

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 01/11/2016
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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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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: 01/11/16</p> <p>Facility Number: 000148 Provider Number: 155526 AIM Number: 100275500</p> <p>At this Life Safety Code survey, Persimmon Ridge Rehabilitation Center 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 resident sleeping rooms. The facility has a capacity of 112 and had a census of 65</p>	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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K 0021 SS=E Bldg. 01	<p>at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled with exception of the closet in room 206 and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 01/13/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen corridor doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect up to 15 residents outside the kitchen doors.</p>	K 0021	<p>1. No residents were affected by this alleged negative practice. The jug has been removed from the kitchen/scullery door.</p> <p>2. In an effort to identify additional doors being propped, the administrator and maintenance director completed a walkthrough of the entire building and no additional findings were noted.</p>	02/10/2016

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K 0022 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 1:04 p.m., the kitchen/scullery door leading into the kitchen from the corridor was propped open with a jug. Based on interview, this was acknowledged by the Maintenance Supervisor and Administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit from the 100 hall lounge was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit</p>	K 0022	<p>3. In an effort to ensure ongoing compliance, the maintenance director and all staff was re-educated on the Life Safety Code Standard for doors to only be held open by a device which would allow it to close automatically upon activation of the fire alarm system.</p> <p>4. As a means of quality assurance, the maintenance director or designee will check doors daily 5 times a for any propping for 2 weeks, then weekly for 4 weeks, then monthly thereafter. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p> <p>1. No residents were affected by this alleged negative practice. A "NO EXIT" sign has been placed on the 100 hall lounge door.</p> <p>2. In an effort to identify additional doors not properly marked as a no exit, the administrator and maintenance director completed a walkthrough of</p>	02/10/2016	

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K 0025 SS=E Bldg. 01	<p>shall be identified by a sign that reads: NO Exit. This deficient practice could affect 17 residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 01:25 p.m., the door leading to the outside from the 100 hall lounge lacked a sign that identified the door either as an exit or not an exit. Based on interview at the time of observation, the Maintenance Director acknowledged the door was not identified either way.</p> <p>3.1-19(b)</p> <p>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 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>the entire 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 no exit doors being properly marked.</p> <p>4. As a means of quality assurance, the maintenance director or designee will check "No exit" doors daily for one week, then weekly for 4 weeks, then monthly thereafter to ensure non exit doors are marked with a sign indicating "NO EXIT." Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p>	

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	<p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 smoke barrier walls were 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 up to 45 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 01/11/16 between 1:50 p.m. and 2:10 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) in the attic the 100 hall smoke wall contained a one inch unsealed penetration around a sprinkler line.</p> <p>b) in the attic the 300 hall smoke wall contained a one inch unsealed penetration around a sprinkler line.</p>	K 0025	<p>1. No residents were affected by this alleged negative practice. The one inch unsealed penetration around the sprinkler lines in the attic 100, 300, and 500 hall smoke walls were sealed. The half inch unsealed penetration in the ceiling of the 200 hall above the nurses station, the one inch unsealed crack around the sprinkler head in the ceiling of the closet in room 112, and the 42 inch unsealed crack in the ceiling of the service hall were all sealed. 2. In an effort to identify additional unsealed penetrations, the administrator and maintenance director completed a walkthrough of the entire building and no additional findings were noted. 3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard related to penetrations in smoke barriers. 4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building daily five times a week for one week, then weekly for four weeks, then monthly thereafter to ensure no penetrations in fire barriers are noted. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately and reported to the administrator. Results of the monitoring will be reviewed at least quarterly in the</p>	02/10/2016			

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	<p>c.) in the attic the 500 hall smoke wall contained a one inch unsealed penetration around a sprinkler line.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the penetrations and provided the measurements.</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 were 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 could affect 45 residents in 3 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 between 11:15 a.m. and 1:30 p.m., the following ceiling smoke barriers contained unsealed penetrations.</p> <p>a. in the ceiling of 200 hall above the nurses' station there was an unsealed half inch penetration around a sprinkler head.</p> <p>b. in the ceiling of the closet in room 112 there was an unsealed one inch crack around the sprinkler head.</p>		<p>QA meetings for continued compliance. Monitoring will be ongoing.5. Date completed 2/10/16.</p>	

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K 0027 SS=E Bldg. 01	<p>c. in the ceiling service hall there was a 42 inch long unsealed crack. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 5 smoke barrier doors were providing a fire resistance of at least 20 minutes. This deficient practice could affect up to 38 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 between 11:50 a.m. and 1:00 p.m., the</p>	K 0027	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. The paint was removed from the labels on the 100, 300, and 400 hall smoke barrier doors to expose a label that shows a rating of 1 ½ hours on 2 of the doors and the third door has a 3 hour rating. In an effort to identify additional smoke barrier doors with paint over the labels, the administrator and maintenance director completed a walkthrough of the entire building and no additional findings were noted. 	02/10/2016

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K 0029 SS=E Bldg. 01	<p>double set of smoke barrier doors in the 100, 300, and 400 hall smoke barrier walls had labels that were painted over and the fire rating could not be determined.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the painted labels and could not provide documentation of the smoke doors fire rating.</p> <p>3.1-19(b)</p> <p>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 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 the corridor doors</p>	K 0029	<p>3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for smoke barrier door ratings.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a monthly walkthrough of the entire building to ensure there is no paint covering the ratings on smoke barrier doors. Findings will be documented monthly on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p> <p>1. No residents were affected by this alleged negative practice. Self closers were installed on all shower</p>	02/10/2016	

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	<p>to 4 of 4 shower rooms that contain soiled linens totaling more than 32 gallons, and 1 of 2 laundry room doors were self closing and latching. This deficient practice could affect up to 45 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 between 11:15 a.m. and 1:30 p.m., the following was noted:</p> <p>a.) there was no self closer on 2 of 2 doors to the 300 hall shower room door where five containers containing soiled linens totaling more than 32 gallons were stored.</p> <p>b.) there was no self closer on the door to the 100 hall shower room door where five containers containing soiled linens totaling more than 32 gallons were stored.</p> <p>c.) there was no self closer on the door to the 500 hall shower room door where five containers containing soiled linens totaling more than 32 gallons were stored.</p> <p>d.) there was no self closer on the door to the Central Bathing shower room door where five containers containing soiled linens totaling more than 32 gallons were stored.</p>		<p>room doors containing 32 or more gallons of soiled linens. The self closer on the laundry room door was adjusted and now latches properly into the door frame.</p> <p>2. In an effort to identify additional----- issues, the administrator and maintenance director completed a walkthrough of the entire 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 soiled linen storage and self closing and latching doors.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building daily for one week, then weekly for four weeks, then monthly thereafter to ensure soiled linen is properly stored in a secure area and self closing doors latch properly. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p>	

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K 0050 SS=F Bldg. 01	<p>b.) 1 of 2 laundry room doors did self close but failed to latch into the door frame.</p> <p>Based on an interview, this was acknowledged by the Maintenance Director and the Administrator at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Record" with the Maintenance Director and Administrator on 01/11/16</p>	K 0050	<p>1. No residents were affected by this alleged negative practice. The maintenance director conducted a fire drill on second shift at 4:00pm and one on third shift at 4:00am in addition to the first shift drill at 10:30am previously scheduled for this month. The location and type of simulated fire was noted on documentation for all three drills.</p> <p>2. All residents have the potential to be affected. Fire drills of varying times, location, and type of fire will be conducted quarterly on</p>	02/10/2016

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	<p>at 10:30 a.m., there was no record of a second or third shift fire drill for the second quarter of 2015, and there was no record of a second shift drill for the fourth quarter of 2015. Based on an interview with the Maintenance Director and Administrator at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills for third shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Record" with the Maintenance Director and Administrator on 01/11/16 at 10:30 a.m., all third shift fire drills took place between 10:30 p.m. and 11:00 p.m. for the last four quarters, and all second shift fire drills took place between 8:00 p.m. and 9:00 p.m. for the last four quarters. Based on interview, this was confirmed by the Maintenance Director at the time of record review.</p>		<p>each shift.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for fire drills.</p> <p>4. As a means of quality assurance, the administrator will review each fire drill conducted on a monthly basis to ensure fire drills are being held quarterly on each shift at varying times, locations, and types of fire. Findings will be documented monthly on the facilities preventative maintenance form. Any negative findings will be corrected immediately. 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 2/10/16.</p>		

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K 0051 SS=E Bldg. 01	<p>3.1-19(b) 3.1-51(c)</p> <p>3. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 9 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Record" with the Maintenance Director and Administrator on 01/11/16 at 10:30 a.m., 9 of the last 12 calendar months fire drill documentation did not include the location of the fire drill and the type of fire simulated. Based on interview, this was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic</p>				

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 01/11/2016
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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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	<p>detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the 200 hall was installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect six residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 11:15 a.m., the smoke detector in 300 hall by the north nurses' station was located within three feet of an air supply duct. Based on interview, this was acknowledged by the Maintenance</p>	K 0051	<p>1. No residents were affected by this alleged negative practice. The smoke detector was moved greater than 3 feet away from the return vent.2. In an effort to identify additional smoke detectors too close to return vents, the administrator and maintenance director completed a walkthrough of the entire building and no additional findings were noted. 3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for smoke detectors and return vents. 4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building weekly for 4 weeks, then monthly thereafter to ensure no other smoke detector are too close to return vents. Findings will be documented monthly on the facilities preventative maintenance form. Any negative findings will be corrected immediately and reported to the</p>	02/10/2016

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 01/11/2016
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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K 0056 SS=E Bldg. 01	<p>Director and the Administrator 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>1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in room 109 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 2 residents in room 109</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director</p>	K 0056	<p>administrator. Results of the monitoring will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.5. Date completed 2/10/16.</p> <p>1. No residents were affected by this alleged negative practice. Elwood fire company came to the building on 1/20/16 and new pendants were ordered to correct the spacing between the two sprinkler heads in room 109, the spacing of the sprinkler head by the medical record room that was too close to the wall, and the closet in room 206 that lacked sprinkler coverage. The new pendants will be installed immediately upon arrival.</p> <p>2. In an effort to identify additional issues, the administrator and maintenance director completed a walkthrough of the</p>	02/10/2016	

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 01/11/2016
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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	<p>and the Administrator on 01/11/16 at 1:15 p.m., in room 109 there were two sprinkler heads located four and a half feet apart. Based on interview, the measurement was given and acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads installed by the records room was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice could affect five residents outside of the records room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 1:02 p.m., the sprinkler head by the records room was mounted one inch from the wall. Based on interview, the measurement was given and acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>entire 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 sprinkler spacing and coverage.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building weekly for four weeks, then monthly thereafter to ensure no other concerns with spacing of sprinklers or areas without sprinkler coverage are noted. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p>		

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 01/11/2016
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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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	<p>3. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 closets in room 206 in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry-type electrical equipment is used. (c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (d) No combustible storage is permitted to be stored in the room. This deficient practice could affect two residents in room 206</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 1:42 p.m., the closet in the room 206 lacked sprinkler coverage. Based on an interview at the time of observation, the Maintenance Director stated the closet was not equipped with a sprinkler because the closet had a mesh vent around the top of the closet which would allow the sprinkler in the room to proved</p>			

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 01/11/2016
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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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K 0062 SS=E Bldg. 01	<p>coverage for the closet. Based on measurements of the sprinkler head and the mesh vent taken with the Maintenance Director at the time of observation, from the ceiling the mesh vent measured four and 3/4th inches and the from the ceiling to the bottom of the sprinkler measured five and half inches making the sprinkle head too low to provide sprinkler coverage for the closet. This was acknowledged by the Maintenance Director when measurements were taken.</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 observation and interview, the facility failed to replace 1 of 12 sprinklers in the kitchen which was corroded. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted,</p>	K 0062	<p>1. No residents were affected by this alleged negative practice. Elwood Fire Company came to the building on 1/20/16 and a new pendant was ordered to replace the corroded sprinkler in the dish room. The new pendant will be installed immediately upon arrival.</p> <p>2. In an effort to identify additional issues, the administrator and maintenance director completed a walkthrough of the entire building and no additional</p>	02/10/2016

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 01/11/2016	
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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K 0066 SS=F Bldg. 01	<p>corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect up to 15 residents in the hallway outside of the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 1:00 p.m., the automatic sprinkler in the kitchen above the dishwasher was corroded with a green substance. Based on interview at the time of observation, the corroded automatic sprinkler was acknowledged by the Maintenance Director and the Administrator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p>				<p>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 sprinkler standards.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building weekly for four weeks, then monthly thereafter to ensure no other concerns are noted with corroded sprinkler heads. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p>		

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 01/11/2016
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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
	<p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>1. Based on observation, record review, and interview, the facility failed to provide 1 of 1 smoking policies for the facility. This deficient practice could affect all residents and affect any staff evacuating through the service hall exit.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and the Administrator on 01/11/16 at 10:49 a.m. there was no smoking policy available for review. Based on observation at 9:30 a.m. three staff members were observed outside the service hall exit against the building smoking. Based on interview at the time of record review, The Administrator did stated there is no smoking for residents, but staff can smoke outside in the designated area which has a picnic table located off the service hall exit away from the building.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K 0066	<p>1. No residents were affected by this alleged negative practice. A smoking policy was created for the facility. Staff is smoking in the designated smoking area. The butts in the ash trays were all properly disposed of. The butts on the ground were all picked up and disposed of properly. Staff is disposing of the butts properly.</p> <p>2. In an effort to identify additional issues, the administrator and maintenance director completed a walkthrough around entire building and no additional findings were noted.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director and all staff was re-educated on the Life Safety Code Standard related to smoking and butt disposal as well as the new smoking policy for the facility.</p> <p>4. As a means of quality assurance, the maintenance director or designee will check the smoking area twice daily five times a week for two weeks, then once a day five times a week for two weeks, then weekly for two weeks, then monthly checks thereafter to ensure staff are</p>	02/10/2016

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 01/11/2016	
NAME OF PROVIDER OR SUPPLIER PERSIMMON RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371			
(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 facility failed to ensure the proper disposal of cigarette butts in 1 of 1 smoking areas. The smoking area was provided with a metal container with a self-closing cover which ashtrays can be emptied and were readily available. This deficient practice was not in a resident care area but could affect at least 10 staff using the smoking area.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 12:49 p.m. in the staff designated smoking area; at least 20 cigarettes butts were sticking out of two ashtrays on a picnic table. Based on an interview at the time of observation, the Maintenance Director and Administrator acknowledged cigarette butts sticking out of the ash trays.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted was maintained. This deficient practice was not in a resident care area but could affect at least 10 staff using the smoking area.</p> <p>Findings include:</p>		<p>smoking in the designated area, all ash trays are used properly and butts are disposed of properly. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p>				

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 01/11/2016
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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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K 0143 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 12:49 p.m., the Staff designated smoking area was provided with a long neck approved container used for cigarette butt disposal, but there were at least 10 cigarette butts observed on the ground in and around the smoking area. Based on interview, this was acknowledged by the Maintenance Director and Administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to provide posted signs indicating transferring is occurring in 1 of</p>	K 0143	1. No residents were affected by this alleged negative practice. A sign was placed on the oxygen transfill	02/10/2016

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 01/11/2016	
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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K 0144 SS=F Bldg. 01	<p>1 oxygen transferring locations. This deficient practice could affect 6 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 11:20 a.m., the oxygen transferring room lacked the required sign stating transferring is occurring. Based on interview at the time of observation, the Maintenance Director confirmed the oxygen room was used for oxygen transferring and the door lacked the proper signage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected on a</p>	K 0144	<p>location to indicate when a transfill is in progress.</p> <p>2. There are no other transfill areas in the building so no other residents could be affected.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director and all staff responsible for transfilling oxygen was re-educated on the Life Safety Code Standard for oxygen transfilling.</p> <p>4. As a means of quality assurance, the maintenance director or designee will check the oxygen transfill area 5 times a week for 1 week, then weekly for 4 weeks, then monthly thereafter to ensure the signage remains on the door and is being used when a transfill is in progress. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately 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 2/10/16.</p> <p>1. No residents were affected by this alleged negative practice. A weekly generator inspection was</p>	02/10/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/11/2016
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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K 0147 SS=E Bldg. 01	<p>weekly basis. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the weekly generator inspection checklist with the Maintenance Director and Administrator on 01/11/16 at 11:00 a.m., a weekly inspection had not been conducted since 11/30/15. Based on an interview with the Maintenance Director at the time of observation, no other documentation was available for review to verify the weekly checks were conducted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in</p>		<p>completed immediately.</p> <p>2. All residents have the potential to be affected. The generator will be inspected weekly.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety Code Standard for generator inspection.</p> <p>4. As a means of quality assurance, the administrator or designee will check the generator inspection logs weekly. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately. 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 2/10/16.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/11/2016
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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	<p>accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 wet location was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 6 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at 11:35 a.m., the med room at the north nurses' station had an electrical receptacle on the wall within three feet of a sink. When tested using a GFCI testing device the receptacle did not trip. Based on interview at the time of observation, the</p>	K 0147	<p>1. No residents were affected by this alleged negative practice. The electrical receptacle was replaced with a GFCI protected outlet in the north nurse station med room. The hydrocollator, parabath heater, and nebulizer was unplugged from the power strip and plugged into the wall outlets.</p> <p>2. In an effort to identify additional issues, the administrator and maintenance director completed a walkthrough of the entire building and no additional findings were noted.</p> <p>3. In an effort to ensure ongoing compliance, the maintenance director was re-educated on Life Safety Code Standard for ensuring that GFCI protected outlets are installed near any wet location and all staff was re-educated on the Life Safety Code Standard for use of power strips.</p> <p>4. As a means of quality assurance, the maintenance director or designee will do a walkthrough of the entire building weekly for four weeks, then monthly thereafter to ensure no other concerns are noted. Findings will be documented on the facilities preventative maintenance form. Any negative findings will be corrected immediately and reported to the administrator. Results of the monitoring will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring</p>	02/10/2016	

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 01/11/2016
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	<p>Maintenance Director confirmed the receptacle lacked GFCI protection to prevent electrical shock.</p> <p>3.1-19(b)</p> <p>2. 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 and 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment. 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 could affect up to 6 residents in the therapy gym and 2 residents in room 108.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 01/11/16 at between 11:47 a.m. and 1:10 p.m., the following was noted:</p> <p>a.) A Hydrocollator and a Parabath heater, which contain a heating element making them high power draw equipment, were plugged into an extension cord power strip in the therapy</p>		<p>will be ongoing.</p> <p>5. Date completed 2/10/16.</p>		

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	gym storage closet. b.) in room 108 a nebulizer was plugged into an extension cord power strip. Based on interview at the time of observations, the Maintenance Director acknowledged power strip. 3.1-19(b)				