

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/26/2014
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NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
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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: 11/26/14</p> <p>Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in resident rooms 301 to 306 and 324 to 326. The</p>	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after December 19, 2014. We respectfully request a desk review in lieu of a post survey revisit.	

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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K010020 SS=F	<p>remaining resident rooms had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts and equipment and Christmas decorations.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/05/14.</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 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 2 of 9 stairway doors in had a one hour rating, closed and latched into the door frame. LSC 19.3.1.1 requires any vertical opening to</p>	K010020	<p>K020 NFPA 101Life Safety Code Standard It is thepolicy of this facility to ensure that stairways, elevator shafts, light andventilation shafts,</p>	12/19/2014

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	<p>be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.3.3.1 requires a one hour rated door in a one hour vertical opening. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect all residents should the need arise to evacuate through the south stairway from the second and third floors.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 11/26/14 at 11:15 a.m. and then again at 12:42 p.m., the south stairway doors on the second and third floors failed to latch into the door frame. Based on an interview with the Maintenance Supervisor at the time of observations, a bar had been installed on the latching side of both doors preventing the doors from latching into the door frame.</p> <p>3.1-19(b)</p>		<p>chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> <li>· The bar in the south stairway doors on the second and third floors bar was adjusted to allow proper door latching immediately.</li> </ul> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice.</li> <li>· All stairway doors have been checked to ensure proper latching into the door frame by Maintenance Director/Designee and Customer Care Representatives.</li> <li>· All Management will be in-serviced on proper door latching to be audited during morning rounds. Education will be provided by the Maintenance Director/Designee and completed by December 19, 2014.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> <li>· Maintenance Director/Designee</li> </ul>		

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K010025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may		<p><i>and Customer Care Representatives will audit stairway doorlatching on morning rounds.</i></p> <ul style="list-style-type: none"> <li>·All Management will be in-serviced on proper door latching to be audited during morning rounds. Education will be provided by the Maintenance Director/Designee and completed by December 19, 2014.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> <li>·A CQI monitoring tool called Stairway Door Latching CQI will be utilized every week x 4 and Monthly x 3.</li> <li>·Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</li> <li>·Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>·December 19, 2014</li> </ul>		

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	<p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 third floor smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any of the 42 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 11/26/14 at 11:57 a.m., above the ceiling tile at the third floor smoke barrier there was annular space</p>	K010025	<p>K 025 NFPA 101Life Safety Code Standard It is the policy of this facility to ensure that Smoke barriers are constructed to provide at least a one half 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 and steel 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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <i>The call light wiring was sealed immediately above the ceiling tile on the third floor using state approved CP25WB+</i></p>	12/19/2014

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	<p>surrounding the call light system wiring that was not sealed. Based on an interview with the Maintenance Supervisor at the time of observation, he acknowledged the unsealed penetration stating a new call light system was recently installed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 11/26/14 at 9:52 a.m., the annular space surrounding a conduit in the ceiling of the service hall mechanical room was not sealed. Based on an interview with the Maintenance Supervisor at the time of observation, he acknowledged the unsealed ceiling penetration.</p> <p>3.1-19(b)</p>		<p><b><i>Intumescent Fire Barrier Sealant.</i></b></p> <p><i>·The conduit in the ceiling of the service hallmechanical room was sealed immediately usingstate approved CP25WB+</i></p> <p><b><i>Intumescent Fire Barrier Sealant.</i></b></p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p><i>·Allresidents and staff have the potential to be affected by the alleged deficientpractice.</i></p> <p><i>·Allwiring/conduits were checked to ensure proper sealing by the MaintenanceDirector/Designee.</i></p> <p><i>·AllManagement will be in-serviced on the proper sealing of wiring andconduits. Education will be provided bythe Maintenance Director/Designee and completed by December 19, 2014.</i></p> <p>What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur;</p> <p><i>·All wiring and conduits will remain sealedat all times including new construction and</i></p>				

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K010056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection,		<p><i>will be checked by Maintenance Director/Designee.</i></p> <ul style="list-style-type: none"> <li>· <i>All Management will be in-serviced on proper sealing of wire and conduits. Education will be provided by the Maintenance Director/ Designee completed by December 19, 2014.</i></li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> <li>· <i>A CQI monitoring tool called Wire and Conduit Sealing CQI will be utilized every week x 4 and Monthly x 3.</i></li> <li>· <i>Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</i></li> <li>· <i>Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</i></li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>· <i>December 19, 2014</i></li> </ul>	

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	<p>Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 sprinkler heads in the third floor lounge were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect approximately 12 residents in the third floor lounge area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 11/26/14 at 10:43 a.m., the third floor lounge had two sprinkler heads located sixty six inches apart. Based on interview at the time of observation, the Maintenance Supervisor stated the facility had removed a partial wall separating the aforementioned sprinkler heads therefore the sprinkler heads were now sixty six inches apart.</p> <p>3.1-19(b)</p>	K010056	<p>K 056 NFPA 101Life Safety Code Standard It is the policy of this facility to ensure that all sprinkler heads are located no closer than 6 feet apart. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·One sprinkler head was removed <i>immediately; however surrounding sprinklers were checked by Maintenance Director to ensure compliance regarding sprinkler spacing.</i></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents have the potential to be affected by the alleged deficient practice. ·All sprinkler heads were checked by the Maintenance</p>	12/19/2014			

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			<p><i>Director to ensure allsprinkler heads are 6 feet apart.</i></p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> <li>· <i>Maintenance</i></li> <li><i>Director/Designee will add proper distance placement of sprinkler heads to the annual preventative maintenance binder for a monthly audit.</i></li> <li>· <i>During new construction, the Maintenance Director/Designee will inspect the construction area to ensure sprinkler heads will be at least 6 feet apart.</i></li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> <li>· <i>A CQI monitoring tool called Sprinkler Head CQI will be utilized every week x 4 and Monthly x 3.</i></li> <li>· <i>Data will be collected by Executive Director/Designee and submitted to the CQI Committee.</i></li> </ul>	

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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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to document and conduct annual and weekly tests of the fire pump in accordance with LSC Section 9.7.5 and 19.3.5.1 and NFPA 25. NFPA 25, Table 5-1.1 and then 5-3.3.1 requires an annual test of each pump assembly shall be conducted under minimum, rated, and peak flows of the fire pump by controlling the quantity of water discharged through approved test devices. Section 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions-heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, suction reservoir is</p>	K010062	<p><i>If the threshold of 95% is not met, an action plan will be developed.</i></p> <p><i>·Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</i></p> <p>By what date the systemic changes will be completed. <i>·December 19, 2014</i></p> <p>K 062 NFPA 101 Life Safety Code Standard It is the policy of this facility to ensure that all automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <i>·Fire Pump located in the sprinkler riser room was inspected immediately.</i></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; <i>·All residents have the potential to be affected by the alleged</i></p>	12/19/2014	

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	<p>full. Additionally, 5-3.2.1 requires a no flow; ten minute pump test shall be performed weekly. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview on 11/26/14 at 9:50 a.m., the Maintenance Supervisor acknowledged the facility was not conducting annual and weekly inspections of the fire pump located in the sprinkler riser room.</p> <p>3.1-19(b)</p>		<p><i>deficient practice.</i></p> <ul style="list-style-type: none"> <li>·Maintenance Director/Designee will be in-serviced on proper fire pump inspections. Education will be provided by the Executive Director/Designee and completed by December 19, 2014.</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> <li>·Fire Pump Weekly and Annual Inspections will be added to the annual preventative maintenance binder.</li> <li>·Executive Director/Designee will ensure inspection occurs on a weekly and annual basis.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> <li>·A CQI monitoring tool called Fire Pump Inspections will be utilized every week x 4 and Monthly x 3.</li> <li>·Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</li> <li>·Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>·December 19, 2014</li> </ul>	

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

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