

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2015
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NAME OF PROVIDER OR SUPPLIER  PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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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: 01/08/15</p> <p>Facility Number: 000148 Provider Number: 155526 AIM Number: 100275500</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Persimmon 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 one story facility was determined to be of Type V (111) construction and fully sprinkled. 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</p>	K010000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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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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K010046 SS=E	<p>resident sleeping rooms. The facility has a capacity of 112 and had a census of 67 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/14/15.</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 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 exits was provided with emergency powered exterior lighting. This deficient practice could affect 18 residents who reside on the 300 Hall and would use the 300 Hall exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 01/08/15 at</p>	K010046	<p>K 046</p> <p>1. No residents were affected by this alleged negative practice. A double light fixture connected to the facility emergency generator has been mounted on the west side of the building providing emergency lighting along the one hundred foot long sidewalk surface at the 300 hall.</p> <p>2. In an effort to identify additional emergency exterior lighting concerns, the administrator and maintenance director</p>	01/21/2015

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K010072 SS=C	<p>11:40 a.m. with the maintenance supervisor, the 300 Hall exit discharged onto a sidewalk surface which extended one hundred feet on the west side of the facility to the parking lot. Furthermore, the one hundred foot long sidewalk surface on the west side of the facility had a double light electric fixture located on the neighboring building. Based on an interview with the maintenance supervisor on 01/08/15 at 11:50 a.m., the facility no longer owns the adjoining building and the double light fixture mounted on the exterior of the building is no longer electrically wired to the facility emergency generator. The lack of outside emergency lighting along the one hundred foot long sidewalk surface at the 300 Hall was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 01/08/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the</p>	K010072	<p>completed a walkthrough of the exterior building and no additional findings were noted.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for emergency exterior lighting.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a monthly walkthrough of the entire exterior building checking for emergency external lighting. Findings will be documented monthly on the facilities preventative maintenance form. Any negative findings will be corrected and reported to the administrator. Results of the monitoring will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.</p> <p>5. Date completed 1/21/15.</p>	01/21/2015

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	<p>facility failed to ensure 1 of 8 means of egress was continuously maintained free of obstructions. This deficient practice affect all staff who work in the Service Hall and would use the Service Hall exit during an evacuation in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 01/08/15 at 12:15 p.m., the Service Hall corridor next to the exit door had five, fifty pound plastic bags of salt stored on the floor, an eight foot by six foot employee metal locker stored along the wall, and two wheel chairs and eight cardboard boxes of paper products stored in the center of the corridor. Furthermore, the corridor width was reduced from eight feet to two feet along a twenty foot path down the corridor and up to the Service Hall exit door. The Service Hall corridor near the exit door used for storage of plastic bags of salt, and employee metal locker, wheel chairs, and cardboard boxes of paper products was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 01/08/15 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>were affected by this alleged negative practice. The service hall corridor has been cleared of all obstructions and impediments, enabling a full 8 feet along the twenty foot path down the corridor and up to the service hall exit door. 2. In an effort to identify any additional obstructions in the means of egress, a walkthrough of the entire facility was completed by the administrator with the maintenance director, with no additional findings at this time. 3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for means of egress.4. As a means of quality assurance, the maintenance director or designee will do a monthly walkthrough of the entire building checking all means of egress for any obstructions or impediments. The findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected and reported to the administrator. Results of the monitoring will be reviewed in quarterly QA meetings for continued compliance. Monitoring will be ongoing.5. 1/21/15</p>				

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

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