STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING -- B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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: 04/08/25 Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930 At this Emergency Preparedness survey, Autumn Woods Health Campus 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 91 certified beds and had a census of 79 at the time of this visit. Quality Review completed on 04/10/25	E 0000	The submission of this plan of correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided and the living environment provided to the residents of Autumn Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is 04/24/2025 If there are any questions, please contact me at (812) 941-9893. Sincerely, Brandy D'Angelo, HFA, BSW Autumn Woods Health Campus Executive Director Brandy.Dangelo@autumnwoodshc.com	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandy D'Angelo		04/24/2025

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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	155681	A. BUILDING 01 B. WING	04/08/2025

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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 Dates: 04/08/25 Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930 At this Life Safety Code survey, Autumn Woods Health Campus 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 91 and had a census of 79 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/10/25	K 0000	The submission of this plan of correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided and the living environment provided to the residents of Autumn Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is 04/24/2025 If there are any questions, please contact me at (812) 941-9893. Sincerely, Brandy D'Angelo, HFA, BSW Autumn Woods Health Campus Executive Director Brandy.Dangelo@autumnwoodshc.com	

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K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Based on observation and interview, the facility failed to ensure 1 of 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations (DOPO) on 04/08/25 at 2:50 p.m. the 1 ½ hour rated fire door set near resident room # 400 was used as a horizontal exit and as a smoke barrier. When tested the doors failed to latch, and remain positively latched into the frame due to the door header not being secure. Based on interview at the time of observation, the DOPO stated the fire door set was not latching into the frame because the door header was not attached securely and was pushing up when the door was pushed upon. This finding was acknowledged by the DOPO at the time of discovery and again at the exit conference with the DOPO and Executive Director present. 3.1-19(b)	K 0226	1. Director of Plant Operations repaired the door header of the 1 1/2 hour rated fire door set near resident room # 400 to ensure the door set was latching properly and secure. 2. The deficient practice had potential to affect 15 residents. 3. The Director of Plant Operations is now knowledgeable of ensuring that all self-closing doors shall swing easily and freely and are now equipped with a closing device to cause the door to close and latch each time it is opened. 4. As a quality measure, the Director of Plant Operations / designee will ensure that all fire doors have properly working self-closing devices on rounding weekly X 4 weeks, then every other week X 8 week, then monthly on latch and gap inspection. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	04/24/2025

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 staff in the kitchen area. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations (DOPO) on 04/08/25 at 2:10 p.m. the kitchen Storage room, more than 50 square feet contained a number of combustible items, such as, paper, plastic, and 16 cardboard boxes. The 2 corridor doors to this storage room did not self-close and latch into the door frame. This finding was acknowledged by the DOPO at the time of discovery and again at the exit conference with the DOPO and Executive Director present. 3.1-19(b)	K 0321	1. Director of Plant Operations added properly working self-closing devices to the kitchen storage room doors. 2. This deficient practice had the potential to affect more than 5 staff in the kitchen area. 3. The Director of Plant Operations is now knowledgeable to ensure that all hazardous area enclosures have properly working self-closing devices. All hazardous area doors provided with self-closing devices on doors. 4. As a quality measure, the Director of Plant Operations /designee will ensure that all hazardous area enclosures have properly working self-closing devices on rounding weekly X 4 weeks, then every other week X 8 week, then monthly on latch and gap inspection. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	04/24/2025
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	K 0324	1. The Director of Plant Operation will provide an approved method to ensure that the appliances (residential cooking equipment) are returned to an approved design location under kitchen hood	04/24/2025

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	Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 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. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations (DOPO) on 04/08/25 at 2:40 p.m. the (4) burner gas range and flat grill and griddle, all with wheels which were located on the cooking line under the hood in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the DOPO, at 2:45 p.m., 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.		extinguishing/ventilation equipment. 2. This deficient practice had the potential to affect 5 staff in the kitchen area. 3. The Director of Plant Operations, Director of Food Services, and Assistant Director of Food Services are now knowledgeable that an approved method to ensure that the appliances are returned to under kitchen hood extinguishing/ ventilation equipment after being moved for maintenance and cleaning as required by the NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. 4. As a quality measure, the Director of Plant Operations will ensure that all appliances (residential cooking equipment) are returned to their approved location under the kitchen hood extinguishing/ ventilation equipment after being moved for maintenance and cleaning on rounding weekly X 4 weeks, then every other week X 8 week, then monthly during hood inspection. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	

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	This finding was acknowledged by the DOPO at the time of discovery and again at the exit conference with the DOPO and Executive Director present. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations (DOPO) on 04/08/25 at 1:07 p.m. a power strip was in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on interview at the time of observation, the DOPO agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1. This finding was acknowledged by the DOPO at the time of discovery and again at the exit conference with the DOPO and Executive Director present. 3.1-19(b)	K 0920	1. The Director of Plant Operations removed 1 of 1 flexible cord power strip that did not meet the required UL rating of 1363A or 60601-1. 2. This deficient practice had the potential to affect 5 residents in the therapy gym. 3. The Director of Plant Operations is now knowledgeable of ensuring that all flexible cord power strips in patient care vicinity meet 1363A or 60601-1. House wide audit completed to ensure that all flexible cord power strips meet the required UL rating of 1363A or 60601-1. Flexible cord power strip in therapy gym replaced. 4. As a quality measure, the Director of Plant Operations /designee will ensure that all flexible cord power strips in resident care areas meet UL rating 1363A or 60601-1 on rounding weekly X 4 weeks, then every other week X 8 week, then monthly X12 weeks. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	04/24/2025

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K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and tour with the Director of Plant Operations (DOPO) on 04/08/25 at 11:40 a.m. and facility tour throughout	K 0921	1. The Director of Plant Operations has conducted and documented PCREE testing on all required equipment on 04/18/2025. 2. The deficient practice had the potential to affect all occupants. 3. The Director of Plant Operations is now knowledgeable of ensuring that all PCREE have documentation of the required testing. All PCREE tested to ensure compliance is met with NFPA99 as complete system. Education completed with DPO regarding ensuring that all PCREE is tested before any PCREE is put into service and after any repair or modification as well as record maintenance of all PCREE testing repairs and modifications to ensure compliance. 4. As a quality measure, the Director of Plant Operations/designee will round weekly X 4 weeks, then every other week X 8 week, then monthly X12 weeks. To ensure all new PCREE and PCREE that have undergone maintenance have been tested.	04/18/2025

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	the afternoon, no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour throughout the afternoon revealed that the facility provided electric beds for all residents. The DOPO stated that PCREE such as nebulizers, oxygen concentrators, and other electrical medical equipment was present and in use at the facility and that they had recently became aware of the requirement and were purchasing equipment to conduct the required testing. This finding was acknowledged by the DOPO at the time of discovery and again at the exit conference with the DOPO and Executive Director present. 3.1-19(b)			