STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155486	A. BUILDING -- B. WING	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 11/06/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/22/23 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this PSR Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 45 certified beds. At the time of the survey, the census was 12. Quality Review completed on 01/02/24	E 0000	K 000 This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and Licensure Survey conducted on 11/6/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/22/23 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600	K 0000	K 000 This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerrod Moore	Administrator	01/12/2024

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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	At this PSR Life Safety Code survey, Middletown Nursing and Rehabilitation Center 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. This facility consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one-story wing determined to be Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing (Old Hall), and hard-wired smoke detectors in the fifteen resident rooms on the South Wing (New Hall) which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 12 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 01/02/24		plan of correction is prepared and/or executed solely because it is required by state and federal law.	
K 0363 SS=E Bldg. 02	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			

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	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 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 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 12 residents.	K 0363	**Tag K 363** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/28/2023

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	Findings include: Based on observations and interview during a tour of the facility with the Environmental Services Director on 12/22/23 at 11:35 a.m., the Double door set near the Nurses station, failed to self-close and latch into the door frame. The Environmental Services Director stated that he had fixed this door recently but agreed that following more than 3 attempts the hardware in the door still was not allowing the doors to latch as designed. This finding was acknowledged at the time of discovery by the Environmental Services Director and again at the exit conference with the Environmental Services Director present. This deficiency was cited on 11/06/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**practice:** If a resident's door or fire door does not latch properly that could potentially allow smoke to enter in the event of fire and affect residents presiding both in that particular room or corridor. The latch for the fire door has been fixed by Security Door Services December 28, 2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** In the event that there is smoke in the building all doors must be properly sealed and close to prevent smoke inhalation. The latch on the fire has been fixed professionally. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be permitted to notify the Environmental Specialist in the event they notice a door not working properly. These are all doors and rooms that nursing, housekeeping and dietary staff may enter and notice an issue. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** During quarterly QA	

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			meetings if the staff notices any new issues, it will immediately be brought to the Environmental Specialist's attention if it has not already been done. **By what date the systemic changes for each deficiency will be completed:** The fire door latch was repaired by Security Door Service on December 28, 2023. Please see the attached invoice.	