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 08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	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). Survey Date: 08/25/14 Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460 Surveyor: Mark Bugni, Life Safety Code Specialist 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. 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. The healthcare	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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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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	portion of the facility has a capacity of 68 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review by Dennis Austill, Life Safety Code Specialist on 08/28/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010029 SS=E	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 the corridor door to 1 of 1 kitchen hazardous area, such as combustible storage rooms over 50 square feet in size, 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 44 residents who use	K010029	Self closing device has been installed in accordance with the code. All residents have the potential to be affected. Inspection to identify any other areas of the facility that could potentially be affected has been completed. Any other area that meets this criteria will have self closing device installed per life safety code. Inspections of this	09/24/2014

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	the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 08/25/14 at 11:20 a.m. with the director of plant operations, the kitchen food storage room, which measured three hundred twenty square feet and stored twenty eight shelves of cardboard boxes of food supplies in wooden boxes and paper, lacked a self closing device on the door. The lack of self closing device on the food storage room door was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 08/25/14 at 3:00 p.m. 3.1-19(b)		and any other area that meets this specific criteria will be added to preventive maintenance checklist. Checklist will be reviewed weekly x 5 weeks, and then monthly thereafter until substantial compliance is achieved. Results of monitoring will be discussed with QA team monthly for at least 6 months for ongoing needs and action. Plant Operations or designee will complete checklists with random audits by Adminstrator.	
K010046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be	K010046	Plant Operations immediately completed 30 minute and 90 minute check to backup lighting. All residents have the potential to be affected. Life Safety recommended form has been implemented to ensure compliance of this code. This will be checked monthly until	09/24/2014

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	provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility during periods of power outages. Findings include: Based on record review on 08/25/14 at 9:50 a.m. with the director of plant operations, the Emergency Lighting Log was reviewed and indicated a monthly test was conducted on the emergency generator battery backup light over the past year but lacked an annual ninety minute test. Based on an interview with the director of plant operations on 08/25/14 at 10:10 a.m., the emergency generator battery backup light is not tested annually for ninety minutes. The lack of a ninety minute annual test on the emergency generator battery backup light was verified by the director		substantial compliance is achieved. Results of monitoring will be discussed with QA team monthly for at least 6 months for ongoing needs and action. Plant Operations or designee will complete checklists with random audits by Adminstrator.	

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	of plant operations at the time of interview and acknowledged by the administrator at the exit conference on 08/25/14 at 3:00 p.m. 3.1-19(b)			
K010144 SS=F	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. Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator 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: a. Under operating temperature	K010144	Plant Operations immediately implemented a new form to indicate all the required information per life safety code in regards to K144 code. All residents have the potential to be affected. This will be monitored by utilizing a checklist weekly x 5 weeks, and then monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for at least 6 months for ongoing needs and action. Plant Operations or designee will complete the audits.	09/24/2014

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	conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 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, staff and visitors. Findings include: Based on a review of the Emergency Generator Monthly Load Test Log with the director of plant operations on 08/25/14 at 10:45 a.m., the monthly load test reports dating from 08/12/13 through 08/19/14 failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load tests reports each indicated voltage for the three branches of power. The lack of a documented thirty percent monthly load test was verified by the director of plant operations at the time of record review and telephone interview, and acknowledged by the administrator at the exit conference on 08/25/14 at 3:00 p.m. 3.1-19(b)			