

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0000  Bldg. 01	<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: 11/04/15</p> <p>Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570</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 9 resident rooms 301 to 306 and 324 to 326. The remaining resident rooms had battery operated smoke detectors. The facility</p>	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0018 SS=B Bldg. 01	<p>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 completed on 11/16/15 - DA</p> <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 1¾ 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 50 resident room doors on the second floor closed and latched into the door frame. This deficient practice took place in an empty hall but could affect up to 24 residents on</p>	K 0018	K018 (SS=B) NFPA 101 Life Safety Code Standard It is the policy of the facility to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are	12/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
	<p>the south 200 hall when open.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 11/04/15 at 12:17 p.m., the corridor door to resident room 205 failed to latch into the door frame. Based on interview at the time of observation, this was acknowledged by the Administrator.</p> <p>3.1-19(b)</p>		<p>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 Roller latches are prohibited by CMS regulations in all health care facilities. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -Door latch for room 205 was immediately repaired 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 corridor doors have been checked to ensure proper latching into the door frame by the Maintenance Director/ Designee -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 4th, 2015. What measures will be put into place or what systemic changes will be</p>	

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied		made to ensure that the deficient practice does not recur; -Maintenance Director / Designee will audit door latching during 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 December 4th, 2015. 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 Corridor Door Latching CQI will be utilized every week x 4 and Monthly x 5. -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.	

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  11/04/2015
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992		
(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	
	<p>protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure corridor doors to 1 of 3 soiled utility rooms on the second floor was provided with self closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 22 residents on the second floor.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Administrator on 11/04/15 at 12:10 p.m., the soiled utility room door on the second floor by room 212 did self close but failed to latch into the frame. The soiled utility room contained barrels of trash and hazardous waste. Based on interview, this was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>	K 0029	<p>K029 (SS=E) NFPA 101 Life Safety Code Standard It is the policy of the facility to ensure one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -The soiled utility room door mechanics were immediately adjusted to ensure proper self closing and latching. 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 soiled utility room doors were checked by maintenance to ensure doors closed and latched properly -All Management will be in-serviced</p>	12/04/2015	

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour		on proper soiled utility door latching to be audited during morning rounds. Education will be provided by the Maintenance Director/Designee and completed by December 4th, 2015. 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/Designee will audit corridor door latching on morning rounds. -All Management will be in-serviced on proper soiled utility door latching to be audited during morning rounds. Education will be provided by the Maintenance Director/Designee and completed by December 4th, 2015. 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 Soiled Utility Door Latching CQI will be utilized every week x 4 and monthly x 5. -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.	

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  11/04/2015	
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992			
(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			
	<p>duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, records and interview; the facility failed to ensure emergency light fixtures for 1 of 1 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 11/04/15 at 11:30 a.m., a battery powered emergency light was observed by the generator. Based on records review of the "Battery Operated Emergency Light Test Log" with the Maintenance Supervisor on 11/04/15 at 10:15 a.m., a 90 minute</p>	K 0046	<p>K 046 (SS=C) NFPA 101 Life Safety Code Standard It is the policy of the facility to ensure emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -All Emergency lighting were properly tested to standards and logged. 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 and staff have the potential to be affected by the alleged deficient practice. -All battery powered emergency lighting systems were tested to standards -Maintenance Director will be in-serviced on proper emergency lighting and maintenance. Education will be provided by the Executive Director /Designee and completed by December 4th, 2015. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; -All battery powered emergency lighting will be checked monthly for required amount and annually for the required amount by the Maintenance Director/Designee and properly logged.</p>	12/04/2015			

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  11/04/2015	
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992			
(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			
K 0062 SS=F Bldg. 01	<p>annual test was conducted in January of 2015, but the last 30 second monthly test was conducted on 07/03/2015. Based on interview at the time of record review, when ask if the emergency battery powered light has been tested 30 seconds monthly since 07/03/2015; the Maintenance Supervisor stated the emergency battery powered light were tested for 30 seconds since then but they were not recorded.</p> <p>3.1-19(b)</p> <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 sprinkler water flow alarm devices were tested quarterly for 1 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires water flow</p>	K 0062	<p>-Maintenance Director will be in-serviced on proper emergency lighting and maintenance. Education will be provided by the Executive Director /Designee and completed by December 4th, 2015. 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 auditing tool called Emergency Lighting CQI will be utilized every week x 4 weeks and Monthly x 5. -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.</p> <p>K 062 (SS=F) NFPA 101 Life Safety Code Standard It is the policy of the facility to ensure 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 What corrective action(s) will be</p>	12/04/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED  11/04/2015
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992		
(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	
	<p>alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the sprinkler inspection documentation with Maintenance Supervisor on 11/04/15 at 10:00 a.m., the facility lacked documentation of a sprinkler inspection where the water flow alarms were tested for the fourth quarter of 2014. Based on an interview at the time of record review, the Maintenance Supervisor was unable to provide any documentation to show a completed sprinkler inspection for the fourth quarter of 2014.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the deficient practice;</p> <p>-Documentation of completed sprinkler inspection for the fourth quarter of 2014 was immediately obtained (see attachment )</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. -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 4th, 2015. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>-Sprinkler systems inspections to be kept in preventative maintenance binder by Maintenance Director/ Designee</p> <p>-Executive Director / Designee will ensure inspection occurs quarterly and is properly logged and maintained. -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 4th, 2015. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</p>		

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0064 SS=E Bldg. 01	<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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 K Class portable fire extinguishers in the kitchen cooking area was provided maintenance when the gauge on the fire extinguisher indicated it was overcharged. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice could affect 15 residents using the main dining room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0064	<p>quality assurance program will be put into place; and -A CQI monitoring tool called Sprinkler System Inspection CQI will be utilized monthly x 6. -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.</p> <p>-Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>K 64 (SS=E) NFPA 101 Life Safety Code Standard It is the policy of the facility to ensure portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -Kitchen K Class fire extinguisher was immediately removed and serviced. -K class placard was immediately placed near the extinguisher stating the fire protection system shall be activated prior to using the fire extinguisher. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	12/04/2015

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  11/04/2015
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992		
(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	
	<p>facility with the Administrator on 11/04/15 at 11:30 a.m., the gauge on the K class portable fire extinguisher located in the kitchen indicated the extinguisher was over charged. Based on an interview at the time of observation, the Administrator confirmed the kitchen K Class fire extinguisher was over charged.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient</p>		<p>what corrective action(s) will be taken; -All residents have the potential to be affected by the alleged deficient practice. -All portable fire extinguishers were checked by Maintenance Director to ensure proper charge and signage. -Maintenance Director will be in-serviced on proper inspection of fire extinguishers and signage. Education will be provided by the Executive Director / Designee and completed by December 4th, 2015. 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 be in-serviced on proper inspection of fire extinguishers and signage. Education will be provided by the Executive Director / Designee and completed by December 4th, 2015. -Maintenance Director / Designee will inspected all portable fire extinguishers to ensure proper charge and signage monthly 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 Fire Extinguisher inspection and signage will be utilized every week x 4 for one month and Monthly for 5 months. -Data will be collected by Executive Director/Designee and submitted</p>		

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  11/04/2015	
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992			
(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			
K 0074 SS=B Bldg. 01	<p>practice could affect 15 residents using the main dining room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Administrator on 11/04/15 at 11:30 a.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview at the time of observation, the Administrator confirmed the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the</p>		<p>to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</p> <p>-Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</p>				

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
	<p>criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 curtains located in the conference room was flame retardant. This deficient practice could affect up to 15 residents near the conference room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator on 11/04/15 at 12:01 p.m., there were four curtains covering a dry erase board in the conference room. Upon inspection of the curtains, no flame retardant rating was found. Based on interview at the time of observation, the Administrator indicated there was no documentation regarding flame retardants for the curtains.</p> <p>3.1-19(b)</p>	K 0074	<p>K 074 (SS=B) NFPA 101 Life Safety Code Standard It is the policy of the facility that draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -Curtains were immediately removed and treated with flame retardant 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/Designee inspected all</p>	12/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
			<p>facility draperies, curtains, est. to ensure compliance with provisions 10.3.1 and NFPA 13. -All Management will be in-serviced on proper textile flame retardant rating and documentation. Education will be provided by the Maintenance Director/ Designee completed by December 4th, 2015. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; -All new draperies, curtains, est. will be inspected by the maintenance director/ designee to ensure proper flame retardant rating and documentation. -Maintenance Director/Designee will add proper textile flame retardant rating and documentation annual preventative maintenance binder for a monthly audit. -All Management will be in-serviced on proper textile flame retardant rating and documentation. Education will be provided by the Maintenance Director/ Designee completed by December 4th, 2015. 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 Textile flame retardant rating / documentation will be utilized every week x 4 for one month and Monthly for 5 months -Data will be collected by Executive Director/Designee and</p>	

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
K 0147 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two residents in room 316.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Administrator on 11/04/15 at 12:00 p.m., a refrigerator was plugged into an extension cord power strip in room 316. Based on interview, the Administrator acknowledged the extension cord power strip at the time of observation.</p>	K 0147	<p>submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</p> <p>-Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>K 147 (SS=B) NFPA 101 Life Safety Code Standard It is the policy of this facility to ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -Extension cord was immediately removed from resident room and refrigerator was plugged into hard wired outlet 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 outlets were inspected by Maintenance Director / Designee and Customer Care Representatives to ensure no flexible cords were used to substitute fixed wiring for applicable equipment / appliances. -All Management will</p>	12/04/2015

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  11/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
--	---

(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
	3.1-19(b)		<p>be in-serviced on the proper use of flexible cords / power strips. Education will be provided by the Maintenance Director/Designee and completed by December 4th, 2015 - 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 be in-serviced on the proper use of flexible cords / power strips. Education will be provided by the Maintenance Director/Designee and completed by December 4th, 2015 -Management will ensure proper usage of electrical outlets when doing their daily rounds - 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 proper outlet usage will be utilized every week x 4 and monthly x 5 -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</p>	