

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155735		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/13/2024	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 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: 05/13/24 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 52 at the time of the survey. Quality Review completed on 05/15/24			E 0000	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 and true representations of the quality of care and services provided to the residents of Ashford Place Health Campus. This facility recognized 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 the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (317) 398-8422. Sincerely, Zach Simpson, Executive Director		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Zachary Simpson

Executive Director

05/29/2024

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 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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

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 05/13/2024	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 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
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: 05/13/24 Facility Number: 004268 Provider Number: 155735 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 52 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 05/15/24			K 0000	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 and true representations of the quality of care and services provided to the residents of Ashford Place Health Campus. This facility recognized 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 the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (317) 398-8422. Sincerely, Zach Simpson, Executive Director		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024
FORM APPROVED
OMB NO. 0938-039

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 05/13/2024	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 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
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 2 of over 7 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 15 residents and staff using the 300 Hall Exit. Findings include: Based on observations and interview during a facility tour with the Facilities Management Support Professional and Director of Plant Operations on 05/13/24 between 11:50 a.m. and 1:30 p.m., the exit discharge from (1) the Service Hall Exit known as the "Dumpster Exit" and (2) the 300 Residence Hall Exit merged together and were not free of obstruction to a level egress to the public way. The sidewalk from the aforementioned facility exits, marked as exits, led around to a plastic storage shed which obstructed the path of egress. Moving past the shed were pipes and connections to the facility's generator which completely obstructed the sidewalk. Between the aforementioned exits and obstructions, the sidewalk had a curb and at no point sloped down to the blacktop or to the public way. Based on interview at the time of observation, the Director			K 0271	The Director of Plant Operations has hired the contractor Fitzpatrick construction to pour a concrete sidewalk from level with the existing sidewalk between exits 1 and 2 to the level with the blacktop public way behind the building. The Director of Plant Operations was educated by the Executive Director on K271- Discharge from Exits. Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. The Director of Plant Operation will inspect the deficient discharge exits for compliance 1 x 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		06/21/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

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 05/13/2024	
NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 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
	of Plant Operations Facilities Management Support Professional acknowledged that the walkway was in need of a ramp to have a complete level walking surface that was free of obstructions leading to the common way. This finding was acknowledged by the Facilities Management Support Professional and Director of Plant Operations at the time of observation and again at the exit conference with the Facilities Management Support Professional and Director of Plant Operations and Administrator all present. 3.1-19(b)				further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice could affect 15 residents and staff using the 300 Hall Exit. Exhibit A- K271 Discharge from Exits audit Exhibit B- Photos and other documentation		