the time of this visit. The fire alarm control panel at the center nurses station now displays the correct time of day. **·how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	10/06/2023

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			taken; All residents have the potential to be affected Maintenance Director audited facility to ensure there were no other fire alarm control panels with an incorrect display of time. **·what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director or designee will audit area to ensure the fire alarm control panel display the correct time of day. **·how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team “QAPI Tool” weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and	

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			follow up.	
K 0353 SS=E 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 1 of over 10 sprinkler heads in the North Activity Room were free of leakage in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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	K 0353	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 10-2-2023. We respectfully request a desk review in lieu of a post survey Revisit. It is the intent of this provider to have an emergency preparedness	10/06/2023

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	element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the North Activity Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 09/13/23, the ceiling mounted sprinkler in the North Activity Room by the entrance door set was green with corrosion and had a green liquid on the deflector which showed signs of leakage from the sprinkler. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned automatic sprinkler location was green with corrosion and showed signs of leakage. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		communication plan that complies with Federal, State, and local laws. K353 Sprinkler System – Maintenance and Testing **·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Sprinkler heads on schedule to be replaced. **·how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director will continue to audit facility for other sprinkler heads green with corrosion or showing signs of leakage and will have replaced as needed. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director will add to TELS monitor system and add to routine maintenance **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place: QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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			

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	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. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 09/13/23, the following was noted: a. the corridor door to resident sleeping Room 404 was propped in the fully open position with a chair placed up against the door. b. one of three corridor doors to the kitchen from the Magnolia Dining Room was held in the fully open position with a wall mounted magnetic hold open device set to release the door to close with fire alarm system activation and was equipped with a self closing device but the door failed to fully self close and latch into the door frame when tested to close multiple times. The latching mechanism on the door kept hitting the door frame when tested to close which caused the latching	K 0363	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 10-2-2023. We respectfully request a desk review in lieu of a post survey Revisit. It is the intent of this provider to have an emergency preparedness communication plan that complies. with Federal, State, and local laws. K363 Corridor Doors – **·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/06/2023

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	mechanism to not protruded into the door frame when tested to close. Based on interview at the time of the observations, the Maintenance Director had maintenance staff make the necessary corrections to each door but agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**practice;** The chair that was placed up against the door used to prop open corridor door to resident sleeping room 404 in the fully open position was immediately removed. Wall mounted magnetic hold open device is functioning properly in the Magnolia Dining Room corridor door. The self-closing door was adjusted to fully self-close and latch into the door frame to resist the passage of smoke. **·how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected The Maintenance Director or designee will continue to audit facility for other chairs placed up against doors to prop open corridor doors and ensure this practice does not reoccur. The Maintenance Director or designee will audit to ensure a magnetic hold device continues to function properly in the Magnolia Dining Room corridor door. The Maintenance Director or designee will continue to audit the self-closing door to ensure the door fully self-closes and latches into the door frame to resist the passage of smoke.	

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director will add to TELS monitor system and add to routine maintenance **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance.	
K 0521 SS=F 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 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	K 0521	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	10/06/2023

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	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 review of "Life Safety Code Waiver Request" documentation dated 07/16/21 with the Maintenance Director during record review from 10:05 a.m. to 12:30 p.m. on 09/13/23, the facility applied for an annual Life Safety Code waiver with IDOH for using the egress corridor as a return air system in 2021. 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 since 07/16/21. Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 09/13/23, 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 agreed all 57 resident sleeping rooms are using the egress corridor for the return air system. These findings were reviewed with the Maintenance Director during the exit conference.		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 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.	

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	3.1-19(b)		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.	