

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 05/23/2024
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/23/24</p> <p>Facility Number: 005954 Provider Number: 155767 AIM Number: 201068810</p> <p>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.</p> <p>The facility has 74 certified beds. At the time of the survey, the census was 54.</p> <p>Quality Review completed on 05/28/24</p>	E 0000	<p>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 May 23rd, 2024.</p> <p>Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 13, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 05/23/24</p> <p>Facility Number: 005954 Provider Number: 155767</p>	K 0000	<p>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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Wilson	Executive Director	06/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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 0222 SS=E Bldg. 01	<p>AIM Number: 201068810</p> <p>At this Life Safety Code survey, Springhurst 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.</p> <p>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 54 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 05/28/24</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall</p>		<p>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 May 23rd , 2024.</p> <p>Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 13, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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	<p>be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p>			

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	<p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 12 residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 05/23/24 between 11:50 a.m. and 2:15 p.m., the exit door exit door from the 200 hall into the courtyard, marked an exit, was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Plant Operations Director and the Facilities</p>	K 0222	<p>K-222 – Egress Doors</p> <p>Immediate Intervention The Director of Plant Operation has installed signage indicating that the exit door located on the 200 Hall could be opened in 15 seconds by pushing on the doors. To meet this deficiency that could affect 12 residents. Exhibit A – Photo</p> <p>Compliance Date – 6/13/2024</p> <p>The Director of Plant Operations was educated by Regional Facilities on K222 Means of Egress, LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high and not less than 1/8 in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress. "PUSH UNTIL ALARMSOUNDS. DOOR CAN BE OPENED IN 15</p>	06/13/2024
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K 0321 SS=E Bldg. 01	<p>Support Manager each present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p>		<p>SECONDS"</p> <p>Exhibit B – Inservice</p> <p>The Director of Plant Operations will visually inspect the door for proper signage monthly X 6</p> <p>Exhibit C – Audit tool</p> <p>Results of this visual inspection will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p>	

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	<p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 staff and visitors near the front door business office.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Plant Operations Director and the Facilities Support Manager on 05/23/24 between 11:50 a.m. and 2:15 p.m., the Business Office, near the front entrance, greater than 50 square feet contained a number of combustible items, such as, paper, lots of cardboard boxes, and several unassembled cardboard boxes. The corridor door to this office did not self-close and latch into the door frame.</p> <p>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.</p> <p>3.1-19(b)</p>	K 0321	<p>K321 Hazardous Areas – Enclosure</p> <p>Immediate intervention Combustible boxes and supplies were removed from the office area to a secure location to meet deficiency that could affect more than 5 staff members Exhibit D - Photo</p> <p>Compliance date 6/13/2024</p> <p>The director of plant operations was educated by regional support on NFPA 101- hazardous areas as regards to the corridor door to this room that would require a self-closing device in accordance to 8.7.1 or 19.3.5.9, 19.3.2.1 Exhibit B – Inservice Documentation</p> <p>The director of plant operations will</p>	06/13/2024
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K 0511 SS=E Bldg. 01	<p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupters (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 2 staff.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Plant Operations Director (POD) and the Facilities Support Manager on 05/23/24 between 11:50 a.m. and 2:15 p.m., when the GFCI electric receptacle outside the</p>	K 0511	<p>visually inspect all doors that exit onto the common corridor weekly x 3 months then monthly x3. Exhibit E – Audit tool</p> <p>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.</p> <p>K511 Utilities – Gas and electric</p> <p>Immediate intervention The Director of Plant Operations replaced the GFCI located outside of the maintenance area to meet deficiency K511 this practice could affect 2 Staff members Exhibit F – Photo</p> <p>Compliance date 6/13/2024</p> <p>Director of plant Operations was educated by the regional support on K511 NFPA 70, National</p>	06/13/2024

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	<p>facility near the maintenance office was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the POD agreed the GFCI electric receptacle did not work properly when tested.</p> <p>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.</p> <p>3.1-19(b)</p>		<p>Electric Code. Existing installations can continue in service provided no hazard to life 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2.</p> <p>Exhibit B – Inservice Documentation</p> <p>Director of plant Operations will verify operation of GFCI weekly X3months then followed monthly X3.</p> <p>Exhibit G – Audit tool</p> <p>The Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.</p>	