

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155295	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2014
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NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041
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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: 05/13/14</p> <p>Facility Number: 000192 Provider Number: 155295 AIM Number: 100291120</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Clinton House Health and Rehab Center 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 III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The facility has the capacity</p>	K010000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility is requesting a desk review.</i></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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K010029 SS=E	<p>for 88 residents and had a census of 67 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has an unsprinklered detached wood frame garage with a brick exterior used for storing facility maintenance equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/19/14.</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 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>			
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	<p>Based on observation and interview, the facility failed to ensure a door to a hazardous area such as the kitchen in 1 of 8 smoke compartments closed automatically or upon activation of the fire alarm system. Doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 20 or more residents in the dining room which is open to the corridor.</p> <p>Findings include:</p> <p>a. Base on observation with the Maintenance Director on 05/13/14 at 12:50 p.m., the north door separating the kitchen from the dining room was equipped with a self closing device which could not work. The self closing arm had been disconnected from the door so the door stood wide open. The maintenance director said at the time of observation, the screw which attached the self closer's arm to the door fame had been removed.</p> <p>b. Based on observation with the Maintenance Director on 05/13/14 at 12:50 p.m., the south door separating the kitchen from the dining room stood wide open. The door was prevented from closing because it was pushed over a warped floor which would not allow the door to close automatically upon</p>	K010029	<p><b>K029 NFPA 101 Life Safety Standard</b></p> <ul style="list-style-type: none"> <li>· The north door separating the kitchen from the dining was did have the closure by replacing the screw that secured the door to the closure. The south door separating the kitchen from the dining room did have the door adjusted to ensure it would close utilizing the closure.</li> <li>· Any door in the facility has the potential to be effected by this alleged practice. All staff and residents have been informed of their ability to report doors that do not function appropriately and the appropriate systems to do such.</li> <li>· The maintenance supervisor was re-educated on the proper maintenance for all doors with closures. A review of doors in the facility was conducted and found none other doors out of compliance.</li> <li>· Correct operation of doors will occur every other week for six weeks and month and monthly after. Department heads were re-educated on how to report maintenance issues. Non-compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of all audits will be reviewed monthly in QA&amp;A for 6 months and quarterly with</li> </ul>	05/30/2014			

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K010073 SS=E	<p>activation of the fire alarm system. The Maintenance Director acknowledged at the time of observation, the door would not automatically close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation and interview, the facility failed to ensure combustible decorations were limited in use in 1 of 8 smoke compartments. This deficient</p>	K010073	<p>subsequent plan development and implementation as appropriate.</p> <p><i>K073 NFPA 101 Life Safety Code Standard</i></p> <p>The assembled puzzles were</p>	05/30/2014

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	<p>practice affects visitors, staff and 10 or more residents on the 600 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 5/13/14 at 1:45 p.m., assembled puzzles covered a 20 foot distance along the upper half of the walls of the 600 resident sleeping room hall. The Maintenance Director said at the time of observation, he had no Flame Spread Rating information for the puzzles covering the wall.</p> <p>3.1-19(b)</p>		<p>removed from the 600 hallway.</p> <ul style="list-style-type: none"> <li>· Any hallway and wall in the facility has the potential to be effected by this deficit practice. All residents were instructed on the regulation and they understood and suggested that we remove the puzzles.</li> <li>· The maintenance director was educated what 10% of the walls were and that if a greater area was covered by a combustibile product they would need to be treated or removed.</li> <li>· The Executive Director will monitor weekly for decorations or personal artwork that is combustibile and not treated. Non-compliance will be addressed through re-education and progressive disciplinary actions as indicated. Results of all audits will be reviewed monthly in QA&amp;A for 6 months and quarterly with subsequent plan development and implementation as appropriate.</li> </ul>		