

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 12/17/2013
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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: 12/17/13</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, in areas open to the corridor and hard wired smoke detectors in</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 January 10, 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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	<p>resident rooms 301 to 306 and 324 to 326. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 100 and had a census of 64 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, equipment and Christmas decorations.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/26/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 24 third floor resident room corridor doors closed and latched into the door frame. This deficient practice could affect any of the 15 residents on third floor south hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/17/13 at 1:24 p.m., the corridor door to resident room 304 failed to latch into the door frame. This was acknowledged by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010018	<p>K018NFPA 101 Life Safety Code StandardIt is the policy of this facility to ensure that there are no impediments to the closing of doors. Doors are provided with a means suitable for keeping the door closed.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident Room 309's door was fixed immediately and able to latch into the door frame. 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 resident's doors have been checked to ensure proper latching into the door frame by Maintenance Director. All</p>	01/10/2014	

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			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 January 10, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All Management will audit resident door latching on morning rounds.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 January 10, 2014. 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; andA CQI monitoring tool called Door Latching CQI will be utilized every week x 4 and Monthly x 3.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.Non-Compliance with facility procedure may result in disciplinary action up to and including termination. By what date the systemic changes will be completed.January 10, 2014		

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K010038 SS=E	<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. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 5 exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. exit door. This deficient practice could affect staff evacuated through the second floor west exit and 15 residents evacuated through the third floor west exit door and 15 residents evacuated through the main dining room</p>	K010038	<p>K 038NFPA 101 Life Safety Code StandardIt is the policy of this facility to ensure that exit access is arranged so that all exits are readily accessible at all times.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Snow was immediately cleared on the exit discharge sidewalk and steps from the main dining room and the second and third floor west exit doors. "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" signage was added to 2 of 3 exit doors on the third floor.Kitchen Egress was cleared immediately. 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 Management and kitchen staff will be in-serviced on the immediate clearing of snow on all egresses by Maintenance Director. All doors were checked to ensure proper signage on all exit doors by the Maintenance Director.All egresses were checked by the Maintenance Director for proper clearance. Education will be provided by the</p>	01/10/2014			

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	<p>Findings include:</p> <p>Based on observation with maintenance supervisor on 12/17/13 from 2:26 p.m. to 2:40 p.m., the exit discharge sidewalk and steps from the main dining room and the second and third floor west exit doors were covered with three inches of snow. Based on an interview with the maintenance supervisor at the time of observation, his facility snowblower required repairs and was in the repair shop. He was shoveling by hand and had not gotten to these areas yet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 3 third floor exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 41 residents on the third floor.</p>		<p>Maintenance Director/Designee and completed by January 10, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Snow removal will occur once snow starts to accumulate by the Maintenance Director/Designee and oversee by the Executive Director/Designee. All exit doors will have the signage stating, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" to be checked by the Maintenance Director weekly. All Egresses will remain unobstructed at all times to be checked by Maintenance Director/Designee. All Management will be in-serviced on snow removal on all egresses, proper signage on exit doors and proper egress clearance. Education will be provided by the Maintenance Director/ Designee completed by January 10, 2014. 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 A CQI monitoring tool called Egress CQI will be utilized every week x 4 and Monthly x 3. 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. Non-Compliance</p>				

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	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/17/13 from 1:49 p.m. to 2:05 p.m., the exit doors from the center hall and the west end of the third floor were equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked signage regarding pushing the door to open. Based on an interview with the maintenance supervisor at the time of observations, signs had been posted but were recently removed.</p> <p>3.1-15(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 5 ground floor exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect staff evacuated through the second floor west exit and 15 residents evacuated through the third floor west exit door and 15 residents evacuated through the main dining room</p> <p>Findings include:</p> <p>Based on an observation with the maintenance director on 12/17/13 at 2:35 p.m., when evacuating from the</p>		with facility procedure may result in disciplinary action up to and including termination. By what date the systemic changes will be completed. January 10, 2014		

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K010056 SS=D	<p>second and third floor west exit doors, there were 18 milk crates, one trash can, one bag of trash and a mop bucket stored in the ground floor corridor between the stairway door and the exit door. This was acknowledged by the maintenance director at the time of observation.</p> <p>3.1-19(b)</p> <p>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, 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 2 sprinkler heads in the MDS office closet and 2 of 2 sprinkler heads in the activity office closet 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 was</p>	K010056	K 056NFPA 101 Life Safety Code StandardIt 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; Two sprinkler heads were removed immediately. How other residents having the potential to be affected by the	01/10/2014

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	<p>not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/17/13 between 1:18 p.m. and 2:21 p.m., the MDS office closet had two sprinkler heads mounted 30 inches apart and the activities office closet had two sprinkler heads mounted four feet apart. Measurements were provided by the maintenance supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>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 Director to ensure all sprinkler heads are 6 feet apart.All Management will be in-serviced on the proper distance placement of sprinkler heads. Education will be provided by the Maintenance Director/Designee and completed by January 10, 2013. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director will add proper distance placement of sprinkler heads to the annual preventative maintenance binder for a monthly audit.During upcoming construction, the Maintenance Director will inspect the construction area to ensure sprinkler heads will be at least 6 feet apart.All Management will be in-serviced on the proper distance placement of sprinkler heads. Education will be provided by the Maintenance Director/Designee and completed by January 10, 2013. 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; andA CQI monitoring tool called Sprinkler Head CQI will be utilized every week x 4 and</p>		

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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 record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on interview during the record review process with the maintenance supervisor on 12/17/13 at 3:42 p.m., he was unable to provided documentation to indicate an internal inspection of the pipes had been done in the past five years.</p>	K010062	<p>Monthly x 3.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.Non-Compliance with facility procedure may result in disciplinary action up to and including termination. By what date the systemic changes will be completed.January 10, 2014</p> <p>K 062NFPA 101 Life Safety Code StandardIt 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; Automatic Sprinkler piping system will be inspected immediately if deemed appropriate by ISDH.Sprinkler system is inspected quarterly by Plumbing Industrial Piping Enterprises, Inc.See Attachment A- Federal Regulation.See Attachment B- Evidence of Quarterly Wet Sprinkler Piping System 1-29-13See Attachment C- Evident of Quarterly Wet Sprinkler Piping System</p>	01/10/2014	

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	3.1-19(b)		4-5-13See Attachment D-Evidence of Quarterly Wet Sprinkler Piping System 7-19-13See Attachment E-Evidence of Quarterly Wet Sprinkler Piping System 10-14-13 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.Maintenance Director will be in-serviced on proper sprinkler pipe inspections. Education will be provided by the Executive Director/Designee and completed by January 10, 2014.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Sprinkler Pipe Inspection will be added to the annual preventative maintenance binder.Executive Director will ensure inspection occurs every 5 years if deemed appropriate by ISDH. 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; andA CQI monitoring tool called Sprinkler Pipe Inspections will be utilized every week x 4 and Monthly x 3.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		

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K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure the fire extinguisher in 2 of 2 medication rooms was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/17/13 from 2:00 p.m. to 2:13 p.m., the fire extinguisher mounted on the wall in the second and third floor medication rooms measured five foot eight inches from the floor to the top of the fire extinguisher. Measurements were provided by the maintenance supervisor.</p>	K010064	<p>developed. Non-Compliance with facility procedure may result in disciplinary action up to and including termination. By what date the systemic changes will be completed. January 10, 2014</p> <p>K 064NFPA 101 Life Safety Code Standard It is the policy of this facility to provide portable fire extinguishers. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Portable Fire Extinguishers in the medication rooms on the second and third floor were placed no more than 60 inches off the floor. 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 of being affected by the alleged deficient practice. All portable fire extinguishers were checked by the Maintenance Director to ensure placement is no more than 60 inches above the floor. All Management staff will be in-serviced on proper portable fire extinguisher placement of no more than 60 inches off the floor. Education will be provided by the Maintenance Director/Designee and completed by January 10, 2014. What</p>	01/10/2014

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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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	3.1-19(b)		measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Managers will audit portable fire extinguisher placement on morning rounds. During remodeling, Maintenance Director will ensure placements of portable fire extinguisher are no more than 60 inches off the floor. All Management staff will be in-serviced on proper portable fire extinguisher placement of no more than 60 inches off the floor. Education will be provided by the Maintenance Director/Designee and completed by January 10, 2014. 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 A CQI monitoring tool called Portable Fire Extinguisher Placement will be utilized every week x 4 and Monthly x 3. 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. Non-Compliance with facility procedure may result in disciplinary action up to and including termination. By what date the systemic changes will be completed. January 10, 2014		