

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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: 08/18/16</p> <p>Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930</p> <p>At this Life Safety Code survey, Autumn Woods Health Campus 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and sprinkled.</p> <p>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 93</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: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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 0025 SS=F Bldg. 01	<p>and had a census of 88 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 08/22/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 attic smoke barrier walls in the original building 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 58 residents who reside in the original building.</p> <p>Findings include:</p> <p>Based on observations with the director</p>	K 0025	<ol style="list-style-type: none"> The 100 Hall attic smoke barrier wall and the Legacy Hall attic wall will provide a one hour fire resistance rating. The repairs will be completed by Rufing Remodeling by September 17, 2016. 58 of 88 residents had the potential to be affected by the deficient practice. The Director of Plant operations was educated by the Executive Director on the requirement that smoke barrier walls provide atleast a one half hour fire resistance rating. Director of Plant Operations will do a followup inspection after 	09/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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>of plant operations on 08/18/16 during a tour of the original building attic from 12:20 p.m. to 12:45 p.m., the following attic smoke barrier walls in the original building had penetrations not fire stopped;</p> <p>a. The 100 Hall attic smoke barrier wall had four, one inch to three inch gaps around sprinkler pipe and electrical conduit penetrations not fire stopped and a two inch gap around a duct penetration not fire stopped.</p> <p>b. The Legacy Hall attic smoke barrier wall had five, two inch to four inch gaps around sprinkler pipe penetrations not fire stopped, two duct penetrations with three inch gaps around the duct penetrations not fire stopped, and two, four inch by four inch square area of drywall missing in the center of the wall. This was verified by the director of plant operations at the time of observations and acknowledged by the executive director at the exit conference on 08/18/16 at 1:00 p.m.</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>smoke barrier wall work is completed.</p> <p>4. Director of Plant Operations will perform monthly audits once per month for six months to ensure the integrity of the repair made to the smoke barrier wall. Results of this audit will be presented by the Executive Director to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2016	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150			
(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>Based on record review and interview, the facility failed to ensure 1 of 1 dry pipe automatic sprinkler piping system in the original building was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all residents who reside in the original portion of the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system Quarterly Sprinkler System Inspection Reports on 08/18/16 at 9:10 a.m. with the director of plant operations, the most recent five year internal pipe inspection was conducted on 01/12/10, which was over the five year inspection requirement. This was verified by the director of plant operations at the time of record review and acknowledged by the executive</p>	K 0062	<ol style="list-style-type: none"> 1. The dry pipe automatic sprinkler piping system was inspected on 8/26/2016 by Brown Sprinkler. The sprinkler piping passed the inspection. The next dry pipe sprinkler inspection will be due in 2021. 2. 88 out of 88 residents had the potential to be affected by the deficient practice. 3. The Director of Plant Operations was educated by the Executive Director on 8/29/2016 on the regulatory requirement that the dry pipe automatic sprinkler system must be inspected every five years. 4. Director of Plant Operations will track through the Trilogy Plant Operations Manual to ensure the inspection is completed in 2021. 	09/17/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150		
(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 0067 SS=E Bldg. 01	<p>director at the exit conference on 08/18/16 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 fire dampers on the Legacy Hall were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 22 residents who reside on the Legacy Hall.</p> <p>Findings include:</p>	K 0067	<p>1. The fire dampers were inspected on 8/31 and 9/1/2016 by Koorsen Fire & Security. The next fire damper inspection will be 2020. 2. 22 of 88 residents had the potential to be affected by the deficient practice. 3. The Director of Plant Operations was educated by the Executive Director on ensuring the fire dampers are inspected every four years in accordance with NFPA 90A. 4. Director of Plant Operations will track through the Trilogy Plant Operations Manual to ensure inspection is completed in 2020.</p>	09/17/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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. 02	<p>Based on observations on 08/18/16 during a tour of the Legacy Hall with the director of plant operations from 9:50 a.m. to 10:40 a.m., the Legacy Hall corridor supply air ducts had six fire dampers located in the corridor supply air ducts. Based on an interview with the director of plant operations on 08/18/16 at 10:40 a.m., the Legacy Hall six fire dampers have not had four year maintenance. The lack of a four year fire damper inspection on the six Legacy Hall fire dampers was acknowledged by the executive director at the exit conference on 08/18/16 at 1:00 p.m.</p> <p>3.1-19(b)</p> <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: 08/18/16</p> <p>Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930</p> <p>At this Life Safety Code survey, Autumn</p>	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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 0025 SS=F Bldg. 02	<p>Woods Health Campus 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) and 410 IAC 16.2. The 400 Hall was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and sprinkled.</p> <p>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 93 and had a census of 88 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 08/22/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2016	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150			
(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	<p>8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 attic smoke barrier wall in the 400 Hall new portion of the building was maintained to provide a one 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 30 residents who reside on the 400 Hall.</p> <p>Findings include:</p> <p>Based on observation with the director of plant operations on 08/18/16 at 12:45 p.m., the attic smoke barrier wall on the 400 Hall was constructed of one layer of 5/8 inch drywall with a fire resistance rating of 1/2 hour. The lack of a one hour fire resistance rated smoke barrier wall on the 400 Hall attic smoke barrier wall was verified by the director of plant operations at the time of observation and acknowledged by the executive director at the exit conference on 08/18/16 at 1:00 p.m.</p> <p>3.1-19(b) NFPA 101</p>	K 0025	<p>1. The 100 Hall attic smoke barrier wall and the Legacy Hall attic wall will provide a one hour fire resistance rating. The repairs will be completed by Rufing Remodeling by September 17, 2016.</p> <p>2. 58 of 88 residents had the potential to be affected by the deficient practice.</p> <p>3. The Director of Plant operations was educated by the Executive Director on the requirement that smoke barrier walls provide atleast a one half hour fire resistance rating. Director of Plant Operations will do a followup inspection after smoke barrier wall work is completed.</p> <p>4. Director of Plant Operations will perform monthly audits once per month for six months to ensure the integrity of the repair made to thesmoke barrier wall. Results of this audit will be presented by the Executive Director to the QA committee forfurther recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.</p>	09/17/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
--	---

(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
SS=F Bldg. 02	<p>LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 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 dry pipe automatic sprinkler piping system in the new 400 Hall portion of the building was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects 30 residents who reside in the 400 Hall.</p> <p>Findings include:</p> <p>Based on review of sprinkler system Quarterly Sprinkler System Inspection Reports on 08/18/16 at 9:10 a.m. with the director of plant operations, the most recent five year internal pipe inspection</p>	K 0062	<ol style="list-style-type: none"> 1. The dry pipe automatic sprinkler piping system was inspected on 8/26/2016 by Brown Sprinkler. The sprinkler piping passed the inspection. The next dry pipe sprinkler inspection will be due in 2021. 2. 88 out of 88 residents had the potential to be affected by the deficient practice. 3. The Director of Plant Operations was educated by the Executive Director on 8/29/2016 on the regulatory requirement that the dry pipe automatic sprinkler system must be inspected every five years. 4. Director of Plant Operations will track through the Trilogy Plant Operations Manual to ensure the inspection is completed in 2021. 	09/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150		
(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	
	was conducted on 01/12/10, which was over the five year inspection requirement. This was verified by the director of plant operations at the time of record review and acknowledged by the executive director at the exit conference on 08/18/16 at 1:00 p.m. 3.1-19(b)				