

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155387	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2015
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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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K 0000 Bldg. 01	<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: 12/08/15</p> <p>Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550</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 has a capacity of 50 and had a census of 48 at the time of this visit.</p>	K 0000	Preparation and submission of this plan of correction by, Caroleton Manor , 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.	

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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K 0025 SS=E Bldg. 01	<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>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 observation and interview, the facility failed to ensure 1 of 3 attic smoke barriers was maintained to provide a one half hour fire resistance rating. This deficient practice could affect 6 residents who use the therapy room on the East Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/08/15 at 11:20 a.m., the East Hall attic smoke</p>	K 0025	<p>K 025</p> <p>1. The Maintenance Director on 12/10/15 repaired the one half inch crack in the concrete block East Hall attic smoke barrier to ensure that at least a one half hour fire resistance rating is maintained as required.</p> <p>2. The Maintenance Director on</p>	12/28/2015

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K 0062 SS=E Bldg. 01	<p>barrier had a one half inch crack in the concrete block attic smoke barrier where the mortar was missing in the mortar joint extending for five feet from the top of the smoke barrier wall. The East Hall attic smoke barrier one half inch gap where the mortar was missing in the concrete block was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/08/15 at 11:45 a.m.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to ensure 1 of 48 room sprinkler heads and 1 of 3 corridor sprinkler heads were maintained. This deficient practice could affect 22</p>	K 0062	<p>12/10/15 inspected the facility attic smoke barriers to ensure that the one half hour fire resistance rating is maintained as required.</p> <p>3. The Maintenance Director was reeducated on 12/10/15 by the Administrator related to ensuring attic smoke barriers maintain at least a one half hour fire resistance rating as require.</p> <p>4. The Maintenance Director will inspect the attic smoke barriers weekly for 4 weeks and monthly for 2 months to ensure that at least a one half hour fire resistance rating continues to be maintained as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up</p> <p>K 062</p>	12/28/2015

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	<p>residents who reside on the South Hall and 22 residents who reside on the North Hall.</p> <p>Findings include:</p> <p>Based on observations on 12/08/15 during a tour of the facility with the maintenance supervisor from 9:35 a.m. to 11:35 a.m., the South Hall sprinkler in the soiled utility room and the North Hall sprinkler in the corridor by the central bath room each had a quarter inch gap around the sprinkler escutcheon where the sprinklers were not tight fitting to the ceiling.</p> <p>This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/08/15 at 11:45 a.m.</p> <p>3.1-19(b)</p>		<p>1.The Maintenance Director on 12/10/15 repaired the quarter inch gap around the sprinkler escutcheon in the South Hall soiled utility room to ensure the sprinkler is tight fitting to the ceiling as required.</p> <p>2.The Maintenance Director on 12/10/15 repaired the quarter inch gap around the sprinkler on the North Hall corridor by the central bathroom to ensure the sprinkler is tight fitting to the ceiling as required.</p> <p>3.The Maintenance Director on 12/10/15 inspected the facility sprinkler heads to ensure sprinklers are maintained as required.</p> <p>4.The Maintenance Director was reeducated on 12/10/15 by the Administrator related to the requirements of maintaining sprinklers per life safety code.</p> <p>5.The Maintenance Director will inspect the sprinklers weekly for 4 weeks and monthly for 2 months to ensure the sprinklers continue to be maintained as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be</p>	

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K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure extension cords including powerstrips were not used as a substitute for fixed wiring in 1 of 48 rooms in the facility. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 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 affects 6 residents who use the therapy room in the East Hall next to the director of nursing office.</p> <p>Findings include:</p> <p>Based on observation on 12/08/15 at 9:35 a.m. with the maintenance supervisor, the director of nursing office had a refrigerator plugged into a white extension cord and pig tailed into a power strip. This was verified by the maintenance supervisor at the time of observation and acknowledged by the</p>	K 0147	<p>responsible for monitoring and follow up.</p> <p>K 147</p> <p>1.The Maintenance Director on 12/9/15 removed the white extension cord and the power strip from the director of nursing office and plugged the refrigerator into the 110 electrical wall outlet as required.</p> <p>2.The Maintenance Director on 12/10/15 inspected the facility to ensure extension cords and power strips were not being used as a substitute for fixed wiring as required.</p> <p>3.The Maintenance Director was reeducated on 12/10/15 by the Administrator related to ensuring extension cords and power strips are not being used as a substitute for fixed wiring as required.</p>	12/28/2015

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	administrator at the exit conference on 12/08/15 at 11:45 a.m. 3.1-19(b)		4. The Maintenance Director will inspect the facility weekly for 4 weeks and monthly for 2 months to ensure extension cords and power strips are not being used as a substitute for fixed wiring as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.		