STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING -- B. WING	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	300 J H WALKER DR PENDLETON, IN 46064

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/19/24 Facility Number: 000248 Provider Number: 155357 AIM Number: 100291270 At this Emergency Preparedness survey, Rawlins House Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 107. Quality Review completed on 09/23/24	E 0000	Submission of this plan of correction in no way constitutes an admission by Rawlins House Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/19/24 between	E 0041	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Missing three year 4-hour generator run test. **II. The facility will identify other residents that may potentially be affected by the**	10/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Covey	HFA	10/01/2024

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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	9:45 a.m. and 12:15 p.m., the facility provided documentation for testing of the natural gas fired emergency generator, however could not provide documentation of a three year 4 hour run test. The MD stated that his TELS documentation just recently populated that this was needed. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference.		**deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Corporate Director or Maintenance corrected the task in TELS and will be completed every 4 years. Maintenance Director completed the run test. See attached. **IV The facility will monitor the corrective action by implementing the following measures.** Task added to TELS and task attached.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/19/24 Facility Number: 000248 Provider Number: 155357	K 0000	Submission of this plan of correction in no way constitutes an admission by Rawlins House Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in	

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	AIM Number: 100291270 At this Life Safety Code survey, Rawlins House Health and Living Community was found not in compliance with Requirements for Participation in Medicare, 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 one-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 107 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 09/23/24		this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key or special knowledge from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient	K 0222	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – 4-digit code posted at front entrance was worn and difficult to read. **II. The facility will identify**	10/01/2024

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	practice could affect over 10, staff and visitors if needing to exit the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 09/19/24 between 12:15 p.m. and 2:45 p.m., the main exit doors were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the main exit in a manner which was easily recognizable and obvious. The posted code was worn and not readable. The Executive Director replaced the code during the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)		**other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Director corrected the deficient practice by replacing label. See attached. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee audit door codes as a monthly TELS task. See attached.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011	K 0324	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – missing a method to ensure cooking appliances are	10/01/2024

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	Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 5 staff and no residents. The findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 09/19/24 between 12:15 p.m. and 2:45 p.m., the 6 burner gas range with burner flat grill located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was reviewed with the Executive Director and Maintenance Director at the time of		returned to original location if moved. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All kitchen staff have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Floor marked to identify where range wheel is to be placed. Staff in serviced on returning equipment to specific location. **IV The facility will monitor the corrective action by implementing the following measures.** Permanent repair completed so there is no follow up at this time. See attached picture.	

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	discovery and again during the exit conference. 3.1-19(b)			
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 09/19/24 between 12:15 p.m. and 2:45 p.m., the fire alarm control panel (FACP) door was not locked. The Main FACP is located near a facility entrance in a high traffic area. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)	K 0341	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Fire control panel was left unlocked. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident and Staff have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Fire panel locked and keys provided to leadership. **IV The facility will monitor the corrective action by implementing the following measures.**	10/01/2024

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			Maintenance Supervisor and Assistant educated on keeping panel locked.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 5 staff and 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 09/19/24 between 12:15 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The Dining Room Door into the Kitchen Dish Room, equipped with a self-closing device, failed to self-close and latch into the door frame. b) Resident Room #29. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)	K 0363	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – 2 interior doors failed to latch into the door frame. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Kitchen staff and 2 Residents had the potential to be affected by this. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Both doors were adjusted and latch appropriately. **IV The facility will monitor the corrective action by implementing the following measures.**	10/01/2024

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			Current TELS task to audit all doors and ensure they latch. See attached TELS task.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC Based on record review, observation and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect 23 residents, staff and visitors.	K 0521	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Failed to ensure fire dampers were inspected every 4 years. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Fire damper inspection was added as a TELS task every 4 years. **IV The facility will monitor the corrective action by**	10/01/2024

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	Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/19/24 between 9:45 a.m. and 12:15 p.m., no documentation was available for the required fire/smoke damper tests at the facility. The MD stated that the facility has 2 fire dampers in 1 fire wall and that he had been in contact with someone to come and inspect the dampers but the inspection had not yet been done. The Executive Director asked if the facilities sprinkler and smoke alarm contractor did the inspection and the MD state no they do not. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)		**implementing the following measures.** Complete Mechanical completed fire damper inspection on September 23, 2024. See attached completed audit.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review and interview with the Maintenance Director on 09/19/24 between 9:45 a.m. and 12:15 p.m., no documentation was available to show a second and third shift fire drill for the second quarter of 2024 was conducted. Based on interview at the time of record review,	K 0712	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – No documentation was available to show documentation of two fire drills. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice.	10/01/2024

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	the Maintenance Director stated he believed the aforementioned drills were done but could not find the paperwork showing the drills were completed. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b) 3.1-51(c)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Director in serviced on completion and proper documentation of Fire Drills. **IV The facility will monitor the corrective action by implementing the following measures.** Administrator will audit fire drills monthly for 1 year.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.	K 0918	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Missing three year 4-hour generator run test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice.	10/01/2024

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	Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/19/24 between 9:45 a.m. and 12:15 p.m., the facility provided documentation for testing of the natural gas fired emergency generator, however could not provide documentation of a three year 4 hour run test. The MD stated that his TELS documentation just recently populated that this was needed. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Corporate Director or Maintenance corrected the task in TELS and will be completed every 4 years. Maintenance Director completed the run test. **IV The facility will monitor the corrective action by implementing the following measures.** Task added to TELS and task attached.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 1 resident. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director	K 0920	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Facility failed to ensure 1 of 1 Resident room did not use multi plug adapter. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	10/01/2024

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	on 09/19/24 between 12:15 p.m. and 2:45 p.m., room 42 contained a multi-plug adaptor powering electronic equipment. Based on interview at the time of observation, the Maintenance Director agreed a mulita-plug adaptor was in use in room 42 and he removed the adaptor. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference. 3.1-19(b)		All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Quarterly TELS task to verify correct power strips are being utilized. **IV The facility will monitor the corrective action by implementing the following measures.** Inservice building leadership to audit all resident rooms while doing routine rounds. See attached.	