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	11/14/2023

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: 11/14/23 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 a capacity of 112 and had a census of 58 at the time of this survey. Quality Review completed on 11/16/23	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: 11/14/2023 Facility Number: 000148 Provider Number: 155526 AIM Number: 100275500 At this Life Safety Code survey, Persimmon Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in	K 0000	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. The Plan of Correction is prepared and submitted because of requirements under state and federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Hodgson	Administrator	11/29/2023

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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	155526	A. BUILDING 01 B. WING	11/14/2023

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	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 VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 112 and had a census of 58 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 11/16/23			
K 0211 SS=D 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 4 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60	K 0211	1 No Residents were affected but 3 Residents had the potential to be affected. The PPE cart without wheels was immediately removed and the PPE cart was replaced with wheels. 2 In an effort to identify additional PPE carts without wheels, the Administrator	11/29/2023

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	in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 3 residents on 200 Hall. Findings include: Based on an observation during a tour of the facility with the Administrator and Maintenance Director on 11/14/23 at 01:05 p.m., on 200 hall a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to be moved out of the hall during an emergency. The PPE cart was located in the corridor by room 212. Based on an interview at the time of observation, the Administrator agreed the PPE cart was not equipped with wheels and would need to be replaced by one with wheels. The PPE cart was replaced at the time of discovery. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		completed a walkthrough of the entire building, and no additional findings were noted. 3 In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety code means of egress. A visual inspection form has been initiated for the Maintenance Director to complete. 4 As a means of quality assurance the Maintenance Director will do a walkthrough of the building 5x weekly for 1 month, 2x weekly for 1 month, then weekly thereafter to ensure PPE carts without wheels are not in use as part as the preventative maintenance program. Findings will be documented on the facility's preventative maintenance form. Any negative findings will be corrected immediately and reported to the Administrator. Results of the findings will be reviewed quarterly in the QA meeting for continued compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the			

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	egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire			

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	detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 10 residents. Findings include: Based on observation with the Administrator and Maintenance Director on 11/14/23 at 1:30 p.m., the exit door at the Main Entrance was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad. The code was posted at the	K 0222	1 No Residents were affected but all Residents had the potential to be affected. The code at the Main entrance was changed and the code is posted at the front entrance. 2 The code at the Main entrance has been changed and the code is posted at the front entrance. 3 In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety code egress doors. A visual inspection form has been initiated for the Maintenance Director to complete monthly when the code is changed. 4 As a means of quality assurance, the Maintenance	11/29/2023

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	exit on top of the access control pad. The instructions stated; To leave facility Push * + our street address, Example *###. It was unclear if a visitor would be able to exit with the provided instructions. Based on interview at the time of observation, the Maintenance Director stated the code to open the exit door at the Main Entrance was posted on the top of the access control pad. This requires special knowledge to open the exit door. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Director will monitor the changing of the code 1x monthly for 6 months. The Maintenance Director will review any findings and subsequent corrective actions taken reporting to the facility's QA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 16 of 16 battery backup emergency light were tested monthly for 30 seconds and annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 40 residents in the facility.	K 0291	1 No Residents were affected but all Residents had the potential to be affected. The 90 minute emergency light testing has been completed by the Maintenance Director. 2 The Maintenance Director completed the 90 minute emergency light testing. The 90 minute emergency light testing is scheduled annually every November hereafter, 3 In an effort to ensure ongoing compliance the Maintenance director and Administrator will ensure the 90	11/29/2023

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	Findings include: Based on records review with the Administrator and Maintenance Director (MD) on 11/14/23 at 11:30 a.m., annual testing for the battery backup emergency lights for 2023 was unavailable. The Battery Operated Emergency Light Test Log indicated the annual 90 minute testing for the 16 battery backup emergency lights was to be conducted in December 2023 but there was no documentation of the annual test being completed within the last year. Based on an interview at the time of records review, the Maintenance Director stated the annual 90 minute testing for the 16 battery backup emergency lights was probably conducted in the past year but there is no documentation available. The finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		minute emergency light testing is completed annually and documented. The Maintenance Director was re-educated on the Life Safety code emergency lighting. 4 As a means of quality assurance, the Maintenance Director will monitor the emergency light testing annually, scheduled every November hereafter. The Maintenance Director will review any findings and subsequent corrective actions taken reporting to the facility's QA committee on annual basis and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	
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.			

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	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)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director (MD) on 11/14/23 at 01:10 p.m., room 217 contained over 50 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the MD agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room did not self-close and latch when	K 0321	1 No Residents were affected but 10 Residents had the potential to be affected. The storage room corridor door self close latch was fixed to latch appropriately. 2 The Maintenance Director fixed the storage room corridor door self close latch to latch appropriately. 3 In an effort to ensure ongoing compliance the Maintenance director was re-educated on the Life Safety code hazardous area- enclosure. A visual inspection form has been initiated for the Maintenance Director to complete weekly x6 months. 4 As a means of quality assurance, the Maintenance Director will monitor the corridor doors self-close latch to latch	11/29/2023

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	tested. The finding was reviewed with the Administrator and the MD during the exit conference. 3.1-19(b)		appropriately 1x weekly for 6 months. The Maintenance Director will review any findings and subsequent corrective actions taken reporting to the facility's QA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door			

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	frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 504. Findings include: Based on observation with the Maintenance Director (MD) on 11/14/23 at 01:20 p.m., the corridor door to resident sleeping room 504 would not close and latch into the frame when tested. There was a Hospice bed located in the room by the corridor door that obstructed the opening and would not allow the door to close. Based on interview at the time of observation, the MD agreed the corridor door to room 504 would not close and latch into the door frame. The bed was moved at the time of observation which allowed the door to close and latch. The finding was reviewed with the Administrator and MD during the exit conference.	K 0363	1 No Residents were affected but 2 Residents had the potential to be affected. Room 504 bed was re-arranged so the door could close properly. 2 In an effort to identify additional corridor doors with no impediment to closing room doors, the Maintenance Director completed a walkthrough of the entire building, and no additional findings were noted. 3 In an effort to ensure ongoing compliance, the maintenance director was re-educated on the Life Safety code corridor doors. A visual inspection form has been initiated for the Maintenance Director to complete 1x weekly for 6 months. 4 As a means of quality assurance, the Maintenance Director will monitor the corridor doors to ensure no impediments to closing room doors 1x weekly for 6 months. The Maintenance	11/29/2023

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	3.1-19(b)		Director will review any findings and subsequent corrective actions taken reporting to the facility's QA committee on a monthly basis for a minimum of 6 months and the frequency of the monitoring will be increased or decreased if indicated to maintain compliance.	