

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240
---	---

(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
K 0000 Bldg. 01	<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: 11/10/15</p> <p>Facility Number: 012854 Provider Number: 155797 AIM Number: 201104690</p> <p>At this Life Safety Code survey, Aspen 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 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 64 and had a census of 62 at the time of this</p>	K 0000	<p>The submission of this Plan of Correction does not indicate an admission by Aspen Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Aspen Health Campus. This facility recognized it's obligation to provide legally and medially necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240
---	---

(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
K 0018 SS=E Bldg. 01	<p>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 11/17/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observations and interview, the facility failed to ensure 1 of 2 main dining room doors was provided with latching hardware. This deficient practice affects 35 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 11/10/15 at 11:50 a.m. with the director of plant operations, the north dining room door lacked latching hardware which prevented the door from latching into the door frame. This was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on</p>	K 0018	<ol style="list-style-type: none"> The latch on the dining room door was assessed by the director of plan operations 11/20/15 and was taken off and adjusted to secure the latching on 11/25/15. 35 residents that eat in this dining room had the potential to be affected. Director of plant operations was educated by the Home office support on Life Safety Requirements for the importance of the need for positive latching hardware. 	11/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/10/2015	
NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240			
(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
K 0025 SS=E Bldg. 01	<p>11/10/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 attic smoke barriers was maintained to provide a one half hour fire resistance rating. This deficient practice affects 14 residents who reside on the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation with the director of plant operations on 11/10/15 during a tour of the attic smoke barriers from</p>			K 0025	<p>4. The door will be monitored weekly by the director of plant operations x 2 weeks, then monthly x 2 months. All doors protecting corridors were audited on 11/20/15. Results will be reviewed during the QA meeting and any further recommendations will be made.</p> <p>1. The 300 hall attic smoke barrier wall had a one half inch gap extending five feet along the truss/smoke barrier wall juncture where the drywall tape was missing, exposing one half inch between the two joints. The joints have been retaped and patched to close the exposure 11/25/15.</p> <p>2. 14 residents that live on this</p>		11/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240
---	---

(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
K 0130 SS=F Bldg. 01	<p>12:15 p.m. to 1:00 p.m., the 300 Hall attic smoke barrier wall had a one half inch gap extending five feet along the truss/smoke barrier wall juncture where the drywall tape was missing, exposing the half inch gap between the two joints. The 300 Hall attic smoke barrier wall half inch gap between the truss/smoke barrier wall juncture was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 11/10/15 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 48 of 48 battery backup exit lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC Section 4.6.12.3 requires equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. Section 7.9.3</p>	K 0130	<p>hall have the potential to be affected.</p> <p>3. Director of plant operations was educated by the Home office support on 11/20/15 on the importance of Life Safety Regulations of sealing all holes for a smoke barrier. During monthly rounding the director of plant operations will inspect the building and seal up any breaks.</p> <p>Director of plant operations will do weekly audits x 4 weeks, then monthly audits x 3 months inspect the building on a monthly basis for breaks or holes and correct any smoke barriers.</p> <p>K130 completion date 11/20/15</p> <p>1. The ninety minute backup exit light load test was not completed annually. The test was completed 11/19/15.</p> <p>2. All 48 residents had the potential to be affected.</p> <p>3. Director of plant operations was educated by the Home office support on 11/19/15 on Life Safety Regulations and the importance of running the ninety minute load test. The load test will be completed</p>	11/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/10/2015
NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240		
(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	
	<p>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 affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 11/10/15 at 10:15 a.m. with the director of plant operations, the Exit Light Test Log indicted the last annual ninety minute test conducted on forty eight battery backup exit lights was conducted on 05/09/14. Based on an interview with the director of plant operations on 11/10/15 at 10:30 a.m., there was no annual ninety minute test conducted on the forty eight battery backup exit lights since 05/09/14. The lack of an annual ninety minute test on forty eight battery backup exit lights was verified by the director of plant operations at the time of record review and interview and acknowledged by the administrator at the exit conference on</p>		<p>annually.</p> <p>4. DPO conducted a load test on 11/19/15 and will conduct monthly load test in accordance with Life Safety Regulations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/10/2015
NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240		
(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	
	11/10/15 at 1:00 p.m. 3.1-19(b)				