STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	09/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/29/21 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 09/28/21 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this PSR survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in 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.	K 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 1-16-2022. We respectfully request a desk review in lieu of a post survey Revisit It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	Quality Review completed on 10/04/21			
K 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls on 3 of 3 floors met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.	K 0331	It is the intent of this provider to have an emergency preparedness communication plan that complies 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 practice;** Facility requesting temporary construction waiver. Contractors will remove the veneer material and replace it with a rated material. Contractors will install Palladium rigid vinyl sheet or like material; spec sheet attached. Materials on backorder due to pandemic. **how other residents having the potential to be affected by the same deficient practice will be**	01/16/2022

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	This deficient practice could affect all residents in the building. Findings include: Based on observation with the Administrator on 09/28/21 between 10:30 a.m. and 11:00 a.m., in all halls on all three floors the corridor walls were either covered with vinyl paneling or carpet on the lower third of the walls. Based on records review at 11:10 a.m., no documentation of the flame spread rating for the wall coverings was available for review. Based on interview at the time of observation, the Administrator stated there was no flame spread documentation and all the wall coverings will be removed and replaced. This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**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 veneer product mounted on the corridor walls from 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 any future interior corridor finish materials have the appropriate documentation for a flame spread 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 weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. **What date the systemic changes for each deficiency will be completed**	