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	02/14/2023

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: 02/14/23 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 77 at the time of this visit. Quality Review completed on 02/20/23	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 Dates: 02/14/23 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurence Reed	Executive Director	03/02/2023

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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	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 (000) 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 all resident sleeping rooms. The facility has a capacity of 91 and had a census of 77 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 02/20/23			
K 0211 SS=B 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 6 exit means of egress corridors were continuously maintained free of obstructions. This deficient practice could affect 10 or more residents, as well as staff and visitors. Findings include:	K 0211	K211 : Means of egress: 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit 3 halls 5 days per week	03/08/2023

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	Based on observations on 02/14/23 at 1:35 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support person, there was a wheeled chair scale stored in the corridor outside resident room 406. The chair scale was not in use at the time of observation. The chair scale was located in the same place at 2:15 p.m. and still not being used when returning to the area during the tour of the facility. Based on interview at the time of observations, the Director of Plant Operations acknowledged the wheeled chair scale being stored in the corridor and not in use at the times of observations. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b)		x1 month, every other week x2 months, then monthly x3 months to ensure halls are clear. 4.As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months, if warranted, until 100% compliance is met.	
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 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			

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	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 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			

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	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 1 lock courtyard exit gate was readily accessible for residents, staff, and visitors. This deficient practice could at least 5 residents, as well as staff and visitors. Findings include: Based on observations on 02/14/23 between 12:15 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support person, the main courtyard exit gate was magnetically locked and could only be opened by entering a code on a keypad located adjacent to the exit gate. The code to open the gate was not posted anywhere near the keypad. Based on interview at the time of observation, the Director of Plant Operations confirmed the code was not posted anywhere near the keypad and said he was not aware it needed to be posted for a courtyard gate. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0222	K222 Egress Doors 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit exits 5 days per week x1 month, every other week x2 months, then monthly x3 months to ensure codes are visible. 4.As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months if warranted until 100% compliance is met.	03/08/2023
K 0293 SS=E	NFPA 101 Exit Signage			

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Bldg. 01	Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of over 20 exit signs were continuously illuminated. This deficient practice could affect at least 5 residents, as well as staff and visitors. Findings include: Based on observations on 02/14/23 between 12:15 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support person, the exit sign at the main courtyard gate was not illuminated. Based on interview at the time of observation, the Director of Plant Operations said he was not aware that the exit sign was not illuminated but would fix it as soon as possible. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1.19(b)	K 0293	K293 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit exit lights 5 days per week x1 month, every other week x2 months, then monthly x3 months to ensure lights are working. 4.As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months if warranted until 100% compliance is met.	03/08/2023
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			

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	(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)			
	1. Based on observation and interview, the facility failed to properly store containers of combustible fuel in 1 of 4 smoke compartments. This deficient practice could affect at least 50 residents, staff and visitors while in the Private Dining room/Conference room or adjacent main Dining room. Findings include:	K 0321	K321 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit for proper storage of flammable materials and heating elements used in protected areas,	03/08/2023

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	Based on observation during record review on 02/14/23 at 10:30 a.m. with the Director of Plant Operations and the Facilities Management Support person present, there were two, six packs of Chafer Fuel containers being stored on a table in the Private Dining room. When asked about the containers of Chafer Fuel, the Director of Plant Operations said the containers were brought in for a taco bar today, and further said the containers of Chafer Fuel should have been stored in the facility's fire proof cabinet until in use. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Legacy Lane dining room. This deficient practice could affect at least 28 residents, staff and visitors while in the Legacy Lane dining room. Findings include: Based on observations on 02/14/23 between 12:15 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and the Facilities Management Support person, the Legacy Lane dining room had a hot oil popcorn popper plugged into the wall receptacle. Based on interview at the time of observation, when asked where the popcorn popper was used, the Director of Plant Operations said he has never seen it being used, but didn't know why it was plugged into the wall receptacle. The Legacy Lane dining room was not protected as a hazardous area.		5 days per week x1 month, every other week x2 months, then monthly x3 months to ensure materials are properly stored and heating elements are properly utilized in safe areas. 4.As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months if warranted until 100% compliance is met.	

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	This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b)			
K 0363 SS=B 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 frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is			

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	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 of over 100 corridor doors would resist the passage of smoke. This deficient practice could affect up to 28 residents, as well as staff and visitors in the Legacy Lane unit. Findings include: Based on observations on 02/14/23 between 12:15 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support person, the corridor door to the Legacy Lane unit kitchenette had a one and a half inch by one inch hole through the door at the bottom of the keypad/door handle. Based on interview at the time of observation the Director of Plant Operations agreed the door was not smoke resistant and the hole needs to be repaired. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b)	K 0363	K363 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit doors to verify doors resist the passage of smoke 5 days per week x1 month, every other week x2 months, then monthly x3 months to ensure doors resist the passage of smoke. 4.As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months if warranted until 100% compliance is met.	03/08/2023
K 0920 SS=D	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip in 1 of 66 resident rooms met UL rating of 1363A or 60601-1. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident and staff. Findings include:	K 0920	K920 1.All Residents were affected. 2.All residents have the potential to be affected. 3.As a measure of ongoing compliance, the DPO or designee will audit for power strip utilization. 5 days per week x1 month, every other week x2 months, then monthly x3 months to ensure power strips are being used properly. 4.As a quality measure, the	03/08/2023

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	Based on observations on 02/14/23 between 12:15 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Facilities Management Support person, room 201 had a lamp, cell phone, and small oxygen concentrator plugged into the same power strip. Based on interview at the time of observation, the Director of Plant Operations said he was not aware that these items were plugged into the same power strip, but would correct the situation immediately. This finding was reviewed with the Executive Director, Administrator-in-Training, Facilities Management Support, and Director of Plant Operations during the exit conference. 3.1-19(b)		DPO or designee will review any findings and corrective action at least quarterly and ongoing until the campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue for 6 months if warranted until 100% compliance is met.	