

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155319	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/05/2013
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NAME OF PROVIDER OR SUPPLIER  CLINTON GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/05/13</p> <p>Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040</p> <p>Surveyors: Bridget Brown, Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Clinton Gardens was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The was 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 detection in the corridors and spaces open to the</p>	K010000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 100 and had a census of 93 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 6 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 30 or more residents in the center compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 12:00 p.m., the double door set providing access to the director of admissions office had one door equipped with a manual flush bolt latch which would not allow the door to be latched automatically into the door frame. The maintenance director acknowledged at the time of observation,</p>	K010018	An automatic latching device has been installed on door. The automatic latch will be inspected for proper operation daily X 30 days then weekly X 4 weeks then quarterly there after.	06/27/2013			

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	each door could not latch independently into the door frame.  3.1-19(b)				

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure a hazardous area door in 1 of 6 smoke compartments, was held open only by a device which would allow the door to close automatically or upon activation of the fire alarm system. This deficient practice affects 10 or more visitors, staff and residents accessing facility service and the exit in the service corridor</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 11:55 a.m., the corridor door to the housekeeping storage room which was larger than 50 square feet stood wide open. The maintenance director said at the time of observation, the self closing</p>	K010021	The automatic closure mechenism has been replaced with new closure that does not allow door to be held open. Door operation will be inspected daily X 30 Days the weekly X 4 weeks then quarterly there after.	06/27/2013			

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	<p>device was equipped with a feature which allowed the door to stand open when pushed past a certain point. The maintenance director acknowledged at the time of observation, the door could not close automatically then.</p> <p>3.1-19</p>			

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K010022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 2 doors likely to be mistaken for a way of exit from the activity room was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO EXIT. This deficient practice could affect visitors, staff and any residents in the activity room with a capacity for 10 or more.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 12:30 p.m., a glass panel door provided access to the outside from the activity room. The maintenance director said at the time of observation, the door was not an emergency exit but it could be mistaken for a means of exit. The facility evacuation diagram observed at the time confirmed the doorway was not meant to be an exit. The door was not posted with a sign indicating it was "No Exit". The maintenance supervisor agreed at the time of observation, the door could be</p>	K010022	The door has been labeled with vinal lettering as "No Exit." The door will be inspected to ensure labeling remains in place daily for 30 days then weekly for 4 weeks then quarterly thereafter.	06/27/2013			

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	mistaken for a means of exit.  3.1-19(b)			

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 7 smoke compartments were free of foreign materials, such as grime and drywall mud. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 40 or more residents in the A and C wing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 between 11:00 a.m. and 2:30 p.m., a sprinkler head located in the A wing corridor near the smoke barrier had a white foreign material on the bracket and deflector. The maintenance director identified the material at the time of observation as "drywall mud." A sprinkler head in the room 7 bathroom, two heads in room 29, two heads in the C wing corridor outside rooms 25 and 26 and one in the activity room each had the white material or a gray fuzzy film on them. The maintenance director agreed at</p>	K010062	All sprinkler heads sighted were thoroughly cleaned of all debris. Sprinkler heads will be inspected weekly X 4 weeks then monthly X 3 months then quarterly thereafter	06/27/2013			

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	<p>the time of observations, the sprinkler heads were not clean. 3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a supply of at least two spare sprinkler heads was kept on the premises in a cabinet for each type of sprinkler installed. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect any staff or visitor in the laundry with 4 occupants at the time of observation.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 12:35 p.m., an intermediate rated (green bulb) sprinkler head was installed in the area behind the commercial dryers in the laundry. The spare heads were observed with the maintenance director on 06/05/13 at 12:50 p.m.. No intermediate rated sprinkler heads were found. The maintenance director said at the time of</p>						

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	discovery, he was unaware there was an intermediate rated sprinkler head in the building.  3.1-19(b)				

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K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the location of 1 of 2 liquefied petroleum gas (LPG) containers was at least 10 feet away from a designated smoking area. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) requires the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates the minimum distance between a LPG container with a water capacity of 125-250 gallons and an exterior ignition source is 10 feet. This deficient practice could affect any resident, staff or visitors using the smoking area located at the north end of the facility near the north	K010130	The LPG tank was moved to be at least 10 feet away from the smoking area. Distance will be checked weekly for 4 weeks to ensure locations remain within compliance.	06/27/2013	

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	<p>generator.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 12:05 p.m., the LPG container with a capacity of two hundred and fifty gallons was measured to be nine feet from the designated smoking area. The maintenance director acknowledged at the time of observation, the smoking area was located less than the minimum ten foot distance allowed from the LPG container.</p> <p>3.1-19(b)</p>				

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K010144 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 generators serving as the alternate source of power was maintained and capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.2.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load after a short delay. NFPA 99, 3-4.1.1.8 requires the the generator to start and be on line within 10 seconds. This deficient practice affects visitors, staff and 48 or more residents in the original building.</p> <p>Findings include:</p> <p>Based on observation on 06/05/13 at 11:40 a.m., the maintenance director attempted to demonstrate the operation of the north generator providing emergency</p>	K010144	Generator has been serviced and is now fully operational. Generator will be inspected daily X 30 days then weekly as part of the facilities preventative maintenance program.	06/27/2013			

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	<p>power to the original building. The generator initially failed to start and then started and died. The maintenance director said at the time of observation the generator was "flooded" and the odor of fuel was evident. The maintenance director was given another opportunity to demonstrate the operation of the generator using the transfer switch and a manual start on 06/05/13 at 1:00 p.m. and the generator failed to start each time.</p> <p>3.1-19(b)</p>				

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K020000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/05/13</p> <p>Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040</p> <p>Surveyors: Bridget Brown, Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Clinton Gardens was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 2005 addition of 14 rooms on E wing was surveyed with Chapter 18, New Health Care Facilities.</p> <p>The 2005 addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K020000					

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	<p>corridors and spaces open to the corridors. The facility has the capacity for 100 and had a census of 93 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage which was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 1 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 25 or more residents in the E hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 1:05 p.m., the north door providing access to the physical therapy room door was equipped with a deadbolt latch to secure the door into the door frame. There was no means by which the door could latch automatically into the door frame. The maintenance director acknowledged at the time of observation, the door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors</p>	K020018	An automatic latching device has been installed on door. The automatic latch will be inspected for proper operation daily X 30 days then weekly X 4 weeks then quarterly there after.	06/27/2013			

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	<p>protecting corridor openings in 1 of 1 smoke compartments had no impediment to closing. This deficient practice affects staff, visitors and 25 or more residents in the E hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 1:15 p.m., the door to room 107 on E wing was prevented from closing by the privacy curtain which had been wedged behind a night stand and protruded into the path of the door when closing. The curtain was arranged in such a way the door gapped four inches when it hit the impediment.</p> <p>3.1-19(b)</p>				

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K020044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff and 25 or more residents on E hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 1:40 p.m., the fire door set near the west nurses station was tested three times manually with the maintenance director. One door in the fire door set failed to latch two of three times the doors were released to close. The door failed to latch again at 1:45 p.m. when the fire alarm was activated. The maintenance director agreed at the times of observation, there was a problem with the door latching consistently every time.</p>	K020044	An automatic closure has been installed on the door. The door latching mechanism will be inspected for proper operation daily X 30 days then weekly X 4 weeks then quarterly thereafter.	06/27/2013			

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K020046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exterior exit discharge emergency light fixtures for south E wing exit would operate automatically. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. LSC 7.9.2.2(3) requires the emergency lighting system shall be arranged to provide the required illumination automatically in the event of the interruption of normal lighting such as failure of a public utility. LSC 7.9.2.5 requires emergency lighting systems shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect visitors staff and 25 residents on E wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 at 11:15 a.m., the maintenance director identified five exterior light fixtures which could illuminate the south exit discharge from E wing. He said at the time of observation, the emergency light fixture mounted on the south side of the building midway along the path of egress</p>	K020046	The lighting fixture sighted has now been wired into our emergency lighting. This light will be inspected for proper operation weekly X 4 weeks then monthly as part of the facilities preventative maintenance program.	06/27/2013			

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	<p>was connected to the emergency generator and operated by a manual switch. It would not activate automatically.</p> <p>3.1-19(b)</p>			

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K020062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 1 smoke compartments were free of foreign materials such as grime and drywall mud. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 25 or more residents in the E wing smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/13 between 11:00 a.m. and 2:30 p.m., two sprinkler heads in the physical therapy room and a sprinkler head in the E wing dining room had a white foreign material on the bracket and deflectors. The maintenance director identified the material at the time of observation as "drywall mud." The maintenance director agreed at the time of observations, the sprinkler heads were not clean.</p> <p>3.1-19(b)</p>	K020062	All sprinkler heads sighted were thoroughly cleaned of all debris. Sprinkler heads will be inspected weekly X 4 weeks then monthly X 3 months then quarterly thereafter	06/27/2013			

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