STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	N NUMBER A. BUILDING			COMPLETED	
		155162	B. WING			07/29	/2021
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF	PROVIDER OR SUPPLIE	ĸ		600 W	ASHINGTON AVE		
MUTUA	N RIDGE REHABIL	ITATION CENTRE		WABA	SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Blug.	An Emergency Pro	eparedness Survey was	E 00	00	The creation of and submission	on of	
		ndiana Department of Health in		00	this plan of correction does no		
	accordance with 4				constitute admission by this	-	
					provider of any conclusion set	forth	
	Survey Date: 7/29	0/21			in the statement of deficiencie		
					of any violations of regulation.		
	Facility Number:				This provider respectfully requ	lests	
	Provider Number:				that the 2567 plan of correction		
	AIM Number: 10	0289570			considered the letter of credib	le	
					allegation and request a post		
		Preparedness survey, Autumn on Centre was found in			survey review on or after Aug		
	-	Emergency Preparedness			28, 2021. We respectfully required a desk review in lieu of a post		
	-	Medicare and Medicaid			survey Revisit		
	-	iders and Suppliers, 42 CFR					
		y has a capacity of 75 and had a					
	census of 51 at the	time of this survey.					
	Quality Review co	ompleted on 08/03/21					
K 0000							
Bldg. 01							
3. 2.	A Life Safety Cod	e Recertification and State	K 00	000	The creation of and submission	on of	
	-	was conducted by the Indiana	1.00		this plan of correction does no		
	Department of He	alth in accordance with 42 CFR			constitute admission by this		
	483.90(a).				provider of any conclusion set		
					in the statement of deficiencie		
	Survey Date: 07/2	29/21			of any violations of regulation.		
	E-cll'( NL 1	000081			This provider respectfully requ		
	Facility Number: Provider Number:				that the 2567 plan of correctio		
	AIM Number: 10				considered the letter of credib allegation and request a post	ie	
		0207570			survey review on or after Aug	ist	
	At this Life Safety	Code survey, Autumn Ridge			28, 2021. We respectfully requ		
		tre was found not in compliance			a desk review in lieu of a post		
		s for Participation in			survey Revisit		
	1	-	1				1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 08/18/2021

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155162 B. WING 07/29/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in 9 resident rooms and the remaining resident rooms had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 51 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts. Quality Review completed on 08/03/21 K 0211 **NFPA 101** SS=E Means of Egress - General Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 #1. Based on observation and interview, the K 0211 08/28/2021 It is the intent of this provider to facility failed to ensure 1 of 1 exit doors from the have an emergency preparedness copier room only contained one latching communication plan that complies mechanism to release the door and open. LSC with Federal, State, and local 7.2.1.5.10 states a latch or other fastening device laws. 0K9D21 Event ID: Facility ID: 000081 Page 2 of 29 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/18/2021

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	I OF CORRECTION	identification number 155162	A. BUILDING <u>01</u> B. WING			COMPLETED 07/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	JTUMN RIDGE REHABILITATION CENTRE			600 WASHINGTON AVE WABASH, IN 46992			
X4) ID	SUMMAR	IMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	on a door leaf sha	ll be provided with a releasing			K211 Means of Egress - Gen	eral	
	device that has an	obvious method of operation			what corrective action	(s)	
	and that is readily	operated under all lighting			will be accomplished for the	se	
	conditions. 7.2.1.	5.10.4 states the releasing			residents found to have bee		
		open the door leaf with not more			affected by the deficient		
		operation. 7.2.1.5.10.1 states			practice;		
	-	nanism for any latch shall be			#1 Maintenance Director rem	oved	
	-	an 34 inches, and not more than			latching Mechanism		
		he finished floor. This deficient			#2 Items stored in the 200-sto	orade	
	practice could affe			hall corridor were removed	Jugo		
	room.	set staff that use the copier			· how other residents		
	iooni.				having the potential to be		
	Findings include:						
	Findings include.				affected by the same deficie		
	Deseil en eltermore	tion with the Maintenance			practice will be identified an		
					what corrective action(s) will	1	
		21 at 12:13 p.m., the copier room			be taken;		
	-	ipped with two latching devices,			All residents have the potentia	al to	
		n knob and a separate deadbolt			be affected		
		terview at the time of			There are no other latching		
		faintenance Director agreed the			mechanisms in the facility.		
	-	loor was equipped with two			<ul> <li>what measures will be</li> </ul>		
	latching devices.				put into place and what		
					systemic changes will be ma	ade	
	#2 Based on obser	vation and interview, the			to ensure that the deficient		
	facility failed to en	nsure 1 of 3 means of egress on			practice does not recur;		
	the second floor w	vere continuously maintained			Maintenance Director will mo	nitor	
	free of all obstruct	tions or impediments to full			copier room door to ensure lo	cking	
	instant use in the o	case of fire or other emergency.			mechanism is still nonfunctior	ning.	
	This deficient prac	ctice could affect over 10			Staff were educated to ensure	e	
	residents on the se	cond floor.			corridors stay clear in case of	fire	
					or another emergency		
	Findings include:				• how the corrective		
	-				action(s) will be monitored t	o	
	Based on observat	tion with the Maintenance			ensure the deficient practice		
		/21 at 12:43 p.m., a resident bed, a			will not recur, i.e., what qual		
		trash bin were stored in the			assurance program will be p	-	
		orridor. Based on interview at			into place; and		
		servation, the Maintenance			Ongoing compliance with this		
		e means of egress were not			corrective action will be monit		
	-	tained free of all obstructions			through the facility QAPI Prog		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0K9D21 Facility ID: 000081

If continuation sheet

Page 3 of 29

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/29/2021		
	PROVIDER OR SUPPLIE	R ITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETIO DATE	
	or impediments to fire or other emerg The findings were	full instant use in the case of ency. reviewed with the Maintenance Director during		with meetings being held and overseen by the Exe director. The Executive Director of designee will document to findings on the Team QA Tool" weekly for 4 weeks for 3 months, and quarte thereafter to ensure the policy/procedures are fol facility policy. If threshold of 90% is not action plan will be develor Findings will be submitte Executive Director for rev follow up. • by what date the s changes for each defici will be completed. 8-28-21	ecutive r heir PI a, monthly rly lowed per a met, an oped. d to the view and		
< 0222 SS=E Bldg. 01	SS=E Egress Doors						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/29/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP ( ASHINGTON AVE	COD	
AUTUM	N RIDGE REHABIL	ITATION CENTRE		SH, IN 46992		
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COI		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATI	E
		2.2.2.6, 19.2.2.2.5.1,				
	19.2.2.2.6					
	SPECIAL NEED					
		cking arrangements for the				
		he patient are used, all of				
		ecurity Locking requirements				
		addition, the locks must be				
		nat fail safely so as to				
		s of power to the device; the				
	building is protect	ted by a supervised				
	automatic sprink	ler system and the locked				
	space is protecte	ed by a complete smoke				
		n (or is constantly monitored				
		cation within the locked				
		the sprinkler and detection				
		inged to unlock the doors				
	upon activation.					
	18.2.2.2.5.2, 19. DELAYED-EGR	2.2.2.5.2, TIA 12-4				
	ARRANGEMEN					
	-	delayed-egress locking				
		d in accordance with				
		e permitted on door				
		ing low and ordinary hazard				
		ings protected throughout by				
	an approved, su	pervised automatic fire				
	detection system	or an approved, supervised				
	automatic sprink	-				
	18.2.2.2.4, 19.2.					
		ROLLED EGRESS				
		ed Egress Door assemblies				
		dance with 7.2.1.6.2 shall				
	be permitted.	2.2.4				
	18.2.2.2.4, 19.2.					
	LOCKING ARRA	BY EXIT ACCESS				
		xit access door locking in				
	-	7.2.1.6.3 shall be permitted				

DEPARTMENT	OF HEALTH AN	D HUMAN SERVICES	5

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING	COMPL	x3) date survey completed 07/29/2021		
	JAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	<ul> <li>throughout by an automatic fire deta approved, supervisystem.</li> <li>18.2.2.2.4, 19.2.2 Based on observation failed to ensure the 3 stair exits on the 1 accessible for resided diagnosis requiring Doors within a requise equipped with a use of a tool or key otherwise permitted Door-locking arran accordance with 19 practice could affect visitors if needing to emergency on the terming a four-digi pad, but the code with Based on interview Maintenance Direct three exit doors were control pad.</li> <li>This finding was results of the supervise of the superv</li></ul>	on and interview, the facility means of egress through 3 of third floor were readily ents without a clinical specialized security measures. hired means of egress shall not latch or lock that requires the from the egress side unless 1 by LSC 19.2.2.2.4. gements shall be permitted in .2.2.2.5.2. This deficient et over 30 residents, staff, and o exit the facility in an	К 0222	It is the intent of this provider have an emergency prepared communication plan that corr with Federal, State, and local laws. K222 Egress Door what corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; Maintenance director posted four-digit code on the access control pad at the exit on the keypads identified. how other residents having potential to be affected by t same deficient practice will identified and what correcti action(s) will be taken; All residents have the potenti be affected Facility audited four-digit cod posted on access control pad exit doors will continue to mo during morning GEMBA roun what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or designee will ensure the four code stays posted on the access	dness aplies I II en the the be ve dat to e dat at onitor ds nto	08/28/2021	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CO JILDING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155162	B. WING			07/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	COD	
AUTUMI	N RIDGE REHABIL	ITATION CENTRE			ASHINGTON AVE SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)		RECTION	(X5)
PREFIX	× ×	NCY MUST BE PRECEDED BY FULL				HOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION				DATE	
					control pad on at the e	xit on the	
					keypads identified.	<b>t</b> ion(o)	
					how the corrective ac		
					will be monitored to e		
					deficient practice will		
					recur, i.e., what qualit assurance program w	-	
					into place; and	in pe put	
					Ongoing compliance w	/ith this	
					corrective action will be		
					through the facility QA		
					with meetings being he	-	
					and overseen by the E	•	
					director.		
					The Executive Director	r or	
					designee will documer	nt their	
					findings on the Team "		
					Tool" weekly for 4 wee		
					for 3 months, and quar	•	
					thereafter to ensure the		
					policy/procedures are	followed per	
					facility policy.		
					If threshold of 90% is r	•	
					action plan will be dev		
					Findings will be submit		
					Executive Director for	review and	
					follow up. by what date the syst	omio	
					changes for each defi		
					will be completed.	lency	
					8-28-21		
0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01	Exit Signage						
	2012 EXISTING						
		nal signs are displayed in					
		7.10 with continuous					
		served by the emergency					
	lighting system.				1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/29/2021			
	NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3 NATE	(X5) COMPLETION DATE		
	occupancies with where the line of Based on observat failed to ensure 1 of were not obstructe practice could affe floor. Findings include: Based on observat Director on 07/29/ of the 300-hall sm located above the seen when the ceil an interview at the Maintenance Direct above the ceiling t not have been rein after replacement of	one-story existing a less than 30 occupants exit travel is obvious.) ion and interview, the facility of 3 exit paths had exit signs that ed from view. This deficient ect 30 residents on the third ion with the Maintenance (21 at 1:43 p.m., upon inspection oke wall, the exit sign was ceiling tiles and could not be ing tiles were in place. Based on e time of observation, the ctor agreed the exit sign must istalled on the new ceiling tile of the tile. eviewed with the Administrator Director during the exit	К 0293	It is the intent of this provided have an emergency prepare communication plan that com with Federal, State, and loca laws. K293 Exit Signage • what corrective action will be accomplished for the residents found to have been affected by the deficient practice; Maintenance director remove sign from above ceiling tiles. sign is now in visual sight an proper placement. keypads identified. • how other residents having the potential to be affected by the same deficien practice will be identified an what corrective action(s) w be taken; All residents have the potent be affected Maintenance Director audite facility to ensure there were other directional signs or emergency lighting obstructed from view. • what measures will be put into place and what systemic changes will be m to ensure that the deficient practice does not recur. The Maintenance Director or designee will audit area to en	dness nplies il n(s) ose en ed Exit d in ent nd ill ial to d no ed ea hade	08/28/202		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	onstruction 01		ATE SURVEY MPLETED
	of contection	155162	B. WING		<u></u>	07/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP C ASHINGTON AVE	OD	
AUTUMI	N RIDGE REHABIL	ITATION CENTRE			SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO.		RECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
					the exit sign stays in p	roper	
					placement.		
					how the correcti action(s) will be moni		
					ensure the deficient p		
					will not recur, i.e., what		
					assurance program w	vill be put	
					into place; and Ongoing compliance w	uith thic	
					corrective action will be		
					through the facility QAI		
					with meetings being he	•	
					and overseen by the E	xecutive	
					director. The Executive Director	or	
					designee will documen		
					findings on the Team "	QAPI	
					Tool" weekly for 4 wee	-	
					for 3 months, and quar thereafter to ensure the	-	
					policy/procedures are f		
					facility policy.		
					If threshold of 90% is n		
					action plan will be deve		
					Findings will be submit Executive Director for		
					follow up.		
					by what date the	e systemic	
					changes for each defi	ciency	
					will be completed. 8-28-21		
0311	NFPA 101						
SS=E	Vertical Opening						
Bldg. 01	Vertical Opening 2012 EXISTING	s - Enclosure					
	Stairways, elevat	or shafts, light and					
		, chutes, and other vertical					
		n floors are enclosed with ng a fire resistance rating of					
		ng a me resistance rating of			1		

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OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/29/2021 155162 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility K 0311 08/28/2021 It is the intent of this provider to failed to ensure 1 of 3 stairwells and 1 of 1 elevator have an emergency preparedness shafts maintained a one-hour fire rating. LSC communication plan that complies 19.3.1.1 Protection of Vertical Openings, states with Federal, State, and local where enclosure is provided, the construction laws. shall have not less than a 1-hour fire resistance K311 Vertical Openingsrating. This deficient practice could affect 30 Enclosure residents in two smoke compartments. what corrective action(s) will be accomplished for those Findings include: residents found to have been affected by the deficient Based on observation with the Maintenance practice; Director on 07/29/21 at 2:43 p.m., above the ceiling Maintenance director filled in hole tiles of the third-floor south stairwell there was a in the block wall with fire block three-inch hole in the block wall where the fire and fire caulk to ensure there is no brick fell out. Also, above the drop ceiling in the gap present. first-floor elevator shaft there was an inch gap how other residents where the grout was separating. These conditions having the potential to be would not maintain the one-hour fire rating. Based affected by the same deficient on interview at the time of observation, practice will be identified and Maintenance Director agreed there were unsealed what corrective action(s) will penetrations in a one-hour stairwell and elevator be taken: shaft. All residents have the potential to be affected This finding was reviewed with the Administrator Maintenance Director conducted and Maintenance Director during the exit audit to ensure thee ere no other conference. gaps were present what measures will be 3.1-19(b) put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director or 0K9D21 Facility ID: 000081

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED <b>07/29/2021</b>	
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C	ITATION CENTRE STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	SH, IN 46992  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRY DEFICIENCY)  designee will audit the drop cr in the first-floor elevator shaft documentation completed         how the corrective action(s) will be monitored t ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place; and Ongoing compliance with this corrective action will be monit through the facility QAPI Prog with meetings being held mor and overseen by the Executiv director. The Executive Director or designee will document their findings on the Team "QAPI Tool" weekly for 4 weeks, mo for 3 months, and quarterly thereafter to ensure the policy/procedures are followe facility policy. If threshold of 90% is not met action plan will be submitted to th Executive Director for review follow up.         by what date the syste changes for each deficiency will be completed. 8-28-21	DATE DATE DATE DATE DATE DATE DATE	
< 0321 SS=E Bldg. 01	barrier having 1- (with 3/4 hour fire					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/29/2021 155162 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility K 0321 It is the intent of this provider to 08/28/2021 failed to ensure 1 of 2 hazardous rooms on the have an emergency preparedness service hall that contained fuel fired equipment communication plan that complies were separated from other spaces by smoke with Federal, State, and local resistant partitions. This deficient practice could laws. affect 20 residents in one smoke compartment K321 Hazardous Areas- Enclosure what corrective action(s) Findings include: will be accomplished for those residents found to have been Based on observation with the Maintenance affected by the deficient Director on 07/29/21 at 1:10 p.m., in the main practice: mechanical room with fuel fired hot water heaters Maintenance director sealed Event ID: 0K9D21 Facility ID: 000081 Page 12 of 29 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/29/2021	
	NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE		600 W.	ADDRESS, CITY, STATE, ZIP CO ASHINGTON AVE SH, IN 46992	D	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETIC
TAG	contained an unsea water heater vent. of the observation, agreed there were mechanical room of the gap around the The findings were	reviewed with the Maintenance Director during	TAG	penetration with fire cau ensure there is no gap a water heater vent. • how other resider having the potential to affected by the same de practice will be identifie what corrective action() be taken; All residents have the potential to ensure there we other gaps around the with heater. • what measures with put into place and what systemic changes will to ensure that the defice practice does not recur The Maintenance Direct designee will audit the nor room water heater to en is no gap present and with document findings. • how the corrective action(s) will be monitor ensure the deficient pra- will not recur, i.e., what assurance program will into place; and Ongoing compliance witt corrective action will be through the facility QAP with meetings being held and overseen by the Exe director. The Executive Director of designee will document findings on the Team "G	around the nts be eficient ed and (s) will otential to onducted ere no vater fill be t be made cient r. cor or nechanical sure there rill re ored to actice t quality Il be put th this monitored I Program, d monthly ecutive or their	DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction () 01	(X3) DATE SURVEY COMPLETED			
		155162	B. WING		07/29/2021			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992					
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION			
( 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Interior Wall and 2012 EXISTING Interior wall and 2012 EXISTING Interior wall and cexposed interior s as fixed or moval columns, and hav Class A or Class interior finish for a prescribed in 10.2 10.2, 19.3.3.1, 19 Indicate flame sp Based on observati interview, the facil used as an interior 3 floors met the fla Class B in accorda 10.2.3.4 states prod accordance with A Method for Surface Building Materials Test for Surface Building Materials	Ceiling Finish ceiling finishes, including surfaces of buildings such ble walls, partitions, re a flame spread rating of B. The reduction in class of a sprinkler system as 2.8.1 is permitted.	K 0331	Tool" weekly for 4 weeks, mont for 3 months, and quarterly thereafter to ensure the policy/procedures are followed facility policy. If threshold of 90% is not met, a action plan will be developed. Findings will be submitted to the Executive Director for review ar follow up. • by what date the system changes for each deficiency will be completed. 8-28-21 It is the intent of this provider to have an emergency preparedne communication plan that compl with Federal, State, and local laws. K331 Interior Wall and Ceiling Finish • what corrective action(s will be accomplished for those residents found to have been affected by the deficient	bint per in a ic 08/28/202 pss ies			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	A. BUILDING <u>01</u> B. WING		(3) DATE SURVEY COMPLETED 07/29/2021
	PROVIDER OR SUPPLII N RIDGE REHABIL	ITATION CENTRE	600 W/	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	following classes spread and smoke (a) Class A Interio spread 0-25; smok any material class spread test scale a scale. Any element not continue to pro (b) Class B Interio spread 26-75; smo any material class more than 75 on the 450 or less on the This deficient prace the building. Findings include: Based on observat Director on 07/29, p.m., in all halls of walls were either of carpet on the lower records review at the flame spared r available for revie time of each obser Director stated the documentation, bu previous Maintena unable to locate the This finding was r	by Wall and Ceiling Finish. Flame the development 0-450. Includes ified at 25 or less on the flame and 450 or less on the smoke test at thereof, when so tested, shall opagate fire. For Wall and Ceiling Finish. Flame oke development 0-450. Includes ified at more than 25 but not the flame spread test scale and smoke test scale. For event of the state of the flame spread test scale and smoke test scale. For which the Maintenance (21 between 11:00 a.m. and 2:00 n all three floors the corridor covered with vinyl paneling or event 1/4th of the walls. Based on 10:00 a.m., no documentation of ating for the wall coverings was we Based on interview at the twation, the Maintenance events flame spread at it was misplaced by the ance Director and has been	TAG	practice;         Facility requesting temporary construction waiver and will remove the vineer material and replace it with a rated material.         We will install Palladium rigid vin sheet or like material; spec shee attached.         how other residents         having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;         Executive Director and Maintenance Director toured facility to identify all areas that have the wood look vineer produ mounted on the corridor walls fr the floor to handrails.         What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Executive Director/Designee and Maintenance Director/Designee will review are future interior corridor finish materials have the appropriate documentation for a flame spreat classification.         How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Fire QA tool will be utilized weef x 4, monthly x 3, and quarterly x	uct om c e iy ad

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/29/2021	
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600	ET ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BASH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				<ul> <li>4. The results of these audits be reviewed by the QAPI committee overseen by the Executive Director/Designee. threshold is not achieved, an action plan will be developed ensure compliance.</li> <li>What date the systemic changes for each deficiency will be completed 8/28/21</li> </ul>	If to	
K 0341 SS=E Bldg. 01	and components accordance with Code, and NFPA Code to provide of part of the buildin occupied, detecti alarm control uni detection is also appliance circuit supervising static Fire alarm system transmission path integrity. 18.3.4.1, 19.3.4.7 Based on observat failed to ensure 1 of installed in accord requires a fire alarn and maintained in National Electrical Fire Alarm Code. spaces served by a shall not be located	m - Installation em is installed with systems approved for the purpose in NFPA 70, National Electric 72, National Fire Alarm effective warning of fire in any g. In areas not continuously on is installed at each fire t. In new occupancy, installed at notification power extenders, and on transmitting equipment. In wiring or other as are monitored for	K 0341	It is the intent of this provider have an emergency prepared communication plan that com with Federal, State, and local laws. K341 Fire Alarm System - Installation • what corrective action( will be accomplished for tho residents found to have been	ness plies (s) se	

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING	<u>• · · · · · · · · · · · · · · · · · · ·</u>		
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE		600 W/	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C could affect 20 res Findings include: Based on observat Director on 07/29/ second-floor eleva detector next to an prevent proper ope detector was about on interview at the Maintenance Direc was in the direct a within 12 inches o This finding was r	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION idents on the second floor. ion with the Maintenance 21 at 12:55 p.m., in the tor lobby there was a smoke a ir supply where air flow would eration of the detector. The t 12 inches from the vent. Based to time of observation, the ctor agreed the smoke detector irflow from the supply and was f the vent. eviewed with the Administrator Director during the exit	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) affected by the deficient practice; Maintenance Director moved smoke detector 3 feet away fr the vent. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected Maintenance Director measur all smoke detectors near vents ensure the proper distance. • What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee will audit area to ens smoke detector don't get mov and stay within 12 inches of th vent. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be p into place: QA tool will be utilized weekly monthly x 3, and quarterly x 4 The results of these audits wil reviewed by the QAPI commit overseen by the Executive Director/Designee. If threshold not achieved, an action plan w be developed to ensure	om nt d l al to red s to mic sure ed ne o p ity ut x 4, l be tee d is	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01		
15		155162	B. WING		07/29/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD		
AUTUMN	I RIDGE REHABIL	ITATION CENTRE		/ASHINGTON AVE ASH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				compliance. • What date the systemic		
				changes for each deficiency		
				will be completed		
				8-28-21		
0351	NFPA 101					
SS=E	Sprinkler System					
Bldg. 01	Spinkler System	- Installation				
	2012 EXISTING	and hospitals where required				
	•	ype, are protected				
		approved automatic				
	• •	in accordance with NFPA				
		the Installation of Sprinkler				
	Systems.					
		onstruction, alternative				
		ures are permitted to be				
		prinkler protection in specific				
	sprinklers.	e or local regulations prohibit				
		nklers are not required in				
		f patient sleeping rooms				
		f the closet does not exceed				
	6 square feet and	d sprinkler coverage covers				
	the closet footpri	nt as required by NFPA 13,				
		allation of Sprinkler				
	Systems.					
		2, 19.3.5.3, 19.3.5.4,				
		19.3.5.10, 9.7, 9.7.1.1(1) rvation and interview, the	V 0251	It is the intent of this provider.		
		isure only one type of sprinkler	K 0351	It is the intent of this provider the have an emergency prepared		
		ponse or standard sprinklers		communication plan that com		
		of 2 first floor smoke		with Federal, State, and local		
		FPA 13, 2010 Edition,		laws.		
	-	inkler Systems, Section 8.3.3.2		K351 Sprinkler System -		
	-	-response sprinklers are		Installation		
	-	clers within a compartment shall		• what corrective action(		
		unless otherwise permitted in		will be accomplished for tho		
	Section 8 3 3 3 Se	ction 8.3.3.4 states when existing		residents found to have been		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 07/29/2021	
	PROVIDER OR SUPPLIE		600	ET ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE			
AUTUMI	N RIDGE REHABIL	ITATION CENTRE	WAB	ASH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		ION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	light hazard system	ns are converted to use quick		affected by the deficient			
	-	ntial sprinklers, all sprinklers in		practice;			
	a compartmented s	space shall be changed. This		Maintenance Director mov	ved wires		
	deficient practice of	could affect up to 10 residents in		and conduit from pipe			
	1 smoke compartm	nents.		<ul> <li>how other resident</li> </ul>	s		
				having the potential to b	e		
	Findings include:			affected by the same def	icient		
				practice will be identified	l and		
	Based on observat	ion with the Maintenance		what corrective action(s)	) will		
dining/lob response a Based on the Mainte response s	Director on 07/29/	21 at 12:35 p.m., the first-floor		be taken;			
	dining/lobby smok	e compart contained both quick		All residents have the pote	ential to		
	response and stand	lard response sprinkler heads.		be affected			
	Based on an interv	iew at the time of observations		Maintenance Director aud	ited all		
	the Maintenance D	Director agreed there are mixed		smoke compartments to e	ensure		
	response sprinkler	heads in the building and		there were no wires or co			
	stated the facility i	s in the process of getting		on any pipes.			
	-	he standard response sprinkler		What measures wil	l be		
		vide documentation of two		put into place or what sy	stemic		
	quotes.			changes will be made to			
	1			ensure that the deficient			
	#2. Based on obser	rvation and interview, the		practice does not recur:			
		sure 1 of 1 sprinkler system		The Maintenance Director	or		
	-	d to support Non-System		designee will audit area to			
		dance with NFPA 13, 2010		wires and conduit are not			
	<u>^</u>	1.1.7 Support of Non-System		on pipe again	5		
		nkler piping or hangers shall not		How the corrective			
		non-system components. This		action(s) will be monitor			
		could affect 20 residents on the		ensure the deficient prac			
	third floor.			will not recur, i.e., what c			
				assurance program will I			
	Findings include:			into place:	<b>•</b>		
	Ĩ			QA tool will be utilized we	ekly x 4.		
	Based on observat	ion with the Maintenance		monthly x 3, and quarterly	-		
		21 at 2:29 p.m., above the ceiling		The results of these audits			
		oor elevator there were wires		reviewed by the QAPI cor			
		g on top of the sprinkler pipes.		overseen by the Executive			
		v at the time of observation, the		Director/Designee. If three			
		ctor agreed wires and conduits		not achieved, an action pl			
		prinkler pipe on the third floor.		be developed to ensure			
			1	compliance.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155162 B. WING 07/29/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE The findings were reviewed with the What date the systemic Administrator and Maintenance Director during changes for each deficiency the exit conference. will be completed: 8-28-21 3.1-19(b) K 0353 **NFPA 101** SS=E Sprinkler System - Maintenance and Testing Bldg. 01 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1. Based on observation and interview, the K 0353 It is the intent of this provider to 08/28/2021 facility failed to maintain the ceiling construction have an emergency preparedness of 1 of 3 stairwells. The ceiling tiles trap hot air communication plan that complies and gases around the sprinkler and cause the with Federal, State, and local sprinkler to operate at a specified temperature. laws. NFPA 13, 2010 edition, 8.5.4.11 states the distance It is the intent of this provider to between the sprinkler deflector and the ceiling have an emergency preparedness above shall be selected based on the type of communication plan that complies sprinkler and the type of construction. This with Federal, State, and local deficient practice affects all residents. laws. K353 Sprinkler System -Findings include: Maintenance and Testing what corrective action(s) 0K9D21 Page 20 of 29 Event ID: Facility ID: 000081 If continuation sheet FORM CMS-2567(02-99) Previous Versions Obsolete

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	I TIPI E CC	ONSTRUCTION	X3) DATE SU	NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	r í	LDING	<u>01</u>	COMPLET 07/29/20	ED
		CD.	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLI	EK		600 WA	ASHINGTON AVE		
AUTUM	N RIDGE REHABII	LITATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	OMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tion with the Maintenance			will be accomplished for thos	e	
		/21 at 1:30 p.m., in the suspended			residents found to have been		
	-	h stairwell there was a ceiling			affected by the deficient		
	-	ole due to water damage. This			practice;		
		elay the activation of the			Tile was replaced		
	-	d on the suspended ceiling.			Sprinkler heads on schedule to	be	
		w at the time of the observation,			replaced		
	the Maintenance of	lirector agreed the ceiling tile					
	contained a large	hole.			<ul> <li>how other residents</li> </ul>		
					having the potential to be		
	#2. Based on obse	ervation and interview, the			affected by the same deficien	t	
	facility failed to en	nsure 8 of 50 sprinklers in on the			practice will be identified and		
	first floor were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall	ee of corrosion. NFPA 25, 2011			what corrective action(s) will		
		1 sprinklers shall not show signs			be taken;		
				All residents have the potential	to		
				be affected			
	be installed in the	correct orientation (e.g.,			Maintenance Director audited		
	up-right, pendent,	or sidewall). Furthermore, at			facility and replaced ceiling tiles	s	
	5.2.1.1.2 any sprin	hkler that shows signs of any of			with holes or discolored.		
	the following shal	l be replaced: (1) Leakage (2)			Maintenance Director will conti	nue	
	Corrosion (3) Phy	sical Damage (4) Loss of fluid in			to audit facility for other corrode	ed	
	the glass bulb hea	t responsive element (5)			sprinkler heads and will have		
	Loading (6) Paint	ing unless painted by the			replaced as needed.		
	sprinkler manufac	turer. This deficient practice			What measures will be		
	-	and up to 10 residents in one			put into place or what system	ic	
	smoke compartme	-			changes will be made to		
	-				ensure that the deficient		
	Findings include:				practice does not recur:		
	Ŭ				Maintenance Director will add t	o	
	Based on observat	tion with the Maintenance			TELS monitor system and add		
		/21 at 12:28 p.m., sprinkler heads			routine maintenance		
	in the kitchen and outside of the building by			How the corrective action(s)			
		n and showed signs of			will be monitored to ensure the	ne	
		on interview at the time of			deficient practice will not	-	
		faintenance Director agreed			recur, i.e., what quality		
		er heads in the building that			assurance program will be pu	ıt I	
		orrosion and stated the facility			into place:	·•	
	-	f getting quotes to replace the			QA tool will be utilized weekly >	(4	
	sprinkler heads.	- Second quotes to replace the			monthly x 3, and quarterly x 4.	、т,	
	sprimerer neudo.				The results of these audits will	he	

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Event ID: 0K9D21 Facility ID: 000081

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	A. BUILD	IPLE CONSTRUCTION ING <u>01</u>	COM	TE SURVEY
		155162	B. WING 07/29/20			29/2021
	PROVIDER OR SUPPLIE		6	FREET ADDRESS, CITY, STATE, ZIP ( 00 WASHINGTON AVE /ABASH, IN 46992	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETIO DATE
	The findings were Administrator and the exit conference 3.1-19(b)	Maintenance Director during		reviewed by the QAPI overseen by the Exect Director/Designee. If the not achieved, an action be developed to ensur- compliance. • What date the sign changes for each definition will be completed: 8-28-21	utive hreshold is n plan will re <b>ystemic</b>	
( 0511 SS=F Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided 18.5.1.1, 19.5.1.1 #1 Based on observ facility failed to en the first floor and 1 storage hall contain protected from dan Article 406.6, Rece Plates), requires re- installed so as to co and seat against the 2011 Edition. Artic Receptacles shall b terminals are not ex- deficient practice c in on the first and s	I Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 vation and interview, the sure 2 of 40 electrical outlets on of 5 electrical outlets in the ned a cover plate and was nage. NFPA 70, 2011 Edition. eptacle Faceplates (Cover ceptacle faceplates shall be ompletely cover the opening e mounting surface. NFPA 70, ele 406.5 (F) Exposed Terminals, e enclosed so that live wiring coposed to contact. This ould affect 15 residents in room	K 0511	It is the intent of this p have an emergency pu communication plan th with Federal, State, ar laws. K511 Utilities – Gas an what corrective will be accomplished residents found to ha affected by the defici practice; Maintenance Director faceplates (cover plate Maintenance Director junction boxes with face	reparedness nat complies nd local nd electric action(s) for those nve been ent replaced es). covered	08/28/202
	Findings include: Based on observati	on with the Maintenance		<ul> <li>how other resid</li> <li>having the potential t</li> </ul>		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	È É	VILDING NG	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/29/2021	
	PROVIDER OR SUPPLIE	R ITATION CENTRE		600 W/	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	)	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		TION	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	COMPLETI
		21 between 12:00 p.m. and 2:00			affected by the same de	ficient	
	<ul> <li>p.m., in the Busine there were electric plates. Also, in the was damage exposi interview at the tim Maintenance Direc a cover plates, wer were electrical cor</li> <li>#2 Based on obser ensure 3 of 3 elect</li> </ul>	ess Office and in the service hall al outlets with missing cover storage hall part of an outlet ing meatal terminals. Based on ne of observation, the etor agreed outlets were missing e physically damage, and there tacts visible.			practice will be identifie what corrective action(s be taken; All residents have the pol be affected Maintenance Director aud facility all face plates and boxes were properly cove What measures wi put into place or what sy	d and b) will tential to dited l junction ered. II be ystemic	
	condition. LSC 19 with Section 9.1. 1 wiring and equipm National Electrical Article 314.28(3) ( provided with cover suitable for the con- metal covers shall	ined in a safe operating 0.5.1.1 requires utilities comply LSC 9.1.2 requires electrical ent to comply with NFPA 70, Code. NFPA 70, 2011 Edition, c) states junction boxes shall be ers compatible with the box and nditions of use. Where used, comply with the grounding 0.110. This deficient practice idents.		changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee will audit area to ensure electrical outlets and junction boxes are covered with a face plate • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put		or or o ensure ttion face red to ctice quality	
	Based on observation with the Maintenance Director on 07/29/21 between 2:00 p.m. and 3:00 p.m., above the celling tiles by the elevator on all three floors there were electrical junctions and junction boxes that that were not properly protected inside of a box or with a cover plate. Based on interview at the time of the observations, the Maintenance Director agreed the electrical junction boxes were not provided with a cover and there were unprotected exposed wires. The findings were reviewed with the Maintenance Director and Administrator during the exit				into place: QA tool will be utilized we monthly x 3, and quarter! The results of these audit reviewed by the QAPI co overseen by the Executiv Director/Designee. If thre not achieved, an action p be developed to ensure compliance. • What date the syst changes for each deficie will be completed: 8-28-21	y x 4. ts will be mmittee re shold is lan will temic	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/29/2021		
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
IAU	conference.	R LSC IDENTIFTING INFORMATION	IAG		DATE		
	3.1-19(b)						
K 0741 SS=E Bldg. 01	shall include not provisions: (1) Smoking shal ward, or compart liquids, combusti used or stored ar location, and suc signs that read N posted with the ir smoking. (2) In health care smoking is prohit prominently place secondary signs smoking shall no (3) Smoking by p responsible shall (4) The requirem apply where the supervision. (5) Ashtrays of ne safe design shall where smoking is (6) Metal contain devices into whic shall be readily a smoking is permi 18.7.4, 19.7.4 Based on observat failed to ensure 1 of maintained by disp	tions ons shall be adopted and less than the following I be prohibited in any room, ment where flammable ble gases, or oxygen is nd in any other hazardous h area shall be posted with O SMOKING or shall be nternational symbol for no e occupancies where bited and signs are ed at all major entrances, with language that prohibits t be required. atients classified as not be prohibited. ent of 18.7.4(3) shall not patient is under direct oncombustible material and be provided in all areas s permitted. ers with self-closing cover th ashtrays can be emptied vailable to all areas where	K 0741	It is the intent of this provider have an emergency prepared communication plan that com with Federal, State, and local	ness		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE		600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	•	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O This deficient practite the service hall ext Findings include: Based on observat Director on 07/29/ service hall exit th ground and in the the time of observ Director agree the ground outside of This finding was r	ion with the Maintenance (21 at 12:18 p.m., outside of the ere were 5 cigarette butts on the mulch. Based on interview at ations, the Maintenance re were cigarette butts on the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) laws. K741 – Smoking Regulations what corrective action will be accomplished for the residents found to have bee affected by the deficient practice; Maintenance Director remove 5 cigarette butts from the gro how other residents having the potential to be affected by the same deficie practice will be identified ar what corrective action(s) wi be taken; All residents have the potential be affected Maintenance Director audited facility grounds no other area smoke area, no cigarette butt	DATE
				<ul> <li>were found in another area or grounds.</li> <li>What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur:</li> <li>Staff were educated to disposicigarettes in the smoking receptacle only.</li> <li>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quaters assurance program will be printo place:</li> <li>QA tool will be utilized weekly monthly x 3, and quarterly x 4.</li> <li>The results of these audits w reviewed by the QAPI committies of the committ</li></ul>	e mic se of e lity put y x 4, 4. ill be

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	r í	JILDING	G <u>01</u> сомр		e survey pleted 9/2021
	PROVIDER OR SUPPLIE			600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
C 0781 SS=E Bldg. 01	NFPA 101 Portable Space F Portable Space F Portable Space h prohibited in all h except, unless us employee areas v do not exceed 21 degrees Celsius) 18.7.8, 19.7.8 Based on observati failure to ensure 1 were not used in re practice could affer Findings include: Based on observati Director on 07/29/2 fireplace containin resident area. Whe	leaters leaters eating devices shall be ealth care occupancies, ed in nonsleeping staff and where the heating elements 2 degrees Fahrenheit (100 on and interview; the facility of 1 portable space heaters sident areas. This deficient ct 10 residents on the first floor. on with the Maintenance 21 at 12:01 p.m., in the lobby a g a space heater was used in a in tested, the heater did turn on	К 0		overseen by the Executiv Director/Designee. If thre not achieved, an action p be developed to ensure compliance. • What date the syst changes for each deficie will be completed: 8-28-21 It is the intent of this prov have an emergency prep communication plan that with Federal, State, and I laws. K 781 Portable Space He • what corrective ac will be accomplished for residents found to have affected by the deficient practice;	ider to aredness complies ocal eaters tion(s) r those been	08/28/202
	time of observation stated there is a wo heater in a resident This finding was re	Based on interview at the a the Maintenance Director rking electric fireplace with a area. eviewed with the Maintenance nistrator during the exit			Maintenance Director dis element that produced he cosmetic fireplace. • how other resident having the potential to b affected by the same de practice will be identifier what corrective action(s be taken;	eat to the ts be ficient d and	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING					
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETIC DATE			
	3.1-19(b)			All residents have the potential be affected No other cosmetic fireplaces facility • What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee will audit area to en the cosmetic fireplace is not producing heat • How the corrective action(s) will be monitored the ensure the deficient practice will not recur, i.e., what qual assurance program will be pr into place: QA tool will be utilized weekly monthly x 3, and quarterly x 4 The results of these audits wi reviewed by the QAPI commit overseen by the Executive Director/Designee. If threshol not achieved, an action plan with be developed to ensure compliance. • What date the systemit changes for each deficiency will be completed: 8-28-21	al to in mic sure o sure ity put x 4,  Il be ttee d is vill			
< 0920 SS=E Bldg. 01	Extens Electrical Equipm Extension Cords	nent - Power Cords and nent - Power Cords and patient care vicinity are only ents of movable						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162		A. BUILDING <u>01</u> COM		e survey pleted 9/2021
NAME OF PROVIDER OR SUPPLI		600	EET ADDRESS, CITY, STATE, ZIP CO WASHINGTON AVE BASH, IN 46992	DD	
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETIO
patient-care-rela (PCREE) assem assembled by quithe conditions of the patient care non-PCREE (e.g. except in long-tee do not use PCRI meet UL 1363A for non-PCREE (outside of vicini non-patient care other UL standai used with genera cords are not us wiring of a struct temporarily are r completion of the installed and me 10.2.3.6 (NFPA (NFPA 70), 590. #1. Based on obset facility failed to e not used as a subs power equipment NFPA-70/2011, 4 permitted in 400.7 not be used for (1) This deficient pra- residents in front of Findings include: Based on observar Director on 07/29 (high power draw and supplied power Business Office, I observation, the N	28. LSC IDENTIFYING INFORMATION ted electrical equipment bles that have been ualified personnel and meet 10.2.3.6. Power strips in vicinity may not be used for 1., personal electronics), rm care resident rooms that EE. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms ty) meet UL 1363. In rooms, power strips meet rds. All power strips are al precautions. Extension ed as a substitute for fixed ure. Extension cords used emoved immediately upon e purpose for which it was ets the conditions of 10.2.4. 29), 10.2.4 (NFPA 99), 400-8 3(D) (NFPA 70), TIA 12-5 rvation and interview, the nsure 1 of 1 power strips were titute for fixed wiring to provide with a high current draw. 00.8 state unless specifically flexible cords and cables shall as a substitute for fixed wiring. ctice could affect up to 5 office area.	К 0920	It is the intent of this pro- have an emergency pre- communication plan that with Federal, State, and laws. K 920 Electrical Equipt Power cords And Exte · what corrective at will be accomplished for residents found to hav affected by the deficient practice; Maintenance Director re- power strips identified. · how other reside having the potential to affected by the same do practice will be identified	paredness t complies l local ment ns action(s) or those e been nt emoved nts be leficient ed and	08/28/20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED		
155162		B. WING		07/29/2021			
JAME OF	PROVIDER OR SUPPLIE	R.		ADDRESS, CITY, STATE, ZIP COD			
				ASHINGTON AVE			
AUTUM	N RIDGE REHABIL	ITATION CENTRE	WABA	SH, IN 46992			
X4) ID SUMMARY		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMP	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		TE	
	to high power draw equipment.			be taken;			
				All residents have the potentia	al to		
	#2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were			be affected			
				Maintenance Director audited			
		and used in a safe manor. NFPA		facility to ensue there were no	D I		
	99, Section 10.2.4.2 states adapters and extension			other power strips in use in			
	cords meeting the requirements of 10.2.4.2.1			facility.			
	through 10.2.4.2.3 shall be permitted. Section			• What measures will be			
	10.2.4.2.3 states the cabling shall comply with			put into place or what syste	mic		
10.2.3. Section 10.2.3.5.1 states cord strain shall be provided at the attachment of the p cord to the appliance so that mechanical st				changes will be made to			
				ensure that the deficient			
				practice does not recur:			
internal co staff on th Findings i Based on	~	or bend, is not transmitted to		The Maintenance Director or			
		ns. This deficient practice could		designee will audit area to en			
	staff on the storage	e hall.		the facility has no other powe	r		
				strips in use			
	Findings include:			• How the corrective			
				action(s) will be monitored t			
	Based on observation with the Maintenance			ensure the deficient practice			
		21 at 12:33 p.m., in the		will not recur, i.e., what qual	-		
	Housekeeping office a power strip used to power			assurance program will be p	but		
	equipment, was not secured, and was dangling			into place:			
		from the outlet on the wall. This condition could put stress on the power cord causing damage to		QA tool will be utilized weekly			
-				monthly x 3, and quarterly x 4			
-		ased on interview at the time of		The results of these audits wi			
the power strip stated the power set on the floor The findings w		Maintenance Director agreed		reviewed by the QAPI commi	ttee		
	the power strip was dangling, not secured, and			overseen by the Executive			
	stated the power strip will need to be mounted or			Director/Designee. If threshol			
	set on the floor.			not achieved, an action plan	WIII		
				be developed to ensure			
	The findings were reviewed with the Maintenance			compliance.			
	Director and Administrator during the exit			What date the systemi			
	conference.			changes for each deficiency	/		
	3.1-19(b)			will be completed: 8-28-21			
	5.1-19(0)			0-20-21			

0K9D21 Facility ID: 000081

If continuation sheet

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