

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/20/2013
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST 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: 11/20/13</p> <p>Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Shelbyville 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors with battery powered smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>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.</p> <p>The Heritage House of Shelbyville respectfully requests consideration for paper compliance. The findings can primarily be reviewed with use of the attached documentation to support the</p>	

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>has a capacity of 141 and had a census of 83 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>plan of correction for the Life Safety 2567.</p>		

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 doors to hazardous areas such as the kitchen door would self close and latch securely into its frame. This deficiency could affect 20 residents on Center hall west which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 at 1:45 p.m. with the Maintenance Supervisor, the Dietary managers office door which separates the kitchen from the exit access corridor on Center hall west was not provided with a self closing device on the door. Based on interview on 11/20/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned door was open at the time of inspection</p>	K010029	<p>K029</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>The maintenance department has</p>	12/13/2013

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	without a self closing device on the door which would ensure the exit access corridor was not exposed to the kitchen.  3.1-19(b)		installed a self closing door closer on the dietary manager office door  referenced in this finding. The door closer has been tested and will self close  door allowing it to latch in place.  The maintenance department manager  and or designee conducts scheduled physical plant rounds 3 X's weekly on an  ongoing basis. Self closing door closers have been installed previously when a  door adjoining potentially hazardous areas was identified.  Physical plant rounds and  monitoring will continue in accordance with established maintenance department	

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			<p>schedule, which will include inspecting, ensuring doors with self close devises</p> <p>are closed and are not prevented from closing/latching, and meet requirements</p> <p>related to separating potentially hazardous areas.</p> <p>Any concerns identified while being monitored will be corrected immediately, with concerns added to the</p> <p>maintenance department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	

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K010052 SS=E	<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>Based on observation and interview, the facility failed to ensure 1 of 22 manual fire alarm boxes was unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect 28 residents on north hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 at 11:15 a.m. with the Maintenance Supervisor, the manual fire alarm box provided for north hall was located in the exit foyer of the Main front entrance which was only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants. Based on interview on 11/20/13 at 11:20 a.m. with the Maintenance Supervisor, it was</p>	K010052	<p>K052</p> <p>There were no specific residents identified in this finding. The corrective action will address those residents with the potential to be affected by this finding.</p> <p>The manual fire pull alarm box located in the entry foyer has been relocated by a qualified service provider.</p> <p>A copy of the service invoice</p>	12/13/2013			

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	acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.  3.1-19(b)		(attachment A) has been included with this plan  of correction to validate the alarm box has been relocated. The alarm box was  tested after being relocated within the facility and use does not require access  to exit door key pad.  The maintenance department manager  and designee have inspected all entry foyers, and manual fire pull alarm boxes.  All pull boxes can be reached and used without accessing the key pad entry/exit  system.  Ongoing in-house fire alarm system  testing and inspection by both the		

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			<p>maintenance department and qualified fire</p> <p>system maintenance providers will continue. All findings requiring service will</p> <p>be repaired immediately to ensure the fire alarm and suppression systems are</p> <p>fully functioning and are accessible. Inspection and fire drill records are</p> <p>maintained to show ongoing compliance.</p> <p>Any concerns identified while</p> <p>being monitored will be corrected immediately, with concerns added to the</p> <p>maintenance department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 73 of 73 resident rooms were not using the egress corridors as a portion of a return air system/plenum for the heating, ventilating, or air conditioning (HVAC) system. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations on 11/20/13 during a tour of the facility between 11:00 a.m. and 3:14 p.m. with the Maintenance Supervisor, all resident rooms on Station 1, Station 2, Station 3 and Station 4 were using the egress corridors as a return air system. Based on interview on 11/20/13 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air was exhausted in the corridor for the aforementioned adjoining</p>	K010067	<p>K067</p> <p>The Heritage House of Shelbyville respectfully requests a waiver for this finding. Smoke detectors are located in the areas identified in this finding. Activation of the fire alarm system will trigger relays that shut down the air handlers in these portions of the building. Once the air handler is closed, smoke will be prevented from transferring from one smoke zone to another.</p>	12/13/2013			

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	rooms.  3.1-19(b)		<p>Modifications to the existing air handling system will pose a hardship for residents displaced during the installation process. The facility would also incur financial hardship for an estimated cost of \$59,000 conservatively to upgrade the air handling system to meet this requirement. The history of the facility reflects no incidents resulting from this finding.</p> <p>Attachment B, HVAC Quote</p> <p>Attachment C, SF 54147 LSC Waiver</p>	

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			Request  Attachment D, Facility floor plan  Attachment E, Income Statement	

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents</p>	K010144	K144	12/13/2013		There were no specific residents	

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	<p>as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 11/20/13 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load testing was documented but could not verify it to be 30 percent of the EPS nameplate rating for the past twelve months. Based on interview on 11/20/13 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but were unaware it had to be at least 30 percent. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>		<p>identified in this finding. The corrective action will address those residents</p> <p>with the potential to be affected by this finding.</p> <p>The facility has approved for</p>	

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			<p>Vanguard Generator Services Inc. to provide a load bank test on the generator</p> <p>(attachment F). The load test is scheduled to be completed on 12/9/13. The test</p> <p>results will be documented and maintained on file by the maintenance department</p> <p>for inspection.</p>	

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			<p>Additionally the generator service</p> <p>provider has been requested to conduct an independent generator load test with the</p> <p>facility annual generator service. Load testing by maintenance department will</p> <p>be ongoing monthly and recorded on the generator test log. Weekly the</p> <p>maintenance department will continue the generator exercise. Results are</p>	

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			<p>recorded by the maintenance department and available for inspection.</p> <p>Any concerns identified while</p> <p>being monitored will be corrected immediately, with concerns added to the</p>	

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			<p>maintenance department monthly QAPI review to amend the process as needed to</p> <p>resolve or correct findings.</p>	