STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155526	A. BUILDING -- B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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: 08/27/24 Facility Number: 000148 Provider Number: 155526 AIM Number: 100275500 At this Emergency Preparedness survey, Persimmon Ridge Rehabilitation Centre was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 94. Quality Review completed on 08/29/24	E 0000		
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: 08/27/24 Facility Number: 000148 Provider Number: 155526 AIM Number: 100275500 At this Life Safety Code survey, Persimmon Ridge	K 0000	Submission of this plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hodgson	Administrator	09/12/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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
	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 one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 94 at the time of this visit. Quality Review completed on 08/29/24		Please accept this Plan of Correction as our credible allegation of compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview the facility failed to provide grease drip trays for 1 of 1 Kitchens. Cooking equipment is protected in accordance with NFPA 96, 6.2.4 which states: 6.2.4.1 Grease filters shall be equipped with a grease drip tray beneath their lower edges. 6.2.4.2 Grease drip trays shall be kept to the minimum size needed to collect grease. 6.2.4.3 Grease drip trays shall be pitched to drain into an enclosed metal container having a capacity not exceeding 3.8 L (1 gal). This deficient practice could affect staff in the kitchen and 50 residents in the dining room. Findings include: Based on observation with the Administrator and Maintenance Director on 08/27/24 at 12:31 p.m.,	K 0324	1&2. No residents were affected but all residents had the potential to be affected. Grease drip pans were added to the kitchen hood. 3. The maintenance director was re-educated on Cooking Facilities Requirement. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete. Any negative findings will be corrected immediately and reported to the administrator, a visual inspection	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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
	the kitchen was provided with a UL 300 hood system with grease filters but was not equipped with a grease drip tray beneath the lower edges of the hood. Also, the corners of the hood system were dripping grease onto the floor. Based on interview during observation, the Maintenance Director agreed the hood system was not provided with grease drip trays and grease was dripping on the floor. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		of the kitchen hood grease drip pans will be documented on inspection form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5 times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing 5. 9-12-24	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 40 residents in two smoke compartments. Finding includes: Based on observations with the Maintenance Director and Administrator on 08/27/24 at 12:20 p.m. the smoke barrier door assembly in the Memory Care Hall had a 3/8 gap on the lower half between the doors when closed. Based on an interview at the time of observation, the	K 0374	1&2. No residents were affected but all residents had the potential to be affected. The smoke barrier door on the memory care hall was adjusted to ensure gap was less than 1/8 inch when closed. 3. The maintenance director was re-educated on smoke barrier doors. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete. Any negative findings will be corrected immediately and reported to the administrator, a visual inspection form will be completed, any	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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
	Maintenance Director agreed there was a gap larger than 1/8 inch between the smoke doors when closed. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5 times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing. 5. 9-12-24	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations with the Maintenance Director and the Administrator on 08/28/24 at 12:10 p.m., two power-strips in room 211 were in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed power-strips were in use in resident care areas and did not meet 1363A or 60601-1. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0920	1&2. No residents were affected but all residents had the potential to be affected. The two power strips in room 211 were removed. Electrical outlets were added to room 211. 3. The maintenance director was re-educated on Electrical equipment-power cords and extension. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete. Any negative findings will be corrected immediately and reported to the administrator. A visual inspection sheet will be completed. Any negative findings will be corrected immediately and reported to the	09/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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
			administrator. Monitoring will be conducted 5 times per week X4 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing. 5. 9-20-24	
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 12 of 60 resident rooms from the use of liquid oxygen cylinders stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 Liters (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits to be self-closing or automatic closing. This deficient practice affects at least 12 residents. Findings include: Based on observations with the Administrator and Maintenance Director on 08/27/24 between	K 0930	POC not Required for K930	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155526	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PERSIMMON RIDGE REHABILITATION CENTRE	200 N PARK ST PORTLAND, IN 47371

(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
	11:00 a.m. and 1:00 p.m., there were 12 resident rooms that each contained an upright liquid oxygen stationary container on wheels that was not separated from the remainder of the facility by a complete fire barrier. Each resident room door did have a fire rating of 45 minutes but was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed there were liquid oxygen containers in 12 resident sleeping rooms within the patient care area and the resident room doors were not self-closing or automatic closing. The Administrator provided the count of liquid oxygen containers in resident rooms as 12 and stated the reason liquid oxygen are used in the 12 resident rooms is because Medicaid will not reimburse the facility for using oxygen concentrators but only liquid oxygen tanks. Additionally, the Administrator indicated the Respiratory Therapy office keeps track of residents using liquid oxygen and their room locations. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.			