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| 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 11/21/2012 |
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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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| K0000 | <p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 11/21/12</p> <p>Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Ashford Place Health Campus was found not in compliance with 410 IAC 16.2-3.1-19(b).</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 and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 50 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and was found not in compliance with the state law in regard to</p> | K0000 | <p>Ashford Place Health Campus submits this plan of correction in response to the allegation of noncompliance cited during the Quality Assurance Walk-thru Survey that was conducted on November 21, 2012. Please accept this plan of correction as the providers letter of credible allegation of compliance effective December 21,2012.</p> | |
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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>smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached plastic storage shed providing facility storage services which is not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/28/12.</p> | | | |

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| K9999 | <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date of this rule.</p> <p>This State Rule has not been met as evidenced by:</p> <p>1. Based on observation and interview, the facility failed to maintain 6 of 138 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Plant</p> | | | K9999 | <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Air deflectors were installed on the effected supply air ducts to prevent them from adversely affecting the operations of the smoke detectors. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Plant Operations or his designee will monitor the air deflector weekly to ensure that they are positioned appropriately to prevent them from adversely affecting the operations of the smoke detectors, with a report given to the Governing Quality Assurance committee monthly for one quarter and quarterly thereafter.</p> <p>Corrective actions accomplished for those residents found to be affected</p> | | 12/21/2012 |

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| | <p>Operations Director and the Assistant Director of Plant Operations during a tour of the facility from 9:20 a.m. to 10:45 a.m. on 11/21/12, the following corridor smoke detectors were each installed less than three feet from an air supply diffuser or return air opening:</p> <p>a. the smoke detector outside the Health Center Therapy was installed on the ceiling sixteen inches from an air return vent.</p> <p>b. the smoke detector in the Service Corridor outside the Clean Linen room was installed on the ceiling one foot from an air supply vent.</p> <p>c. the smoke detector in the Service Corridor by the Assisted Living entrance doors was installed on the ceiling six inches from an air supply vent.</p> <p>d. the smoke detector by Room 501 was installed on the ceiling ten inches from an air supply vent.</p> <p>e. the smoke detector in the Assisted Living Cafe Lounge was installed on the ceiling eight inches from an air supply vent.</p> <p>f. the smoke detector in the Memory Care Living Room was installed on the ceiling 27 inches from an air return vent.</p> <p>Based on interview at the time of the observations, the Plant Operations Director and the Assistant Director of Plant Operations acknowledged the aforementioned smoke detectors were</p> | | <p>by the alleged deficient practice: No residents were affected by the alleged deficient practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Quarterly inspections were conducted for the sprinkler system by a qualified vendor on the following dates: 2/14/125/14/128/15/1212/13/12 Although the test was conducted timely, the vendor failed to update the inspection tag appropriately and the campus Maintenance personnel misfiled the inspection report. A calendar tracking system has been implemented to included all required inspections are timely conducted. The Director of Plant Operations will be responsible to track and schedule each required inspection. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Director of Plant Operations or his designee will monitor the inspections monthly to ensure that they are completed timely, with a report given to the</p> | | | | |

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| | <p>each installed less than three feet from an air supply diffuser or return air opening.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of R.C. Fire Protection LLC "Sprinkler System Inspection" documentation dated 05/14/12 with the Plant Operations Director and the Assistant Director of Plant Operations during record review from 10:45 a.m. to 10:55 a.m. on 11/21/12, documentation of a third quarter 2012 (July, August September) quarterly sprinkler system inspection was not available for review. Based on interview at the time of record review, the Plant Operations Director and the Assistant Director of Plant Operations</p> | | Governing Quality Assurance committee monthly for one quarter and quarterly thereafter. | |

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| | <p>acknowledged third quarter 2012 sprinkler system inspection documentation was not available for review.</p> <p>3.1-19(b)</p> | | | |