	T OF HEALTH AND HI R MEDICARE & MEDI					OM	RM APPROVED IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155659	A. BU B. W	JILDING		COMPI 09/13		
		199699	D. W.			09/13	/2023	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD DLD HWY # 60				
SELLER	SBURG HEALTHO	CARE CENTER			RSBURG, IN 47172			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
0000								
Bldg								
Diag	An Emergency Pr	eparedness Survey was	E 0	000	The creation of and submission	on of		
		Indiana Department of Health in		000	this plan of correction does no			
	accordance with 4	-			constitute admission by this			
					provider of any conclusion set	t forth		
	Survey Date: 09/1	13/23			in the statement of deficiencie			
					of any violations of regulation.			
	Facility Number:				This provider respectfully requ	uests		
	Provider Number:				that the 2567 plan of correction			
	AIM Number: 20	0221040			considered the letter of credib	le		
					allegation and request a post			
		y Preparedness survey,			survey review on or after			
	-	ncare Center was found in Emergency Preparedness			10-2-2023. We respectfully request a desk review in lieu of	of a		
	~	Medicare and Medicaid			post survey Revisit.	Jia		
	-	iders and Suppliers, 42 CFR						
	483.73.	,						
	The facility has 11	10 certified beds. At the time of						
	the survey, the cer							
	Quality Review co	ompleted on 09/18/23						
K 0000								
Bldg. 01								
		le Recertification and State	K 0	000	The creation of and submission			
		was conducted by the Indiana alth in accordance with 42 CFR			this plan of correction does no	DI		
	483.90(a).	ann maccoluance with 42 UFK			constitute admission by this provider of any conclusion set	t forth		
	105.70(<i>a</i>).				in the statement of deficiencie			
	Survey Date: 09/1	13/23			of any violations of regulation.			
					This provider respectfully requ			
	Facility Number:	010613			that the 2567 plan of correction			
	Provider Number:				considered the letter of credib			
	AIM Number: 20	0221040			allegation and request a post			
					survey review on or after			
	At this Life Safety	Code survey, Sellersburg			10-2-2023. We respectfully			
	At this Life Safety				10-2-2023. We respectfully		(X6) D4T	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Duhaime Ir	nterim Administrator	10/10/2023
Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be e	excused from correcting providing it is determin	
other safegaurds provide sufficient protection to the patients (see instructions) Except for nursing ho	mes the findings stated above are disclosable	

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/13/2023 155659 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7823 OLD HWY # 60 SELLERSBURG HEALTHCARE CENTER SELLERSBURG, IN 47172 (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 Healthcare Center was found not in compliance request a desk review in lieu of a with Requirements for Participation in post survey Revisit. 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 K 0345 **NFPA 101** SS=C Fire Alarm System - Testing and Bldg. 01 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZK7H21 Facility ID: 010613

Page 2 of 12 If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

PRINTED:

10/12/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	3) DATE SURVEY COMPLETED 09/13/2023
	PROVIDER OR SUPPLIEF		7823 C	address, city, state, zip cod DLD HWY # 60 RSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	Bille
	 failed to maintain the that it had accurate accordance with the 2012 edition, Sectional control of the edition of the	on and interview, the facility the fire alarm system to ensure time and date information in e requirements of NFPA 101- ons 19.3.4 and 9.6 and NFPA 72 tions 14.1, 14.1.1. This deficient et all residents, staff and ons with the Maintenance our of the facility from 12:30 in 09/13/23, the time of day for ol panel at the center nurse's et. The display read the time of 1:45 p.m. Based on interview at ervations, the Maintenance main fire alarm control panel not display the correct time of e reviewed with the tor during the exit conference.	K 0345	The creation of and submission this plan of correction does not constitute admission by this provider of any conclusion set for in the statement of deficiencies, of any violations of regulation. This provider respectfully request that the 2567 plan of correction 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 preparedne communication plan that complie with Federal, State, and local laws. K345 Fire Alarm System – Testi 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 pane 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	r ss

STATEMENT O	F DEFICIENCIES ORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION	x3) date survey completed 09/13/2023
			7823 O	ADDRESS, CITY, STATE, ZIP COD NLD HWY # 60 RSBURG, IN 47172	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATI DEFICIENCY) taken;	E (X5) COMPLETI DATE
				taken; All residents have the potential be affected Maintenance Director audited facility to ensure there were no other fire alarm control panels v 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 disp 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 monitor through the facility QAPI Progra with meetings being held month and overseen by the Executive director. The Executive Director or designee will document their findings on the Team "QAPI Tool" weekly for 4 weeks, month for 3 months, and quarterly thereafter to ensure the policy/procedures are followed facility policy. If threshold of 90% is not met, a action plan will be submitted to th Executive Director for review and source of the submitted to th executive Director for review and the facility policy.	with ure blay () ne tt red am, hly thly thly per an e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u>		(X3) DATE SURVEY		
		A. BUILI B. WING		<u>01</u>	COMPLETED 09/13/2023		
	PROVIDER OR SUPPLIE SBURG HEALTHC		7	7823 OL	ddress, city, state, zip cod .D HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETION DATE
(0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, ter accordance with Inspection, Testin Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8 Based on observat failed to ensure 1 of North Activity Roo accordance with N the Inspection, Tes Water-Based Fire Edition, Section 5. show signs of leak foreign materials, j shall be installed in up-right, pendent, 5.2.1.1.2 any sprin the following shall (1) Leakage (2) Corrosion (3) Physical Dama	RKS information on non-required or partial er system. 6, and NFPA 25 on and interview, the facility of over 10 sprinkler heads in the om were free of leakage in FPA 25. NFPA 25, Standard for ting, and Maintenance of Protection Systems, 2011 2.1.1.1 states sprinklers shall not age; shall be free of corrosion, baint, and physical damage; and in the correct orientation (e.g., or sidewall). Furthermore, at kler that shows signs of any of be replaced:	К 035	3	follow up. follow up. The creation of and submissio this plan of correction does no constitute admission by this provider of any conclusion set in the statement of deficiencies of any violations of regulation. This provider respectfully requ that the 2567 plan of correction considered the letter of credibl allegation and request a post survey review on or after 10-2-2023. We respectfully request a desk review in lieu o post survey Revisit. It is the intent of this provider to have an emergency preparedr	t forth s, or ests n be e f a	10/06/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155659	A. BUILDING B. WING	<u>01</u>	_	pleted 3/2023
	PROVIDER OR SUPPLIE		7823 (ADDRESS, CITY, STATE, ZIP (OLD HWY # 60	COD	
SELLER	SBURG HEALTHC	ARE CENTER	SELLE	ERSBURG, IN 47172		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC
TAG	element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or equipment does no This deficient prace residents, staff and North Activity Roo Findings include: Based on observat Director during a t p.m. to 3:30 p.m. of sprinkler in the No entrance door set w had a green liquid signs of leakage fr interview at the tir Maintenance Direc automatic sprinkle corrosion and show	R LSC IDENTIFYING INFORMATION a painted by the sprinkler a sprinklers that are loaded with d to clean sprinklers with by a vacuum provided that the at touch the sprinkler. tice could affect over 20 a visitors in the vicinity of the com. ions with the Maintenance our of the facility from 12:30 on 09/13/23, the ceiling mounted arth Activity Room by the vas green with corrosion and on the deflector which showed om the sprinkler. Based on ne of the observations, the etor agreed the aforementioned r location was green with ved signs of leakage. re reviewed with the etor during the exit conference.	TAG	communication plan the with Federal, State, are laws. K353 Sprinkler System Maintenance and Tess •what corrective acc be accomplished for residents found to hat affected by the defici- practice; Sprinkler heads on sc replaced. •how other resident the potential to be affected by the deficient pro- be identified and what corrective action(s) we taken; All residents have the be affected Maintenance Director to audit facility for othe heads green with corre- showing signs of leaks have replaced as need •What measures wit into place or what sy changes will be made ensure that the defici- practice does not recor Maintenance Director TELS monitor system routine maintenance •How the corrective will be monitored to of deficient practice will recur, i.e., what quali-	hat complies had local m – ting tion(s) will those ave been ient hedule to be ts having fected by ractice will at will be potential to will continue er sprinkler osion or age and will ded. Il be put stemic e to ient cur: will add to and add to e action(s) ensure the I not ty	DATE

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155659	A. BUILDING B. WING	01	-	pleted 3/2023
	PROVIDER OR SUPPLIE		7823 C	address, city, state, zip co DLD HWY # 60 RSBURG, IN 47172	OD	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION
 ≺ 0363 SS=E Bldg. 01 	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting than required end exits, or hazardo of smoke and are solid-bonded corr capable of resisti minutes. Doors in compartments ar passage of smok to rooms contain combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or corr Clearance betwe covering is not ex doors complying if provided with a the door closed w applied. There is closing of the door release when the permitted. Nonra unlimited height a	corridor openings in other closures of vertical openings, us areas resist the passage e made of 1 3/4 inch e wood or other material ng fire for at least 20 n fully sprinklered smoke e only required to resist the e. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain nbustible material. en bottom of door and floor kceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is a no impediment to the ors. Hold open devices that e door is pushed or pulled are ted protective plates of are permitted. Dutch doors .6 are permitted. Door	TAG	into place: QA tool will be utilized of monthly x 3, and quarter The results of these au reviewed by the QAPI of overseen by the Execu Director/Designee. If the not achieved, an action be developed to ensure compliance.	erly x 4. dits will be committee tive reshold is plan will	DATE

PRINTED: 10/12/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	A. BUIL B. WINC	DING G	<u>01</u>	COMPI 09/13	
	PROVIDER OR SUPPLII SBURG HEALTHO			7823 O	address, city, state, zip cod LD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	(X5) COMPLETIO DATE
	other materials in unless the smok sprinklered. Fixe allowed per 8.3. there are no rest resistance of gla assemblies. 19.3.6.3, 42 CFF 483, and 485 Show in REMAR fire protection ra devices, etc. Based on observar failed to ensure 2 impediment to clo frame and would of This deficient pra- residents, staff and Findings include: Based on observar Director during a p.m. to 3:30 p.m. noted: a. the corridor doo was propped in th chair placed up ag b. one of three con the Magnolia Dim open position with open device set to fire alarm system with a self closing fully self close and tested to close mu mechanism on the	tions with the Maintenance tour of the facility from 12:30 on 09/13/23, the following was or to resident sleeping Room 404 e fully open position with a	К 036	53	The creation of and submission this plan of correction does not constitute admission by this provider of any conclusion set f in the statement of deficiencies of any violations of regulation. This provider respectfully reque that the 2567 plan of correction 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 post survey Revisit. It is the intent of this provider to have an emergency preparedne communication plan that complies. with Federal, State, and local laws. K363 Corridor Doors – •what corrective action(s) wi be accomplished for those residents found to have been affected by the deficient	orth or sts be a	10/06/202

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155659			(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 09/13/2023	
	PROVIDER OR SUPPLIE		7823 0	address, city, state, zip cod DLD HWY # 60 RSBURG, IN 47172		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE (X5) COMPLET DATE	
	when tested to clo Based on interview observations, the I maintenance staff to each door but a corridor doors eac and latching into t resist the passage These findings we	w at the time of the Maintenance Director had make the necessary corrections greed the aforementioned h had an impediment to closing he door frame and would not		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 immediate removed. Wall mounted magnetic hold device is functioning properly the Magnolia Dining Room co door. The self-closing door was adj to fully self-close and latch int the door frame to resist the passage of smoke. •how other residents havin the potential to be affected I the same deficient practice be identified and what corrective action(s) will be taken; All residents have the potential be affected The Maintenance Director or designee will continue to audi facility for other chairs placed against doors to prop open corridor doors and ensure this practice does not reoccur. The Maintenance Director or designee will audit to ensure magnetic hold device continu function properly in the Magn Dining Room corridor door. The Maintenance Director or designee will continue to audi self-closing door to ensure the door fully self-closes and latch into the door frame to resist the passage of smoke.	t ly open in orridor usted to by will al to it up s a es to olia	

	R MEDICARE & MEDIC			CONSTRUCTION		MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	A. BUILDING B. WING		COMP	e survey pleted 3/2023
	PROVIDER OR SUPPLIE		7823	ET ADDRESS, CITY, STATE, ZIP COD OLD HWY # 60 .ERSBURG, IN 47172		
	1					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETIO DATE
				What measures will I put into place or what syst changes will be made to ensure that the deficient practice does not recur: Maintenance Director will a TELS monitor system and routine maintenance ·How the corrective activ will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will b into place: QA tool will be utilized weet monthly x 3, and quarterly The results of these audits reviewed by the QAPI com overseen by the Executive Director/Designee. If thresh not achieved, an action plat be developed to ensure compliance.	add to add to add to on(s) re the e put kly x 4, x 4. will be mittee nold is	
K 0521 SS=F Bldg. 01	comply with 9.2 a accordance with 5 specifications. 18.5.2.1, 19.5.2.1 Based on record re interview; the facil corridors were not system serving adj resident sleeping re conditioning, heati	on, and air conditioning shall nd shall be installed in he manufacturer's , 9.2 view, observation and ity failed to ensure egress used as a portion of a return air bining rooms for 57 of 57 boms. LSC 9.2.1 requires air ng, ventilating ductwork d equipment to be installed in	K 0521	It is the practice of this cen assure that all HVAC syste comply with NFPA 90A at a times. Sellersburg Healthc Center would like to reques waiver of K521 NFPA 90A safety code standard as th	ms all are st a life	10/06/202

SUMMARY (EACH DEFICIEN REGULATORY OF ordance with NI allation of Air (tems. NFPA 90 ess corridors in lities shall not b oly, return, or es oning areas uni- 12.1.3.1 throug	ARE CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION FPA 90A, the Standard for the Conditioning and Ventilating DA, Section 4.3.12.1.1 states nursing and long term care be used as a portion of a khaust air system serving less otherwise permitted by h 4.3.12.1.3.4. This deficient tt all residents, as well as staff		7823 O	ADDRESS, CITY, STATE, ZIP COD LD HWY # 60 RSBURG, IN 47172 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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)	(X5) COMPLETION DATE
(EACH DEFICIEN REGULATORY OF ordance with NI allation of Air (tems. NFPA 90 ess corridors in lities shall not b oly, return, or en- orining areas unla 12.1.3.1 through tice could affect visitors in the f	ACY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION FPA 90A, the Standard for the Conditioning and Ventilating 0A, Section 4.3.12.1.1 states nursing and long term care be used as a portion of a khaust air system serving less otherwise permitted by h 4.3.12.1.3.4. This deficient tt all residents, as well as staff		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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	COMPLETION DATE
tems. NFPA 90 ess corridors in lities shall not b oly, return, or ex- pining areas unla 12.1.3.1 throug tice could affect visitors in the f	A, Section 4.3.12.1.1 states nursing and long term care be used as a portion of a khaust air system serving ess otherwise permitted by h 4.3.12.1.3.4. This deficient et all residents, as well as staff			patients/residents here in our facility based on the following. 1. We are a fully sprinkled	
lings include:				minimum. In addition we have fas response sprinkler heads installe throughout the facility; we have quarterly inspections by licensed sprinkler contractor of the fire	ed
uest" document ntenance Direc 05 a.m. to 12:30 lied for an annu DH for using the em in 2021. Ba ord review, the l ections to the H ess corridor as a n made since 07 n the Maintenan lity from 12:30	IVAC system to not use the return air system have not 7/16/21. Based on observations ce Director during a tour of the p.m. to 3:30 p.m. on 09/13/23, all			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	e
g the egress con ddition to the w dent sleeping ro oly vent was no AC return air lo sing the nurse's ed on interview ervations, the M esident sleeping idor for the retu	rridor as a return air system. all mounted PTAC in each oom, a ceiling mounted HVAC ted in each room with the cated in the central atrium station and support rooms. at the time of the laintenance Director agreed all g rooms are using the egress irn air system.			 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 	ne
	ections to the H ss corridor as a made since 07 the Maintenan ity from 12:30 esident sleeping g the egress con ldition to the w lent sleeping ro ly vent was no AC return air lo ing the nurse's ed on interview rvations, the M esident sleeping dor for the retu-	rd review, the Maintenance Director stated ections to the HVAC system to not use the ss corridor as a return air system have not made since 07/16/21. Based on observations the Maintenance Director during a tour of the ity from 12:30 p.m. to 3:30 p.m. on 09/13/23, all esident sleeping rooms in the facility were g the egress corridor as a return air system. Idition to the wall mounted PTAC in each lent sleeping room, a ceiling mounted HVAC ly vent was noted in each room with the AC return air located in the central atrium ing the nurse's station and support rooms. d on interview at the time of the rvations, the Maintenance Director agreed all esident sleeping rooms are using the egress dor for the return air system.	ections to the HVAC system to not use the ss corridor as a return air system have not made since 07/16/21. Based on observations the Maintenance Director during a tour of the ity from 12:30 p.m. to 3:30 p.m. on 09/13/23, all esident sleeping rooms in the facility were g the egress corridor as a return air system. Idition to the wall mounted PTAC in each lent sleeping room, a ceiling mounted HVAC ly vent was noted in each room with the AC return air located in the central atrium ing the nurse's station and support rooms. ed on interview at the time of the rvations, the Maintenance Director agreed all esident sleeping rooms are using the egress dor for the return air system.	ections to the HVAC system to not use the ss corridor as a return air system have not made since 07/16/21. Based on observations the Maintenance Director during a tour of the ity from 12:30 p.m. to 3:30 p.m. on 09/13/23, all esident sleeping rooms in the facility were g the egress corridor as a return air system. Idition to the wall mounted PTAC in each lent sleeping room, a ceiling mounted HVAC ly vent was noted in each room with the AC return air located in the central atrium ing the nurse's station and support rooms. ed on interview at the time of the rvations, the Maintenance Director agreed all esident sleeping rooms are using the egress dor for the return air system.	ections to the HVAC system to not use the ss corridor as a return air system have not made since 07/16/21. Based on observations the Maintenance Director during a tour of the ity from 12:30 p.m. to 3:30 p.m. on 09/13/23, all esident sleeping rooms in the facility were g the egress corridor as a return air system. Idition to the wall mounted PTAC in each tent sleeping room, a ceiling mounted HVAC ly vent was noted in each room with the AC return air located in the central atrium ing the nurse's station and support rooms. ed on interview at the time of the rvations, the Maintenance Director agreed all esident sleeping rooms are using the egress dor for the return air system.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.S. We are inspected by the local fire department on their time table at least annually for compliance with all NFPA Fire

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZK7H21 Facility ID: 010613

If continuation sheet Page 11 of 12

PRINTED: 10/12/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES	

ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2023		
NAME OF PROVIDER OR SUPPLIER SELLERSBURG HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 7823 OLD HWY # 60 SELLERSBURG, IN 47172				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	3.1-19(b)			 6. We conduct fire drills as required (1 drill per shift, p month, per quarter) and in we conduct fire drills on all shifts monthly at different t for competency, and to encompliance with RACE procedures. 7. We conduct annual fire extinguisher hands on train 	er addition three imes, sure		

ZK7H21 Facility ID: 010613