

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/03/13</p> <p>Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Ashford Place Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New 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 sprinklered. 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 facility has a</p>	K010000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>capacity of 68 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except one detached garage and one large shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/06/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 doors leading to hazardous areas such as the Kitchen was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 16 residents on 400 hall which is adjacent to the Kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 12:57 p.m. with the Maintenance Supervisor, the north corridor door leading into the Kitchen on Service hall east had a closing device on the door, however, when the door was released from an open position the door failed to close completely and latch into its door frame. Based on interview on 06/03/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned corridor door would not completely close and latch into it's door frame.</p>	K010029	<p>On June 3rd, 2013 the door was immediately adjusted to function properly and latch as necessary. On June 6th, 2013 the door closure spring and a new strike plate on the door frame allowing the door to close and latch completely. All residents have the potential to be affected. Plant Operations Director or designee will check this door for proper latching on daily rounds. A checklist has been developed for tracking and monitoring proper operation of the door latch. These checklists will be completed 5x/wk for 4 weeks, then 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. Plant Operations Director or designee will complete the checklists</p>	07/03/2013			

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	3.1-19(b)			

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 11 exit doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks shall automatically unlock upon actuation of an approved fire alarm system and remain unlock until the system is manually reset. This deficient practice could affect 21 residents on 500 hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 06/03/13 during a fire alarm test at 2:47 p.m. with the Maintenance Supervisor, the electromagnetic locks on the east and west Service hall exit doors would not unlock when the fire alarm was activated. Based on interview concurrent with the observations, it was acknowledged by the Maintenance Supervisor both exit doors on Service hall did not unlock after the fire alarm was activated.</p> <p>3.1-19(b)</p>	K010038	<p>Contracted Service Provider was immediately contacted for service call. Contracted Service Provider arrived on June 5th, 2013 and found a defective relay. This was immediately replaced and is fully operational. activity involvement. All residents on health center have the potential to be affected. Random checks will be completed for properly unlocking of these doors when fire panel is activated. 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. Plant Operations Director or designee will complete the audits.</p>	07/03/2013			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 06/03/13 at 2:45 p.m. with the Maintenance Supervisor, the following was shifts were not conducted:</p> <ol style="list-style-type: none"> A fire drill was not documented for the second shift of the fourth quarter of 2012. A fire drill was not documented for the third shift of the third quarter of 2012. A fire drill was not documented for the second shift of the second quarter of 2012. <p>Based on interview on 06/03/13 during the Fire Drill Report review with the Maintenance Supervisor, it was</p>	K010050	<p>Plant Operations Director and Assistant have been inserviced on proper fire drill requirements and procedures.</p> <p>All fire drills have now been listed on Plant Operations calendar according to requirements and procedures.</p> <p>ED or designee will review this calendar for proper procedures monthly. A checklist has been developed for tracking and monitoring proper procedures.</p> <p>These checklists will be completed monthly until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. ED or designee will complete the checklists.</p>	07/03/2013			

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	<p>acknowledged there was no other documentation available for review to verify these drills were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>				

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 5-5.3.2.1.6.1 requires the following: A DACT (Digital Alarm Communicator Transmitter) shall employ one of the following combinations of transmission channels:</p> <p>(1) Two telephone lines (numbers) (2) One telephone line (number) and one cellular telephone connection (3) One telephone line (number) and a one way radio system (4) One telephone line (number) equipped with a derived local channel (5) One telephone line (number) and a one way private radio alarm system (6) One telephone line (number) and a private microwave radio system (7) One telephone line (number) and a two way RF multiplex system (8) A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter</p>	K010052	Digital Alarm Communicator Transmitter had a fully functional primary line. Secondary line was discovered to have been disconnected due to a billing issue. 1. ED contacted AT&T immediately upon discovering the issue and also contacted Accounts Payable to resolve the issue. Secondary line was restored and fully functional on June 14, 2013.2. Service Contractor contacted immediately for system check on the trouble light for panel. System to be fully functional to annunciate at the control center by means of audible and visible indicators. A checklist has been developed for checking of both primary and secondary lines, as well as fully functional visual annunciating trouble light at control center. These audits will be completed 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. Plant Operations Director or designee will complete the audits.	07/03/2013			

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	<p>and the switched telephone network serving central office is monitored for integrity so the occurrence of an adverse condition in the path shall be annunciated at the supervising station within 200 seconds. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an observation on 06/03/13 at 3:05 p.m. with the Maintenance Supervisor, the Secondary telephone line was not working, only the Primary telephone line transmitted a signal to the monitoring company. Based on interview on 06/03/13 at 3:07 p.m. with the Maintenance Supervisor it was acknowledged the Secondary telephone line had been experiencing problems in the past and was currently not working.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems. LSC 9.6.7.5 states: A system trouble signal shall be annunciated at the control center by means of audible and visible indicators. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p>			

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	<p>Based on observation on 06/03/13 at 2:50 p.m. with the Maintenance Supervisor, the fire alarm system was placed into trouble when a phone line from the dialer was disconnected. An audible signal on the Fire Alarm Control Panel (FACP) located at the Main nurses's station was emitted but the FACP did not illuminate any trouble indicators to associate the audible to trouble in the system. Based on interview on 06/03/13 at 3:07 p.m. with the Maintenance Supervisor, it was acknowledged an audible signal did sound, but a trouble light did not illuminate on the FACP.</p> <p>3.1-19(b)</p>			

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K010061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on record review, observation and interview; the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on review of Quarterly sprinkler inspection reports on 06/03/13 at 3:10 p.m. with the Maintenance Supervisor, the sprinkler inspection report conducted by Armor Fire Protection on 05/01/13 indicated the PIV lacked electronic supervision. Based on observation on 06/03/13 at 3:20 p.m. with the Maintenance Supervisor, the PIV shutoff lever was not secured with a lock. Based</p>	K010061	<p>On 6/14/13 Contracted Service Provider was contacted in regard to scheduling repair. Problem was corrected and inservice provided to Plant Operations Director and Assistant for timely follow up of service provider recommendations.</p> <p>ED or designee will check service provider recommendations monthly until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action.</p>	07/03/2013	

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	<p>on interview at the time of record review and observation, the Maintenance Supervisor acknowledged the PIV was not mechanically secured and the PIV was not electronically supervised to transmit a signal to the Fire Alarm Control Panel.</p> <p>3.1-19(b)</p>			

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Systems report on 06/03/13 at 3:30 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for two private fire hydrants on the north end of the facility's property. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed</p>	K010062	<p>1. Plant Operations Director contacted local service provider to request inspections for two private fire hydrants. 2. Automatic Sprinkler Head in mop closet was replacted. These issues were addressed with Plant Operations Director and Assistant through inservice instruction and ongoing checks by ED for routine preventive maintenance checks and rounds to be conducted at least monthly and results of findings immediately addressed and forwarded to QA for continued follow up.</p>	07/03/2013			

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	<p>documentation of an annual fire hydrant inspection was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 9 sprinklers in the Kitchen which had a visible accumulation of corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the 16 residents in the adjacent 400 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 1:25 p.m. with the Maintenance Supervisor, one automatic sprinkler head in the mop closet next to the Dietary Manager's office had accumulated amounts of corrosion on the entire sprinkler head. Based on interview concurrent with the observation with the Maintenance Supervisor, it was acknowledged the sprinkler head should</p>						

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>Based on observation and interview, the facility failed to regulate the use of 1 of 1 portable space heaters in an employee area. This deficient practice could affect anyone visiting the Dietary Manager's office in the Kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 1:45 p.m. with the Maintenance Supervisor, a portable space heater which was plugged in for use was located in the Dietary Manager's office in the kitchen on Service hall. Based on interview on 06/03/13 at 1:50 p.m., it was acknowledged by the Maintenance Supervisor, space heaters were not allowed and this was substantiated in a written portable space heater policy addressing their use.</p> <p>3.1-19(b)</p>	K010070	<p>All staff with space heaters in offices were immediately instructed to remove and discontinue in future use.</p> <p>Plant Operations Director and ED made rounds on 6/3/13 to personally remove any remaining space heaters within the campus.</p> <p>An inservice was conducted to instruct staff not to bring any personal space heaters into the campus in the future.</p> <p>Plant Operations Director or designee will add checking for space heaters into routine rounds and preventive maintenance checks 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. Plant Operations Director or designee will complete the audits.</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155735		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176			
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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Oxygen storage rooms where oxygen transfer occurs had a working electrically powered exhaust vent. This deficient practice could affect 24 residents on 100 hall hall as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 1:22 p.m. with the Maintenance Supervisor, the electrically powered exhaust vent in the oxygen transfill room on 100 hall was not working. Based on interview on 06/03/13 at 1:24 p.m. it was acknowledged by the Maintenance Supervisor, oxygen transfer does occur in</p>	K010143	<p>On 6/12/2013 a new motor was installed to exhaust fan to provide proper ventilation to the room.</p> <p>An in-service was conducted for staff to instruct on communicating through completing work orders for non-functioning exhaust fans and the importance of them. Plant Operations Director or designee will check exhaust fan to routine rounds and preventive maintenance checks 2x weekly for 4 weeks, monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for ongoing needs and action. Plant Operations Director or designee will complete the audits.</p>	07/03/2013			

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	<p>the Oxygen transfill room and the exhaust vent was not working.</p> <p>3.1-19(b)</p>			