

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/09/2014
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NAME OF PROVIDER OR SUPPLIER  CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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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: 12/09/14</p> <p>Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Caroleton Manor 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), 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 battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>Preparation and submission of this plan of correction by, <b>Caroleton Manor</b>, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p>-</p>	

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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K010025 SS=E	<p>has a capacity of 50 and had a census of 49 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the laundry building, the Administration annex building, the twenty four foot by twenty foot garage, and the two twelve foot by six foot storage sheds.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/15/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure 1 of 3 attic smoke</p>	K010025	K-025 1. The Maintenance Director repaired the 5 one inch to four inch gaps around the	12/23/2014

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	<p>barrier walls was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 21 residents who reside on the North Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/09/14 at 1:45 p.m., the North Hall attic smoke barrier wall had five, one inch to four inch gaps around electrical conduit and water pipe penetrations not fire stopped. This was verified by the maintenance supervisor at the time of observation and acknowledged by the maintenance supervisor at the exit conference on 12/09/14 at 2:45 p.m.</p> <p>3.1-19(b)</p>		<p>electrical conduit and water penetrations on the North Hall attic smoke barrier wall on 12-10-14. 2. The Maintenance Director checked the attic smoke barrier walls on 12-10-14 to ensure there are no gaps around electrical conduits and water pipe penetrations. 3. The Administrator will re educate the Maintenance Director by 12-22-14 related to the requirements of ensuring attic smoke barrier walls have no gaps around electrical conduits and water pipe penetrations. 4. The Maintenance Director and Administrator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure attic smoke barrier walls continue to have no gaps around electrical conduits and water pipe penetrations as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up. Date of compliance: 12-23-14</p>	