

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155727	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2014
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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421
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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: 07/08/14</p> <p>Facility Number: 003924 Provider Number: 155727 AIM Number: 200472040</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Stonebridge 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 was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 68</p>	K010000		

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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K010038 SS=E	<p>and had a census of 50 at the time of this survey.</p> <p>All areas where 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 07/15/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure exit egress for 1 of 6 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in</p>	K010038	There were no residents affected by the sidewalk but many have the potential to be, therefore the sidewalk has been repaired to eliminate any tripping hazardsSystemic change was the repairing of the sidewalkand safety walks to be conducted monthlyResults of safety checks will be forwarded to QA committee monthly x12	08/07/2014

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K010046 SS=C	<p>elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect up to 13 residents, as well as staff and visitors while exiting the 300 hall through the south exit door to a public way.</p> <p>Findings include:</p> <p>Based on observation on 07/08/14 at 1:00 p.m. during a tour of the facility with the Director of Plant Operations, a section of the sidewalk from the 300 hall south exit (close to the Maintenance shop) was raised one half to one inch. Based on interview at the time of observation, the Director of Plant Operations acknowledged the section of the sidewalk from the 300 hall was raised one half to one inch and could be a tripping hazard.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review, observation and interview; the facility failed to ensure the documentation for the testing of 2 of 2 battery powered light sets was complete when testing monthly for 30 seconds.</p>	K010046	There were no residents affected or having the potential to be The battery testing documentation was completedPlant operations director was inserviced on requirementLog will be reviewed by Executive director and	08/07/2014			

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	<p>LSC 101, 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. 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. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the battery lights information in the Inspections book on 07/08/14 at 10:45 a.m. with the Director of Plant Operations present, there was no documentation to show the two battery back up light sets (generator and generator transfer room) were tested monthly for at least thirty seconds during the past twelve months. This was confirmed by Director of Plant Operations at the time of record review. Based on observation between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Plant Operations both battery back up light sets worked</p>		forwarded to QA committee monthly for review				

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K010067 SS=F	<p>properly.</p> <p>3-1.19(b)</p> <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. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on observation and interview, the facility failed to ensure over 50 fire dampers in 6 of 6 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect all residents, as well as staff and visitors while in the facility.</p> <p>Findings include:</p>	K010067	<p>There were no residents affected by the deficient practice and all have the potential to be. Therefore through inspection and maintenance as well as schedule implemented to prevent recurrence. All dampers inspected and serviced. Systemic change is adding damper service to QA logging with dates to ensure compliance and tracking. Director of plant operations is serviced on requirement. Director of plant operations to complete service log monthly. Log will be forwarded to QA monthly x12 for review.</p>	08/07/2014

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	<p>Based on observations on 07/08/14 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Plant Operations, there were over 50 fire dampers located in the HVAC supply air plenums in the ceilings throughout the facility. Based on interview with the Director of Plant Operations at the time of observations, the fire dampers have not been inspected and serviced by an HVAC contractor, or by someone in house, within the past four years.</p> <p>3.1-19(b)</p>				