STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING -- B. WING	02/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/03/23 Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460 At this Emergency Preparedness survey, Ashford Place Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The healthcare portion of the facility has a capacity of 68 and had a census of 51 at the time of the survey. Quality Review completed on 02/07/23	E 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/03/23 Facility Number: 004268 Provider Number: 155735	K 0000	The submission of this plan of correction does not indicate an admission by Ashford place health campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Ashford place	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Simpson	Executive Director	02/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	AIM Number: 200504460 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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 68 and had a census of 51 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed. Quality Review completed on 02/07/23		health campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 5 means of egress was continuously maintained free of all obstructions	K 0211	The bench that was obstructing the means of egress from the front living room to the public way was	02/03/2023

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	or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a facility tour with the Facilities Management Support Professional on 02/03/23 between 11:25 p.m. and 1:30 p.m., the exit from the Front Living Room to the outside was obstructed with a large bench which would prevent residents from accessing the public way free of all obstructions or impediments with full instant use in the case of fire or other emergency. This finding was acknowledged by the Facilities Management Support Professional at the time of discovery and again at the exit conference with the Facilities Management Support Professional present. 3.1-19(b)		relocated to a section of the front porch that would not block the means of egress. The Director of Plant Operations and the Assistant Director of Plant Operations were educated by the Executive Director on K211 NPFA 101 Means of Egress – General. Aisles, passageways, corridors, exits discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. The Director of Plant Operations will inspect the deficient area for proper means of egress 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect 20 residents, staff and visitors if needing to exit the facility.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected			

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	throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the freezer in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 4 staff. Findings include: Based on observations and interview during a facility tour with the Facilities Management Support Professional on 02/03/23 between 11:25	K 0351	The items that were stacked to close to the to the bottom of the sprinkler deflector were moved down so there was at least 18 inches between them and the sprinkler deflector. The Director of Plant Operations and the Assistant Director of Plant Operations were educated by the Executive Director on K 351 NFPA 101 Sprinkler System – Installation. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous	02/04/2023

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	p.m. and 1:30 p.m., the walk-in freezer in the kitchen had storage stacked within 18 inches of the ceiling. Based on interview at the time of observation, the Facilities Management Support Professional acknowledged the aforementioned sprinkler head was obstructed. This finding was acknowledged by the Facilities Management Support Professional at the time of discovery and again at the exit conference with the Facilities Management Support Professional present. 3.1-19(b)		obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. The Director of Plant Operations will inspect the walk-in freezer for proper storage height 1 X a week for 1 month and 1 X a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect up to 4 staff.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under	K 0712	The Director of Plant Operations conducted a second shift fire Drill on 2/16/2023.	02/16/2023

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	varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review of the "Logbook Documentation regarding Fire Drills" and interview with the Facilities Management Support Professional on 02/03/23 between 9:40 a.m. and 11:25 p.m., 9 of 12 quarterly fire drills were conducted near the end of the month, between the 26th and 30th day of the month. This finding was acknowledged by the Facilities Management Support Professional at the time of discovery and again at the exit conference with the Facilities Management Support Professional present. 3.1-19(b)		The Director of Plant Operations and the Assistant Director of Plant Operations were educated by the Executive Director on K 712 NFPA 101 Fire Drills. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. The Director of Plant Operations will inspect for the proper timing of fire drills 1 x a week for 1 month and 1 x a month for 3 months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors in the facility.	