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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/15/2013 |
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| NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140 |
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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: 07/15/13</p> <p>Facility Number: 005954 Provider Number: 155767 AIM Number: 201068810</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Springhurst Health Campus was found not in compliance with Requirements for Participation in Medicare, 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 fully sprinklered. 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 facility has a</p> | K010000 | Please accept the following Plan Of Correction as our credible allegation of compliance. | |
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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>capacity of 60 and had a census of 50 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K010029 SS=E | <p>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 2 of 3 doors leading into hazardous areas such as the Kitchen 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 14 residents on 500 hall which is adjacent to the Kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 07/15/13 at 12:57 p.m. and 1:10 p.m. with the Maintenance Supervisor, the Service hall corridor door and the 400 hall corridor door leading into the Kitchen both had closing devices on the doors, however, when the doors were released from an open position the doors failed to close completely and latch into their door frames. Based on interview on 07/15/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned corridor doors would not completely close</p> | K010029 | The 2 doors leading into the kitchen will be adjusted to ensure they close and latch upon release. The Director of Plant Operations will audit the kitchen doors weekly to ensure they close and latch upon release as required, making adjustments as needed. The Director of Plant Operations will report results of the weekly audits through monthly Quality Assurance meetings on an ongoing basis. The Director of Plant Operations is responsible to maintain overall compliance. | 08/14/2013 | | | |

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| K010038 SS=E | <p>and latch into their door frames.</p> <p>3.1-19(b) 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</p> <p>Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 14 exit access doors on 400 hall were not equipped with 2 locking devices on the doors. Section 18.2.2.2.5 states means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 4 to 5 staff members as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/15/13 at 1:33 p.m. with the Maintenance Supervisor, the only corridor door leading into the Front reception room had a door knob lock and a deadbolt lock on the door.</p> <p>Based on interview on 07/15/13 at 1:34 p.m. it was acknowledged by the Maintenance Supervisor there were two locking devices on the Front reception room corridor door.</p> <p>3.1-19(b)</p> | K010038 | The Director of Plant Operations will remove the deadbolt lock from the Business Office door. The Director of Plant Operations toured the campus and determined this is the only door that had a deadbolt lock installed. Director of Plant Operations will monitor to ensure no work orders are completed regarding installation of deadbolt locks on an ongoing basis. Director of Plant Operations is overall responsible to compliance is maintained. | 08/14/2013 |

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| K010050 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station during fire drills for the last 4 of 4 quarters. LSC 18.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 07/15/13 at 3:04 p.m. with the Maintenance Supervisor, the documentation for the drills performed for the past twelve months from 07/2012 to 06/2013, indicated the fire alarm system had been activated, but the verification of the transmission of the signal was not</p> | K010050 | The Director of Plant Operations and/or designee will check on the Fire Drill Report that communication to the monitoring station was completed, ensuring documentation of verification of the signal from now on. Springhurst Health Campus had previously maintained documentation on a monthly basis of transmission of the fire alarm signal to the monitoring station for all fire drills conducted at the campus in the monthly Fire Drill record book (this was shown to surveyor at time of survey). The Director of Plant Operations will monitor on a monthly basis for all Fire Drills to ensure the monitoring station receives the signal, and will document it on the Fire Drill Report. The Director of Plant Operations will review Fire Drill Reports monthly in Quality Assurance Committee on an ongoing basis. The Director of Plant Operations maintains overall responsibility for ongoing | 08/14/2013 | |

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| | <p>documented. Based on interview on 07/15/13 at 3:05 p.m. it was acknowledged by the Maintenance Supervisor none of the fire drill reports for the past twelve months documented the transmission of the signal was received by the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p> | | compliance. | |

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| K010051 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 24 smoke detectors was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 16 residents on 500 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/15/13 at 2:00 p.m. with the Maintenance Supervisor, the smoke detector in the 500 hall lounge was one foot from a ceiling supply vent.</p> | K010051 | The campus will relocate the designated smoke detector to an appropriate distance from the air handling system, allowing the smoke detector to function to it's fullest capacity. The Director of Plant Operations will audit the remainder of the campus to ensure no other smoke detectors are installed too close to the air handling system. Any additional smoke detectors found to be in too close proximity to the air handler system will be relocated to an appropriate distance to maintain compliance. The Director of Plant Operations will report results of the smoke detector audit and corrective actions through the Quality Assurance committee upon completion. The Director of Plant Operations is | 08/14/2013 | | | |

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| | <p>Based on interview on 07/15/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed within one foot of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p> | | responsible to monitor to ensure proper compliance maintained. | | | | |

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| K010062 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 4 of 4 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Systems report on 07/15/13 at 3:31 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspections for four private fire hydrants outside of 100, 300, 400, and 500 halls. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant</p> | K010062 | The campus will obtain and maintain an annual contract with an organization skilled in the maintenance of fire hydrants to inspect and test the hydrants for proper function annually. The campus will maintain documentation of the annual inspection to ensure the 4 of 4 private fire hydrants are continuously maintained in reliable operating condition to ensure the safety of all residents, staff, and visitors in the campus. The annual inspection will be reviewed in the campus Quality Assurance committee to ensure ongoing compliance. The Director of Plant Operations is overall responsible to maintain compliance. | 08/14/2013 | | | |

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| | inspection was not available for review. 3.1-19(b) | | | |

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| K010064 SS=B | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 portable ABC class fire extinguisher pressure gauge readings was in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 16 residents on 500 hall which is next to the Riser room on Service hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/15/13 at 2:45 p.m. with the Maintenance Supervisor, the ABC Class portable fire extinguisher gauge located in the Riser room on</p> | K010064 | The designated fire extinguisher in the riser room on the service hall will be serviced to ensure it is maintained within the acceptable range. The Director of Plant Operations and/or designee will audit all fire extinguishers monthly to ensure they are maintained in an acceptable range to ensure the overall safety of all residents, visitors, and staff. The results of each month's audit will be reported through the Quality Assurance committee on an ongoing monthly basis to ensure compliance is maintained. The Director of Plant Operations is overall responsible to maintain compliance. | 08/14/2013 | | | |

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| | <p>Service hall showed the extinguisher was overcharged. Based on interview on 07/15/13 at 2:46 p.m. with the Maintenance Supervisor, the gauge reading was not in the normal operating range.</p> <p>3.1-19(b)</p> | | | |

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| K010067 SS=E | <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 1 of 1 ventless gas fireplaces was connected to a chimney or vent and installed in accordance with Exception No. 2 to LSC Section 18.5.2.2. Exception No. 2 states the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. In addition, LSC 9.2.2 states ventilating or heat producing equipment shall be in accordance with NFPA 54, National Fuel Gas Code, 1999 Edition. NFPA 54 defines a decorative appliance for installation in a vented fireplace as a self contained, freestanding, fuel-gas burning appliance designed for installation only in a vented fireplace and whose primary function lies in the aesthetic effect of the flame. Section 6.6.2 states a decorative appliance for installation in a vented fireplace shall be installed only in a vented fireplace having a working chimney flue and constructed of noncombustible materials. This deficient practice could affect five residents, staff and visitors in the Main</p> | K010067 | <p>The Director of Plant Operations will disconnect the fireplace, turning off and capping the gas line to ensure the fireplace is inoperable in order to meet compliance until the campus determines if installation of chimney or vent will be done. The Director of Plant Operations will monitor to ensure the fireplace is maintained in an inoperable state until such a decision is made regarding installation of a vent or chimney. The Quality Assurance committee and campus staff members will be informed of the status of the fireplace until a decision is made regarding the addition of venting or chimney. Director of Plant Operations maintains overall responsibility for ongoing compliance.</p> | 08/14/2013 | | | |

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| | <p>Entrance reception area.</p> <p>Findings include:</p> <p>Based on observation on 07/15/13 at 12:15 p.m. with the Maintenance Supervisor the Main Entrance reception area has a self contained, free standing natural gas fired fireplace which was not connected to a chimney or vent. Five residents were observed sitting in the Main Entrance reception area by the fireplace. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Main Entrance reception area natural gas fireplace was not connected to a chimney or vent.</p> <p>3.1-19(b)</p> | | | | |