<u> </u>		X1) PROVIDER/SUPPLIER/CLIA	ſ ´	X2) MULTIPLE CONSTRUCTION (X3)		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155681	B. WING		03/21/2024	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
	I WOODS HEALTH			REEN VALLEY RD		
	N VVOODS MEALTE	I UAIVIEUU	I NEVV A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG E 0000	REGULATORY O.	R LSC IDENTIFYING INFORMATION	TAG	BEIGHNOT	DATE	
L 0000						
Bldg						
	An Emergency Pre	paredness Survey was	E 0000			
	conducted by the In	ndiana Department of Health in				
	accordance with 42	2 CFR 483.73.				
		Survey Date: 02/21/24				
	Survey Date: 03/2	1/24				
	Facility Number: (002657				
	Provider Number:					
	AIM Number: 200					
	At this Emergency	Preparedness survey, Autumn				
	Woods Health Can	npus was found in compliance				
		reparedness Requirements for				
		icaid Participating Providers				
	and Suppliers, 42 (CFR 483.73.				
	The facility has a c	apacity of 91 certified beds and				
	_	at the time of this visit.				
	nau a consus er , ,					
	Quality Review co	mpleted on 03/25/24				
K 0000						
Bldg. 01						
	A Life Safety Code	e Recertification and State	K 0000	The submission of this plan of	:	
	I	was conducted by the Indiana		correction does not indicate a		
	I -	lth in accordance with 42 CFR		admission by Autumn Woods		
	483.90(a).			Health Campus that the findin	gs	
				and allegations contained her		
	Survey Dates: 03/2	21/24		are accurate, true representat		
		20275		of the quality of care provided		
	Facility Number: (the living environment provide		
	Provider Number:			the residents of Autumn Wood	1S	
	AIM Number: 200	J3U073U		Health Campus. The facility	ovido	
	At this Life Safety	Code survey, Autumn Woods		recognizes its obligation to pro- legally and medically necessa		
	· ·	s found not in compliance with		care and services to its reside		
				22 2 3 25. 11000 10 10 100100		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Christophe	er		Wright		04/03/2024	

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		(X2) MULTIPLE C A. BUILDING B. WING	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
AUTUMN	I WOODS HEALTH	CAMPUS		ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE
	Requirements for Pa	articipation in , 42 CFR Subpart 483.90(a),		in an economic and efficient	
		re and the 2012 edition of the		manner. The facility hereby maintains it is in substantial	
		etion Association (NFPA) 101,		compliance with all state and	
		LSC), Chapter 19, Existing		federal requirements governin	a the
		ancies and 410 IAC 16.2.		management of this facility. It	-
	Treatm care occupi	meles and 110 m to 10.2.		thus submitted as a matter of	13
	This one story facil	ity was determined to be of		statute only. The facility	
		ruction and was fully		respectfully requests a desk	
		cility has a fire alarm system		review for substantial complian	nce.
	*	oke detectors in the corridors,		If there are any questions, ple	
		corridors and in all resident		contact me at (812) 941-9896.	
	sleeping rooms. Th	e facility has a capacity of 91		, ,	
	and had a census of	79 at the time of this survey.		Sincerely,	
		idents have customary access		Brandy D'Angelo, HFA, BSW	
	_	nd all areas providing facility		Autumn Woods Health Campu	
	services were sprinl	klered.		Brandy.Dangelo@autumnwoo althcampushc.com	<u>dshe</u>
	Quality Review con	npleted on 03/25/24			
K 0211	NFPA 101				
SS=E	Means of Egress	- General			
Bldg. 01	Means of Egress	- General			
	Aisles, passagewa	ays, corridors, exit			
	discharges, exit lo	cations, and accesses are			
	in accordance with	n Chapter 7, and the means			
	of egress is contin	uously maintained free of			
		full use in case of			
		s modified by 18/19.2.2			
	through 18/19.2.1				
	18.2.1, 19.2.1, 7.1				
		on and interview, the facility	K 0211	K211 Means of Egress – Gen	eral 03/26/2024
		f 10 means of egress was		4 The Discrete CDL CC	4:
		ained free of all obstructions		The Director of Plant Opera The Director of Plant Opera The Director of Plant Opera The Director of Plant Opera	
		full instant use in the case of ency. Section 7.5.2.2.1 states		removed venetian blinds from	ine
				Private Dining Room EXIT.	file
		es shall not be placed over exit that they conceal or obscure		See Pictures Labeled K211 in	IIIE
		erwise provided in 7.5.2.2.2.		2. All occupants had the pote	ntial
1	, -,, 	r · · · · · · · · · · · · · ·	1	, 000apanto naa tilo poto	

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		(X2) M			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155681	B. Wl	ING		03/21/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			REEN VALLEY RD		
AUTUMN	WOODS HEALTH	CAMPUS		1	LBANY, IN 47150		
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ice could affect over 10			to be affected by the deficient		
	_	visitors if needing to exit to			practice.		
		icility from the Private Dining			'		
	Room.	_			3. The Director of Plant Opera	itions	
					is now knowledgeable that all		
	Findings include:				EXITS may not be covered by	,	
					blinds nor any visual obstructi	on.	
		ons with the Executive					
	Director, the Director of Plant Operations (DPO)				4. As a quality measure, the		
		lanagement Support during a			Director of Plant Operations w	rill	
	tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the Private Dining Room has one exit door to the outside of the facility which was marked as a facility exit with an 'EXIT' sign. The exit door was marked with the necessary delayed				ensure that all facility Exits		
					remain free from blinds or other		
					visual obstructions when doing	9	
					daily door checks. Any	4	
		the signage was obscured			findings will be reviewed at lea	สรเ	
	1	linds were installed on the			quarterly and ongoing in the campus Quality Assurance		
		or. The exit door released to			Performance Improvement		
		on the door for 15 seconds.			meetings.		
	Based on interview				ge.		
		PO agreed the aforementioned					
		s not continually maintained					
	free of all obstruction	ons or impediments to full					
	instant use in the ca	se of fire or other emergency					
	due to the blinds be	ing hung on the exit door.					
	TI (* 1:	1 1 M 4 5 2					
	_	e reviewed with the Executive					
	Support during the	and the Facilities Management					
	Support during the t	CAIL CUITETETICE.					
	3.1-19(b)						
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01	Exit Signage						
	2012 EXISTING						
		al signs are displayed in					
		'.10 with continuous					
		erved by the emergency					
	lighting system.		1				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155681	B. W	NG		03/21	/2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					GREEN VALLEY RD		
AUTUMN	NWOODS HEALTH	I CAMPUS		NEW A	ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	19.2.10.1	RESCRIPTION TO BUT ORGANITION		1710			DATE
		no atom, evicting					
	(Indicate N/A in or	-					
		less than 30 occupants					
		exit travel is obvious.)					
		on and interview; the facility	K 0	293	K293 EXIT Signage		03/27/2024
		signage in 1 of 10 means of					
	egress in the facility in accordance with LSC 7.10.				Director of Plant Operations		
		es exits, other than main exterior			installed EXIT Signage from 1		
	exit doors that obviously and clearly are				Hall entering the 300 Hall. The	•	
	identifiable as exits	, shall be marked by an			code to release the door into	the	
	approved sign that	is readily visible from any			300 Hall has been added to th	ie	
	direction of exit acc	cess. LSC 7.10.1.2.2 states			keypad on the 100 Hall side.		
	horizontal compone	ents of the egress path within			See Pictures Labeled K293 in	file	
	an exit enclosure sh	nall be marked by approved exit					
		igns where the continuation of			2. All occupants had the poter	ntial	
		ot obvious. This deficient			to be affected by the deficient		
		et over 20 residents, staff and			practice.		
	_	to exit the 100 Hall by resident			F-3-3-3-3-1		
	sleeping Room 100				3. The Director of Plant Opera	tions	
	sieeping recom roo	•			is now knowledgeable that all	1110110	
	Findings include:				facility EXITS must have		
	i manigs merade.				1		
	Based on observation	ons with the Executive			signage.		
		tor of Plant Operations (DPO)			4. As a quality measure, the		
		Ianagement Support during a			Director of Plant Operations w	dill	
		from 12:25 p.m. to 2:30 p.m. on			ensure that all facility EXITs have		
	-	lor door set serving as the			_		
		Hall from the 100 Hall by			EXIT signage when he is doing	-	
		•			daily door checks. Any finding	WIII	
		oom 100 was not marked as a			be reviewed at least.		
	-	'EXIT' sign. The corridor door			Quarterly and ongoing in the		
		rith delayed egress signage			campus Quality Assurance		
		with magnetic holding devices			Performance Improvement		
		eased by entering a code at a			meetings.		
		set but the code to release the					
	_	ot posted. The door set					
	released to open aft	ter pushing for 15 seconds.					
	The 300 Hall is a se	ecure wing housing Alzheimer's					
		idor door set serving as the					

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entrance to the 300 Hall from the 100 Hall by resident sleeping Room 100 is one of the two

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		JILDING	01	COMPL 03/21/	ETED	
	PROVIDER OR SUPPLIER		2911 GF	DDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	at the time of the ob Facilities Managem egress was not obvic closed and should h the door set in the 1. These findings were Director, the DPO a Support during the of	100 Hall. Based on interview eservations, the DPO and the ent Support agreed the path of ous with the corridor door set ave an 'EXIT' sign installed at 00 Hall by Room 100. The reviewed with the Executive and the Facilities Management exit conference.				
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door.	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of				
	a. Boiler and Fuel- b. Laundries (large	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) ance, and Paint Shops				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155681	B. W	NG		03/21	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8					
A I ITI IN AN	LWOODO LIEALTII	LOAMBLIO			REEN VALLEY RD		
AUTUMN	I WOODS HEALTH	CAMPUS		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)	, ,					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal						
	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 failed to ensure 1 of over 16 hazardous areas such						
			K 0	321	K321 Hazardous Areas –		03/26/2024
			I K U	321	Enclosure		03/20/2024
		red heater rooms were			Enologuie		
		er spaces by smoke resistant			A. Door from service hall corri	dor	
	_				to the kitchen.	uoi	
	partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8.				to the kitchen.		
	This deficient practice could affect over 10				1. The Director of Plant Opera	tions	
	_	visitors in the vicinity of the			repaired the door from the ser		
	kitchen.	visitors in the vicinity of the			hall corridor door to the kitche		
	KITCHEII.						
	Findings include:				and it is now latching properly See Pictures Labeled K321A		
	rindings include.						
	Događan obsamjeti	ons with the Maintenance			Audit Tool Labeled Tag K321	in nie	
		cilities Management Support			2 All secure ante had the meter	4:-1	
					2. All occupants had the poter		
		facility from 12:30 p.m. to 2:15 he following was noted in the			to be affected by the deficient		
		•			practice.		
		ained one natural gas fired			O. The Discrete of Discret Occurs	4:	
	water heater room:	to the kitchen by the as! I			3. The Director of Plant Opera	แบกร	
		to the kitchen by the corridor			is now knowledgeable that all		
		ice hall was equipped with a			doors into hazardous areas		
		to latch the door into the door			must latch properly.		
		failed to latch into the door					
		to close multiple times.			4. As a quality measure, the		
	_	uctwork above the natural gas			Director of Plant Operations/		
		which penetrated the ceiling of			designee will ensure that all de		
		om in the kitchen had dropped			into hazardous areas are latch	-	
		l position to rest on the floor of			properly when completing roun	nding	
		oosed the attic above the water			of all hazardous area		
		vater heater room was open to			enclosures 5 X a week for 4		
	the kitchen.				weeks, then 3 X a week for 4		
	Based on interview				weeks, then 2X a Week for 8		
	observations', the D	PO stated the kitchen door			Weeks,		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 03/21/2024	
	PROVIDER OR SUPPLIER		2911 (ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR frame and the botto were loose which cat to not latch the door DPO stated the duct down is makeup air fired water heater as separated from othe partitions and doors. These findings were Director, the Maintee	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION IN hinge on the kitchen door aused the latching mechanism In into the door frame. The twork which had dropped ductwork for the natural gas and agreed the kitchen was not It spaces with smoke resistant	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) then 1 X monthly on latch and inspection. B. Ductwork above natural ga fired water heater/smoke penetration to attic. 1. The Director of Plant Operations reinstalled the ver through the attic penetration a secured it so that it would no longer fall down. The Director Plant Operations also fire sea the duct work to the ceiling. See Pictures Labeled K321B file 2. All occupants had the potent to be affected by the deficient practice. 3. The Director of Plant Opera is now knowledgeable that all smoke penetrations are to be	s DATE I gap s at and of led in ntial
K 0351 SS=F Bldg. 01	by construction type throughout by an a sprinkler system in	Installation nd hospitals where required		sealed. 4. As a quality measure, the Director of Plant Operations wensure all smoke penetrations sealed.	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/21/2024			
		ROVIDER OR SUPPLIER			2911 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
		In Type I and II coprotection measur substituted for sprareas where state sprinklers. In hospitals, sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure only to be utilized for its Standard for the Insta 2010 Edition; Section sprinklers shall not any new or existing states only new sprinklers in the failed to ensure only to be utilized for its Standard for the Insta 2010 Edition; Section sprinklers shall not any new or existing states only new sprinkler in the failed to include: Based on observation Director, the Director and the Facilities M tour of the facility for 103/21/24, the spare the sprinkler riser respare sprinkler which threads and was states sprinkler manufacturer. Based on 1999 stamper manufacturer. Based on 1999 stamper manufacturer. Based on 1999 stamper manufacturer.	restruction, alternative res are permitted to be rinkler protection in specific or local regulations prohibit restricted in patient sleeping rooms the closet does not exceed sprinkler coverage covers tas required by NFPA 13, llation of Sprinkler (19.3.5.3, 19.3.5.4, 19.3.5.10, 19.7, 19.7.1.1(1) on and interview, the facility of new sprinklers were available sprinkler system. NFPA 13, stallation of Sprinkler Systems, on 6.1.2.2 states reconditioned be permitted to be utilized on a system and Section 6.2.1 inklers shall be installed. This bould affect all residents, staff	K 0		K351 Sprinkler System – Installation 2012 EXISTING 1. The Director of Plant Opera replaced out-of-date replacem sprinkler heads. See Pictures Labeled K351 in 2. All occupants had the poter to be affected by the deficient practice. 3. The Director Plant Operation now knowledgeable that all replacement sprinkler heads in be in date. 4. As a quality measure, the Director of Plant Operations we ensure that all replacement sprinkler heads are visually inspected both in house and be qualified fire sprinkler contract least quarterly. Any findings we be reviewed at least quarterly ongoing in the campus Quality	file file file file fitial file file file file file file file fil	04/01/2024

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, ´		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155681	B. WING		03/21/2024
	PROVIDER OR SUPPLIER		2911 0	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S BLANGE CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	sprinklers were mor them previously ins These findings were	ort agreed both quick response re than 20 years old with one of stalled in sprinkler systems. The reviewed with the Executive and the Facilities Management exit conference.		Assurance Performance Improvement meetings.	
	3.1-19(b)				
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with North Inspection, Testing Water-based Fire Records of system inspection and test secure location and secure system inspection and test secure location are secure system.	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. In system last checked			
	c) Water system	<u>.</u>			
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to maintain the ceiling smoke barried Section 3.3.5.4 definitions continuous ceiling friegularities, lumps	on and NFPA 25 on and interview, the facility ne ceiling construction in 1 of 1 ers. NFPA 13, 2010 edition, nes a smooth ceiling as a free from significant s, or indentations. The ceiling	K 0353	K353 Sprinkler System – Maintenance and Testing / Dr ceiling penetration 1. The Director of Plant Opera repaired all penetrations. See Pictures Labeled K353 in	ations
	cause the sprinkler	ses around the sprinkler and to operate at a specified n 8.5.4.1.1 states the distance		All occupants had the poter to be affected by the deficient	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/21/2024		
	PROVIDER OR SUPPLIER			2911 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	N SHOULD BE	
TAG		er deflector and the ceiling		TAG	practice.	· · · · · · · · · · · · · · · · · · ·	DATE
	above shall be select sprinkler and the type deficient practice co	ted based on the type of pe of construction. This pull affect over 10 residents,			3. The Director of Plant Operations is now knowledgeable that all drop		
	staff and visitors in the vicinity of the kitchen. Findings include:				ceilings must be in place and from open penetration.	free	
	Based on observation Director, the Direct and the Facilities M tour of the facility f 03/21/24, a four inc in one suspended coroom in the kitchen gas pipes. Based or observations, the Di Management Supporting did not main the room. These findings were Director, the DPO a	ons with the Executive or of Plant Operations (DPO) (anagement Support during a from 12:25 p.m. to 2:30 p.m. on h by three inch hole was noted willing tile in the water heater for the passage of two natural in interview at the time of the PO and the Facilities ort agreed the hole in the attain the ceiling construction in the reviewed with the Executive and the Facilities Management			4. As a quality measure, the Director of Plant Operations wensure ceiling tiles are free from penetration by visual inspection. Any findings will be reviewed least quarterly and ongoing in campus Quality Assurance Performance Improvement meetings.	om on. at	
	Support during the 3.1-19(b)	exit conference.					
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other dosures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in the for at least 20 fully sprinklered smoke enonly required to resist the encorridor doors and doors in flammable or					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155681		JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/21/2024		
	PROVIDER OR SUPPLIE			2911 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD			
AUTUM	N WOODS HEALTH	1 CAMPUS		NEW A	LBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE	
	hardware. Roller CMS regulation. apply to auxiliary flammable or com Clearance betwee covering is not ex doors complying if provided with a the door closed wapplied. There is closing of the door release when the permitted. Nonrat unlimited height a meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. I there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARI fire protection ratid devices, etc. Based on observatifailed to ensure 1 or resist the passage of	en bottom of door and floor acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is no impediment to the ors. Hold open devices that door is pushed or pulled are end protective plates of or permitted. Dutch doors 6 are permitted. Door abeled and made of steel or compliance with 8.3, a compartment is a fire window assemblies are in sprinklered compartments ictions in area or fire as or frames in window. Parts 403, 418, 460, 482, KS details of doors such as ngs, automatics closing on and interview, the facility of over 70 corridor doors would of smoke. This deficient ct over 10 residents, staff and	K 0	363	K363 Corridor – Doors 1. The Director of Plant Opera repaired the door from the ser hall corridor door to the kitche	vice	03/22/2024	
	Findings include:				and it is now latching properly resisting the passage of smok See Pictures Labeled K363 &	e.		

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Based on observations with the Executive

Director, the Director of Plant Operations (DPO)

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Audit Tool Labeled Tag 363 in file

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155681		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/21/2024		
	PROVIDER OR SUPPLIER			2911 GI	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	and the Facilities M tour of the facility f 03/21/24, the corridor door set to with a latching mee the door frame but the door frame when the Based on interview observations', the D frame and the botto loose which caused latch the door into the aforementioned corpassage of smoke.	PO stated the kitchen door m hinge on the door were the latching mechanism to not he door frame and agreed the ridor door would not resist the e reviewed with the Executive and the Facilities Management		TAG	2. All occupants had the potent to be affected by the deficient practice. 3. The Director of Plant Operatis now knowledgeable that all doors must latch properly to ensure ability resist the passage of smoke. 4. As a quality measure, the Director of Plant Operations/designee will ensure that all doare latching properly when completing rounding of all doo X times a week for 4 weeks, then 2 Week for 8 Weeks, then 1X monthly on latch and gap inspection.	tial tions ge	DATE
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ecceptors and ventilated in a and 5.1.3.3.3. >300 but <3,000 cccommod storage locations enclosure or within space of non- or liconstruction, with that can be secure stored with flammater from combustibles	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated is by 20 feet (5 feet if closed in a cabinet of					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155681	B. WING			03/21/2024		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	R						
ALITLIMA	N WOODS HEALTH	CAMPUS		2911 GREEN VALLEY RD NEW ALBANY, IN 47150				
AUTOMIN	· WOODS HEALTH	CAIVII 03		NEW ALDANT, IN 47 150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				DEFICIENCY)		DATE	
	noncombustible construction having a							
	minimum 1/2 hr. fire protection rating.							
	Less than or equal to 300 cubic feet							
	In a single smoke compartment, individual							
	cylinders available for immediate use in							
	_ ·	s with an aggregate volume						
	of less than or equal to 300 cubic feet are not							
	required to be stored in an enclosure.							
	Cylinders must be handled with precautions							
	as specified in 11.6.2.							
	A precautionary sign readable from 5 feet is							
	on each door or gate of a cylinder storage							
		sign includes the wording as						
	a minimum "CAUTION: OXIDIZING GAS(ES)							
	STORED WITHIN NO SMOKING."							
	Storage is planned so cylinders are used in							
	order of which they are received from the							
	supplier. Empty cylinders are segregated							
	from full cylinders. When facility employs							
	cylinders with integral pressure gauge, a							
		e considered empty is						
		ty cylinders are marked to						
		Cylinders stored in the open						
	are protected from weather.							
	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)							
	Based on observation	on and interview, the facility	K 0	923	K923 Gas Equipment – Cylind	ler	03/22/2024	
	failed to ensure 1 of	f 1 storage locations of			and Container Storage			
	_	s equal to or greater than 3000						
		ured against unauthorized			1. The Director of Plant Opera	tions		
	1 -	ealth Care Facilities Code, 2012			installed a lock mechanism to	the		
	· ·	3.2.1 states storage locations			door of the oxygen cylinder			
		an enclosure or within an			storage room.			
		ace of noncombustible or			See Pictures Labeled K923 &			
		e construction, with doors (or			Audit Tool Labeled Tag K923	in file		
	l -	can be secured against						
	· ·	This deficient practice could			2. All occupants had the poten	itial		
		ents, staff and visitors in the			to be affected by the deficient			
	vicinity of the oxygen storage and transfilling				practice.			
	room by Room 204	•						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/21/2024			
		155681	B. WI	NG		03/21/	2024		
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 2911 GREEN VALLEY RD NEW ALBANY, IN 47150					
				ID	T		(V5)		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
IAU	Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the corridor entry door to the oxygen storage and transfilling room at the end of the hall by Room 204 was not equipped with a lock or other means to secure against unauthorized entry. The room contained six liquid oxygen containers and eleven 'E' type cylinders. Based on interview at the time of the observations, the DPO agreed the corridor entry door to the oxygen storage and transfilling room was not equipped with a lock or other means to secure against unauthorized entry. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference.			CROSS-REFERENCED TO THE APPRO		door ed c for ek for 8	DATE		

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