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	08/22/2023

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: 08/22/23 Facility Number: 000248 Provider Number: 155357 AIM Number: 100291470 At this Emergency Preparedness survey, Rawlins House Health and Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 110 and had a census of 104 at the time of this survey. Quality Review completed on 08/29/23	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.	
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: 08/22/2023 Facility Number: 000248 Provider Number: 155357 AIM Number: 100291470 At this Life Safety Code survey, Rawlins House Health and Living Community was found not in	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 this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Covey	HFA	09/01/2023

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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	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 V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detection in the resident sleeping rooms. The facility has a capacity of 110 and had a census of 104 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/29/23		Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 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 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 10 residents. Findings include:	K 0211	**K 211** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	09/05/2023

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	Based on observation during a tour of the facility with the Maintenance Supervisor (MS) 08/22/23 at 01:00 p.m., in the exit entrance by the South Hall exit, there was a wheelchair parked in front the exit door in the South Hall. Based on an interview at the time of observations, the MS agreed the wheelchair was obstructing the South Hall exit. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		Observation – Wheelchair obstructing the exit door. **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.** The Maintenance Director corrected the deficient practice by having wheelchair removed. Staff in-service on not placing items in front of exit doors. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director audits hallways weekly to ensure they are clear and exits are free of obstructions. See attached Weekly TELS task to audit the hallways. **V. Plan of Correction completion date.**	

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			Plan of Completion date is September 5, 2023.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in 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)			

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	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 10 rooms which is a hazardous area containing a fuel-fired heater was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 10 residents in the corridor by the Memory Care entrance area. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor (MS) on 08/22/23 at 02:30 p.m., the fuel-fired heater room by the Memory Care entrance, a hazardous area, was equipped with a self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the MS agreed that when tested, the fuel-fired heater room, which is a hazardous area, with a self-closing device on the door, did not latch into the frame. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Door with self-closing device did not latch into frame. **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.** Maintenance Director corrected the deficient practice by adjusting self-closure. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee audits self-closing doors monthly.	09/05/2023

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			See attached Monthly TELS Task showing the inspection of fire, smoke, and resident doors. **V. Plan of Correction completion date.** Plan of Completion date is September 5th, 2023.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood suppression system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been**	09/05/2023

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	shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation with the Maintenance Supervisor (MS) on 08/22/23 at 01:35 p.m., the kitchen contained a UL 300 hood suppression system and a K-class fire extinguisher without posted instructions. Based on interview with the MS, when asked where the instructions were posted for manually operating the fire extinguishing system, he stated that the instructions were not posted. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		**affected by the deficient practice.** Observation – Instructions for operating the hood fire extinguishing system not posted conspicuously in the kitchen. **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.** Permanent sign added by fire extinguishing system. Picture attached. **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. **V. Plan of Correction completion date.**	

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			Plan of Completion date is September 5, 2023.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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, 7.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Spare sprinkler heads stored in box without available slots. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	09/05/2023

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	no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Maintenance Supervisor on 08/22/23 at 01:10 p.m., the spare sprinkler cabinet in the riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in the riser room was opened, the cabinet contained 12 sprinkler heads in protected slots and 4 sprinkler heads positioned on the shelf , not in protected slots, inside the cabinet. Based on interview at the time of the observations, the Maintenance Director agreed the cabinet was not large enough to contain all spare sprinkler heads. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		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.** The Maintenance Director corrected the deficient practice by adding an additional sprinkler head storage box. Pictures attached. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent repair so no additional follow up is needed. **V. Plan of Correction completion date.** Plan of Completion date is September 5, 2023.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility	K 0355		09/05/2023

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	failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff in the kitchen. Findings include: Based on observation with the Maintenance Supervisor (MS) during a tour of the facility at 01:35 p.m. on 08/22/23, a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the MS acknowledged a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		**K 355** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – K-class fire extinguisher missing posted instructions for use. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** 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.** Permanent sign added by K-class extinguisher. Picture attached. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix so no	

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			follow up is needed at this time. **V. Plan of Correction completion date.** Plan of Completion date is September 5, 2023.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of 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 patient care areas 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 room, where the sign includes the wording as			

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	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 threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. 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 and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Supervisor (MS) on 08/22/23 at 02:15 p.m. in the oxygen storage room there was no means to separate full cylinders from empty cylinders. Based on interview at the time of observation, the MS stated that he was not aware that they needed to identify empty cylinders. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0923	**K 923** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Full and empty oxygen cylinders were not segregated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Up to 15 Residents and staff in smoke compartment could be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	09/05/2023

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			Signage is added to the oxygen room to segregate full and empty oxygen cylinders. **IV The facility will monitor the corrective action by implementing the following measures.** Staff to be educated on new signage and the use of the oxygen room. **V. Plan of Correction completion date.** Plan of Completion date is September 5, 2023.	