

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2013
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NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/19/13</p> <p>Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Autumn Hills Health & 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 95 and</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>had a census of 62 at the time of this survey.</p> <p>All areas accessible to residents were sprinklered.</p> <p>A detached brick building housing the fire pump, emergency generator, and stored equipment and a wood storage shed were unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K010025 SS=E	<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>Based on observation and interview, the facility failed to ensure an opening through smoke barriers in 2 of 7 smoke compartments was sealed with a material to provide the 1/2 hour smoke resistance of the smoke barrier. 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 visitors, staff and 20 or more residents in the center and adjacent smoke compartments where Physical Therapy, a dining room and activities area are located.</p> <p>Findings include:</p>	K010025	<p>K 025 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for rooms identified on ACU Hall:</p> <p>a. Based on observation with the maintenance director on 02/19/13 the gap between cables and conduit in the center smoke compartment smoke barrier was filled with expandable foam. A second conduit penetration in the barrier had been filled with fire caulk part of which had fallen out; leaving a one quarter inch annular gap. Maintenance will ensure that identified smoke barriers are properly sealed with Fire Caulk. Foam like expandable material has been removed from</p>	03/21/2013			

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	<p>a. Based on observation with the maintenance director on 02/19/13 at 12:30 p.m., a gap between cables and conduit in the center smoke compartment smoke barrier was filled with expandable foam. A second conduit penetration in the barrier had been filled with fire caulk part of which had fallen out, leaving a one quarter inch annular gap. The maintenance director agreed at the time of observation, the penetration had not been properly sealed.</p> <p>b. Based on observation with the maintenance director on 02/19/13 at 12:05 p.m., a two inch hole in the ceiling behind dryers in the laundry was open into the attic above. The maintenance director agreed at the time of observation, the hole should have been sealed.</p> <p>3.9-19(b)</p>		<p>identified area and resealed with Maintenance will make monthly inspection of smoke barrier areas to ensure all opening are properly sealed. Correction has been completed by 3-7-2013 and facility will allege compliance March 21, 2013. b. Based on observation with the maintenance director on 02/19/13 at 12:05 p.m., a two inch hole in the ceiling behind dryers in the laundry was open into the attic above. Maintenance has patched, sealed, and repainted two inch hole identified as being open to attic behind dryers. Correction has been completed by 3-7-2013 and facility will allege compliance March 21, 2013. 2) How the facility identified other environmental concerns: a. A 100% smoke compartment/smoke barrier inspection has been completed by the maintenance director. 3) Measures put into place / System changes: a. Administrator/Designee will review maintenance TELS records to ensure compliance monthly for six months and Corporate Environmental Consultants will review records and building during routine monthly visits 4) How the corrective actions will be monitored: a. Administrator/Designee will review maintenance TELS records to ensure compliance monthly for six months and</p>		

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			<p>Corporate Environmental Consultants will review records and building during routine monthly visit. If inspections identify areas needing additional repairs they are to be re-caulked and a record of repairs kept in the TELS system and the maintenance director's office and administrator's office. 5)</p> <p>Responsible Person Administrator/Designee 6) Date of Compliance Facility will allege compliance March 21, 2013</p>		

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a fire plan which included the identification of and evacuation of the smoke compartment, the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 89 of 89 residents. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to fire department. 3. response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 02/19/13 at 3:20</p>	K010048	<p>K 048 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for a written plan for the protection of all patients: a. Facility Fire Plan and Procedure has been updated to provide the required information based on the Director of Life Safety, Dennis Austill. Copy of plan is now available in maintenance directors office in life safety manual and a copy is available in each the facilities nurses stations in the disaster manuals. 2) Measures put into place / System changes: a. Facility training of staff and review of the Fire Plan will be completed by 3-22-2013 and a record for in services will become part of employee records. Administrator will ensure the Fire Plan and Procedure form becomes a part of new staff orientation by the maintenance director and a record for trainings will be included in the facility's records for employees. 4) How</p>	03/21/2013			

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	<p>p.m., the Fire Policy and Procedure was incomplete. There was no direction to remove endangered residents to another smoke compartment if indicated, and no identification of smoke zones as places of refuge and their location. In addition, the Fire Policy and Procedure did not identify available fire extinguishers and address the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The plan also referred to "extinguish the fire if it is small." The maintenance director acknowledged at the time of record review, elements were not addressed in the fire plan, and staff were not trained in fire assessment to determine whether a fire was "small."</p> <p>3.1-19(b)</p>		<p>the corrective actions will be monitored: a. Corporate Environmental Consultant will follow-up and review the plan during their routine visits to the facility. Administrator/Designee will review monthly at Quality Assurance meetings that facility fire plan and procedure has been reviewed by new employees receiving orientation by the facility. A record for Quality Assurance will be kept in the life safety manual in the maintenance office. 5) Responsible Person Administrator/Designee 6) Date of Compliance Facility will allege compliance March 21, 2013</p>		

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K010050 SS=C	<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>Based on record review and interview, the facility failed to conduct fire drills at varied times during 4 of the past 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Reports with the maintenance director on 02/19/13 at 2:50 p.m., third shift (11:00 p.m.-7:00 a.m.) drills were conducted at 1:00 a.m. during the second and fourth quarters of 2012 and at 5:00 a.m. the third quarter of 2012 and the first quarter of 2013. First shift fire drills were held at 10:00 a.m. during the first, second and third quarters of 2012. The maintenance director agreed at the time of record review, the drills were conducted at times the staff could expect them based on drills performed in the past.</p>	K010050	<p>K 050 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for a written plan for the protection of all patients: a. Maintenance Director will ensure to provide Fire Drills at various times for each shift and record the results and fax them report to TELS Program to become an electronic record. 2) Measures put into place / System changes: a. Administrator shall follow-up with maintenance to ensure Fire Drills are being conducted properly. Correction will be started immediately with the next drill. 3) How the corrective actions will be monitored: a. Corporate Environmental Consultants will</p>	03/21/2013
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	3.1-19(b) 3.1-51(c)		make a review of the Fire Drill reports on TELS to ensure compliance is being followed and review procedures during their routine visits to the facility. 4) Responsible Person Administrator/Designee 5) Date of Compliance Facility will allege compliance March 21, 2013.		

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K010051 SS=F	<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 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 a smoke detector connected to the fire alarm system in 1 of 7 smoke compartments was properly installed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/21/13 at 12:30 p.m., a corridor smoke detector was resting on top of a lay in ceiling tile at the center compartment smoke barrier. The smoke detector was attached to conduit. The maintenance director confirmed at</p>	K010051	<p>K 051 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for fire alarm system in compartments: a. Smoke detector shall be installed properly with completed by a licensed contractor for facility's fire protection system. 2) Measures put into place / System changes: a.</p>	03/21/2013			

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	<p>the time of observation, the smoke detector was connected to the fire alarm system. He said he did not know why it had not been properly secured to detect smoke in the corridor.</p> <p>3.1-19(b)</p>		<p>Maintenance will ensure all smoke detectors are properly mounted by making routine inspections based on the TELS task schedule on a monthly basis.</p> <p>3) How the corrective actions will be monitored: a. Maintenance shall ensure that when smoke detectors are being checked and or repaired by any outside company, that the detector has been installed properly after work is completed. Corporate Environmental Consultants will follow-up on any repairs or inspections while making their routine visits to the facility. 4) Responsible Person Administrator/Designee 5) Date of Compliance Facility will allege compliance March 21, 2013.</p>		

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K010062 SS=E	<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 ensure sprinkler heads in 1 of 7 smoke compartments was free of foreign materials, such as lint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice could affect staff, visitors and 10 or more residents in the center smoke compartment where PT is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/19/13 at 12:05 p.m., one sprinkler head provided protection for the enclosed space behind the commercial dryers in the laundry. The sprinkler head was covered with a gray fuzzy grime identified as lint by the maintenance director. The maintenance director agreed at the time of observation, the foreign materials could affect the function of the sprinkler head.</p> <p>3.1-19(b)</p>	K010062	<p>K 062 NFPA 101 LIFE SAFETY CODE STANDARDS The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for automatic sprinkler systems continuously maintained:</p> <p>a. Maintenance cleaned and inspected all sprinkler heads in facility in a 100% facility wide inspection. Service inspection for each sprinkler and its proper cleaning during the routine maintenance inspections for that specific area as setup on the TELS Program will be implemented. b. Identified as behind the commercial dryers in the laundry, the sprinkler head covered with gray fuzzy grime identified as lint by the maintenance director was cleaned.</p> <p>2) Measures put into place / System changes:</p> <p>a. Administrator shall follow-up with maintenance to ensure sprinkler heads are being cleaned as required on a monthly basis for</p>	03/21/2013			

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			<p>six months, records for compliance will be kept administrators office and or designee. 3) How the corrective actions will be monitored: a. Corporate Environmental Consultants will make a routine inspection of the service areas to ensure sprinkler heads are being cleaned during their routine visits to the facility. 4) Responsible Person Administrator/Designee 5) Date of Compliance Facility will allege compliance March 21, 2013.</p>		

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K010147 SS=E	<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 4 of 4 flexible cords and/or unapproved multitap adapters were not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, 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 staff, visitors and 13 or more residents in the west and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/19/13 between 11:40 a.m. and 3:00 p.m., an extension cord was piggybacked to a multitap outlet at the west nurses station and in the activities room. The maintenance director acknowledged at the time of observations, the adapters and cords had been incorrectly used in this manner.</p> <p>3.1-19(b)</p>	K010147	<p>K 147 NFPA 101 LIFE SAFETY CODE STANDARDS</p> <p>The facility requests paper compliance for this citation.</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>1) Immediate actions taken for Electrical wiring and equipment:</p> <p>a. Maintenance shall make a 100% inspection of all common areas to ensure power strips are not being used in the facility as replacement for hard wired use.</p> <p>2) Measures put into place / System changes:</p> <p>a. Maintenance shall make a monthly inspection of all common areas to ensure power strips are not being used in the facility as replacement for hard wired use.</p> <p>3) How the corrective actions will be monitored:</p>	03/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2013
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			<p>a. Record of the inspection shall be a part of the TELS task and results to be recorded.</p> <p>b. Administrator shall make an inspection of the common areas to ensure maintenance has been making the proper inspections. Corporate Environmental Consultants will make an inspection of the areas to ensure power strips are not being used during their routine visits to the facility.</p> <p>4) Responsible Person Administrator/Designee</p> <p>5) Date of Compliance Facility will allege compliance March 21, 2013.</p>		