

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br><b>155526</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                 | (X3) DATE SURVEY<br>COMPLETED<br><b>01/16/2025</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><b>PERSIMMON RIDGE REHABILITATION CENTRE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP COD<br><b>200 N PARK ST<br/>PORTLAND, IN 47371</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIE<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE                         |
| K 0000<br><br>Bldg. 01                                                       | <p>An investigation of Complaint Number IN00450977 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Complaint Number IN00450977 - No deficiencies related to the allegation are cited.</p> <p>Unrelated Deficiency Cited</p> <p>Survey Date: 01/14/25</p> <p>Facility Number: 000148<br/>Provider Number: 155526<br/>AIM Number: 100275500</p> <p>At this Complaint survey, Persimmon Ridge 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.</p> <p>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 112 and had a census of 90 at the time of this visit.</p> <p>Quality Review completed on 01/16/25</p> | K 0000                                                                              | <p>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.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p> |                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Melinda Hodgson

Administrator

01/27/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br><b>155526</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____                | (X3) DATE SURVEY<br>COMPLETED<br><b>01/16/2025</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |
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| K 0354<br>SS=F<br>Bldg. 01                                                   | <p><b>NFPA 101</b><br/>Sprinkler System - Out of Service</p> <p>Based on record review and interview, the facility failed to follow 1 of 1 written policy in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on records review and interview with the Administrator, Maintenance Director and Cooperate Maintenance Support on 01/14/25 between 10:30 a.m. and 12:45: p.m., it was discovered that the facility is under a Firewatch. The Firewatch was initiated on 12/10/24 following notification from the sprinkler vendor that a sprinkler system flush revealed solid debris stating that "in the event of fire, I don't think this system would work." During the current Firewatch, beginning on 12/10/24 and still underway, the facility failed to notify (1) the State</p> |                                                                       | K 0354                                                                              | <p>1&amp;2. No residents were affected but all residents had the potential to be affected. Sprinkler System repairs being completed by Gardner Fire Protection due to debris in system. IDOH reportable completed regarding sprinkler system repairs, Fire Dept Fire Chief notified of Fire Watch, Staff Trained on Fire watch, Dedicated Staff designed to Fire Watch rounds until sprinkler repairs completed.</p> <p>3. The maintenance director, Administrator and Corporate Maintenance was re-educated on Fire Watch Requirements. A new Fire Watch Tracking Form has been initiated to ensure all entities are notified when facility is required to initiate fire watch.</p> <p>4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete new fire watch tracking form. Any negative findings will be corrected immediately and reported to the administrator, any fire watch initiation will be documented on tracking form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted Monthly. Results of the</p> | 01/27/2025                 |

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|                                                                           | <p>of Indiana Department of Health and (2) the local fire department, of the Firewatch. The Firewatch plan provided included language stating that at the initiation and conclusion of a Firewatch the (3) Owner, (4) Insurance provider and the aforementioned entities (1 &amp; 2) would be notified. However, the policy was not followed as entities (1) &amp; (2) were not notified when the Firewatch began.</p> <p>This finding was acknowledged by the Administrator, Maintenance Director and Cooperate Maintenance Support at the time of records review and again at the exit conference.</p> <p>3.1-19(b)</p> |                                                                   |                                                                                 | findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing.    |