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| 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 08/03/2016 |
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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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| 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: 08/03/16</p> <p>Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040</p> <p>At this Life Safety Code survey, Clinton Gardens was found not in compliance with Requirements for Participation in Medicare, 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>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all living areas. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 100</p> | K 0000 | The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction. | |

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 0014 SS=B Bldg. 01 | <p>and had a census of 92 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 08/09/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Based on observation and interview, the facility failed to ensure interior finish installed in 4 of 4 corridors serving as an exit or exit component had a flame spread rating of Class A or Class B. This deficient practice could affect 72 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "2012 Renovation by</p> | K 0014 | <p>-No residents were affected by the practice. -All residents have the potential to be affected by the practice. -All wall coverings will be treated with flame retardant. New Retardant treatment is lifetime treatment -Any wall coverings installed in the future will be required to carry at least a B flame spread rating or be treated upon installation with the flame retardant and the treatment</p> | 09/02/2016 | | | |

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| | NBA Builders" documentation with the Administrator and the Maintenance Supervisor from 9:30 a.m. to 11:30 a.m. on 08/03/16, the lower wall laminate installed in corridors was manufactured by Columbia Clicette, was listed as "Oregon Walnut" and was stated as Class C with a flame spread index of 135. Additional documentation for the 2012 renovation indicated the lower wall laminate was initially treated with Fire Retardant's "Burn Barrier" flame retardant to achieve Class B flame spread rating. Documentation of the frequency or need for "Burn Barrier" reapplication was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 08/03/16, a laminate was installed on the lower portion of all corridor walls from the floor to three feet high on the wall. During the tour, a supply of two bottles of "Fire Block" fire retardant was noted in a maintenance room by Laundry Services which indicated reapplication of the fire retardant was needed after cleaning substrates in order to achieve Class B flame spread rating. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated the lower wall laminate is cleaned but did not know the frequency of cleaning or reapplication with fire | | to be documented by the person responsible for application. -Application will be documented. New retardant is lifetime. Any new additions or repairs will be treated. This will be monitored by Maintenance Director with supervision from Executive Director. | |

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| K 0064 SS=D Bldg. 01 | <p>retardant material(s) and acknowledged the lower wall laminate installed in corridors was Class C.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is</p> | K 0064 | <p>-No residents were affected by the practice.</p> <p>-All residents have the potential to be affected by the practice.</p> <p>-Placard was placed over the K Class Fired Extinguisher.</p> <p>-Any replacement or additional K Class Extinguishers will have a placard immediately placed with them on the wall.</p> <p>-Placement of the placard will be monitored weekly for 4 weeks, monthly for 6 months.</p> | 08/15/2016 |

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| K 0067 SS=E Bldg. 01 | <p>supplemental protection. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 08/03/16, a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were</p> | K 0067 | <p>-No residents were affected by the practice.</p> <p>-All residents have the potential to be affected by the practice.</p> | 09/02/2016 |

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| | <p>inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect 72 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and the Maintenance Supervisor from 9:30 a.m. to 11:30 a.m. on 08/03/16, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 08/03/16, one fire damper was observed installed in ductwork for the HVAC system in the ceiling in the corridor by</p> | | <p>-Damper inspection to be completed by IEI by 9/2/16.</p> <p>-Documentation of inspection to be maintained in the Preventative Maintenance Book.</p> <p>-Damper inspection and sticker placement to be monitored monthly x 4 months and quarterly after in Quality Assurance.</p> | | |

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| K 0000 Bldg. 02 | <p>the south nurse's station. The aforementioned fire damper had no affixed sticker for the manufacture date or four year inspection and maintenance date. Based on interview at the time of record review and of observation, the Maintenance Supervisor stated fire dampers are located in the facility and acknowledged fire damper inspection and maintenance documentation within the most recent four year period for all facility fire dampers was not available for review.</p> <p>3.1-19(b)</p> <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: 08/03/16</p> <p>Facility Number: 000212 Provider Number: 155319 AIM Number: 100285040</p> <p>At this Life Safety Code survey, Clinton Gardens was found not in compliance</p> | K 0000 | The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the community's desire to comply with the requirements and to continue to provide a safe and functional environment for our residents. Clinton Gardens would like to respectfully request a desk review of the following plan of correction. | | |

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| K 0025 SS=E | <p>with Requirements for Participation in Medicare, 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 Moving Forward addition which includes resident rooms 101 through 114 was constructed in 2004 and was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>The Moving Forward addition to the one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all living areas. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 92 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 08/09/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> | | | | |

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| Bldg. 02 | <p>Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure openings in 1 of 1 smoke barriers were protected to maintain at least a one hour fire resistance rating for the smoke barrier. LSC 18.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 14 residents, staff or visitors in Moving Forward.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 08/03/16, the following was noted in the attic smoke barrier wall above the ceiling at the corridor door set by Room 101 in Moving Forward:</p> <p>a. an open ended three inch in diameter conduit for the passage of cables was not</p> | K 0025 | -No residents were affected by the practice -All residents have the potential to be affected by the practice. -All noted areas will be fire-stopped by the MaintenanceDirector. -Upon inspection any additional areas found to need fire-stop will have this done. -Barriers will be inspected initially and then monthly thereafter for any gaps in the firestop. | 09/02/2016 | | | |

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| K 0027 SS=E Bldg. 02 | <p>firestopped.</p> <p>b. the one inch annular space surrounding a four inch in diameter pipe was not firestopped.</p> <p>c. the three inch annular space surrounding a one inch in diameter conduit was filled with foam.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor stated he did not know the fire resistance rating of the foam used in the aforementioned hole and acknowledged the attic smoke barrier openings were not firestopped to maintain at least a one hour fire resistance rating for the smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would close to form</p> | K 0027 | <p>-No residents were affected by the practice.</p> <p>-All residents have the potential to be affected by the practice.</p> | 08/16/2016 |

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| | <p>a smoke resistant barrier. This deficient practice could affect 14 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 1:15 p.m. on 08/03/16, the set of smoke barrier corridor doors in the two hour rated fire wall by Room 101 in Moving Forward which each swing in the opposite direction were not equipped with an astragal, rabbet or bevel at the meeting edge. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned smoke barrier door set which swings in the opposite direction was not equipped with an astragal, rabbet or bevel at the meeting edge.</p> <p>3.1-19(b)</p> | | <p>-A bevel was installed on the doors noted.</p> <p>-All other doors inspected for needed adjustments with nonenoted.</p> <p>-Monthly checks to be performed on all doors to ensure proper closure. All doors will be monitored for proper closure weekly x 4 weeks and monthly for 2 months and quarterly thereafter</p> | | |