

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  10/30/2012
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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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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/30/12</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, spaces open to the corridors, and battery operated smoke detectors in</p>	K0000	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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	<p>all resident sleeping rooms. The facility has a capacity of 50 and had a census of 46 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</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 11/02/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=E	<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 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any residents using the Center Hall nurses' station and 34 residents who use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 10/30/12 during a tour of the facility from 9:10 a.m. to 12:05 p.m., the kitchen dietary manager's office ceiling had a two inch by two inch area of drywall missing and the Center Hall nurses' station janitor closet had three, one half inch gaps around</p>	K0025	<p>1. The kitchen dietary manager's office ceiling was repaired by the Maintenance Director on 11-6-12. The janitors's closet ceiling was repaired by the Maintenance Director on 11-6-12.</p> <p>2. An audit was completed on 11-7-12 by the Maintenance Director related to penetrations in the ceiling and walls to ensure there are no further needs for repairs.</p> <p>3. The Maintenance Director was re-educated by the administrator related to the requirements of maintaining facility repairs, including smoke penetrations.</p> <p>4. The Maintenance Director will complete an audit weekly for 4 weeks and monthly for 2 months to ensure smoke penetrations continues to be maintained per Life Safety code. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Maintenance Director will be responsible for monitoring and follow up. The</p>	11/12/2012			

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	<p>electrical conduit penetrations through the ceiling. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 12:15 p.m. exit conference on 10/30/12.</p> <p>3.1-19(b)</p>		<p>Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months. Date of compliance 11-12-12.</p>	

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. 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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors equipped with a coordinator, allowed the door which must close first, to always close first so both doors always close completely. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door that must close first always closes first. This deficient practice affects 34 residents who use the main dining room, which is located next to the smoke barrier doors by the Administration Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/30/12 at 10:45 a.m. with the maintenance supervisor, the Administration Hall set of smoke barrier doors was tested for closing. First the door with the astragal was closed to test the coordinator. The</p>	K0027	<p>1. The Maintenance Director replaced the coordinator on the door on 11-7-12. 2. The Maintenance Director completed an audit on 11-7-12 related to smoke barrier doors to ensure no further doors were in need of repair. 3. The Maintenance Director was re-educated by the Administrator on 11-7-12 related to the requirements of maintaining smoke barrier doors. 4. The Maintenance Director will complete an audit weekly for 4 weeks and monthly for 2 months to ensure smoke barrier doors continue to close as required. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Maintenance Director will be responsible for monitoring and follow up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months. Date of compliance 11-12-12.</p>	11/12/2012			

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	<p>coordinator failed to release the door with the astragal after the door without an astragal was closed, leaving a three inch gap where the door was prevented from closing by the coordinator. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 12:15 p.m. exit conference on 10/30/12.</p> <p>3.1-19(b)</p>			

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K0067 SS=F	<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 observation and interview, the facility failed to ensure 22 of 22 resident rooms were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 10/30/12 during a tour of the facility from 9:10 a.m. to 12:05 p.m. with the maintenance supervisor, resident rooms S2 south, S3 south, S4 south, S5 south, S6 south, S7 south, S8 south, S9 south, S10 south, S11 south, S12 south, S2 north, S3 north, S4 north, S5 north, S6 north, S7 north, S8 north, S9 north, S10 north, S11 north, S12 north were using the egress corridors as a return air system. This was verified by the maintenance supervisor at the time of</p>	K0067	Please see addendum to rescind the waiver request for K-67. Attached is the quote as well as the letter requesting to rescind the wavier. Date of compliance 12-31-12.	11/28/2012			

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	<p>observations and confirmed by the administrator at the 12:15 p.m. exit conference on 10/30/12.</p> <p>3.1-19(b)</p>			

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K0070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable space heating devices were prohibited in areas other than staff areas. This deficient practice could affect 34 residents who use the main dining room and any residents who use the resident sitting room in the Center Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/30/12 during a tour of the facility from 9:10 a.m. to 12:05 p.m. with the maintenance supervisor, the main dining room and the resident sitting room each had a fake fire place with a portable electric space heating device installed inside each unit. This was verified by the maintenance director at the time of observation and confirmed by the administrator at the 12:15 p.m. exit conference on 10/30/12. Furthermore, the administrator indicated the facility did not have a written policy for the use of space heaters during the exit conference.</p> <p>3.1-19(b)</p>	K0070	<p>1. The fireplaces located in the dining room area and the parlor are used for decorative tiems and do not serve as a source of heat. On 10-30-12 the Maintenance Director disconnected both fireplaces to ensure they are no longer operable. 2. The Maintenance Director performed a sweep of the facility on 11-7-12 to ensure there are no operable portable heat devices. 3. The Maintenance Director was re-educated by the Administrator on 11-7-12 related to the requirements of ensuring there are no portable heat devices in use within the facility. 4. The Maintenance Director will complete audits weekly for 4 weeks, and monthly for 2 months to ensure there continues to be no portable heat devices in use within the facility. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Maintenance Director will be responsible for monitoring and follow-up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months. Date of compliance 11-12-12.</p>	11/12/2012