

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  11/07/2013
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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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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: 11/07/13</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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000		

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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	<p>has a capacity of 50 and had a census of 45 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 44 corridor doors were constructed to resist the passage of smoke or provided with a means suitable for keeping the door closed. This deficient practice could affect any residents using the conference room and 6 residents who use the therapy room at a time.</p> <p>Findings include:</p> <p>Based on observations on 11/07/13 during a tour of the facility from 10:45 a.m. to 1:00 p.m. with the administrator and maintenance supervisor, the conference room door had a one inch gap along the entire latching side of the door and the therapy room door was missing latching</p>	K010018	Preparation and submission of this plan of correction by Caroleton Manor of Connerville, LLC, 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. K-018 1. The two corridor doors were repaired on 11-7-13 by maintenance to resist the passage of smoke as required. 2. An audit of corridor doors was completed by the Maintenance director on 11/27/13 to ensure facility doors close as required per Life Safety Code. 3. The Maintenance Director was re-educated by the Regional Maintenance Director, on	11/29/2013			

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	hardware. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/07/13 at 1:10 p.m.  3.1-19(b)		11-26-13 related to the requirements of maintaining corridor doors per life safety code. 4. Doors will be checked by the Maintenance Director and Administrator weekly for four weeks and monthly for two months to ensure facility doors continues to close as required to prevent smoke passage. A report will be submitted to the Quality Assurance Committee monthly for three months. The Administrator and Maintenance Director are responsible for monitoring and follow-up. Date of compliance: 11-29-13		

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K010029 SS=E	<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> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 hazardous areas such as a combustibile storage room over 50 square feet in size was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects any residents who use the main dining room, located adjacent to the kitchen food storage room.</p> <p>Findings include:</p> <p>Based on observation on 11/07/13 at 11:35 a.m. with the administrator and maintenance supervisor, the door to the kitchen food storage room which measured two hundred eighty square feet and stored forty six cardboard boxes of food supplies, lacked a self closing device. This was verified by the</p>	K010029	Preparation and submission of this plan of correction by Caroleton Manor of Connerville, LLC, 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. K-029 1. The door to the food storage room was equipped with a self-closing device on 11-7-13 by the Maintenance Director. 2. An audit of facility doors was completed by the Maintenance Director on 11/27/13 to ensure facility doors requiring self-closers as required per Life Safety Code. 3. The Maintenance Director was re-educated by the Regional Maintenance Director, on 11-26-13 related to the requirements of maintaining	11/29/2013

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	<p>administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/07/13 at 1:10 p.m.</p> <p>3.1-19(b)</p>		<p>self-closer doors per life safety code. 4. Doors will be checked by the Maintenance Director and Administrator weekly for four weeks and monthly for two months to ensure facility doors continues to close as required to prevent smoke passage. A report will be submitted to the Quality Assurance Committee monthly for three months. The administrator and maintenance director are responsible for monitoring and follow-up Date of compliance: 11-29-13</p>	