PRINTED: 10/19/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPI	LETED
		155295	B. W	ING		09/26	/2022
					_		
NAME OF 1	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
				809 W FREEMAN ST			
CLINTO	N HOUSE REHABIL	ITATION AND HEALTHCARE (	CENTE	FRANK	KFORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg			E 00	000			
	Survey Date: 09/26	5/22					
	Facility Number: 0 Provider Number: AIM Number: 1002 At this Emergency	Number: 155295 nber: 100291120					
	At this Emergency Preparedness survey, Clinton House Rehabilitation and Healthcare Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73						
	The facility has 88 of the survey, the cens	certified beds. At the time of us was 77.					
	Quality Review con	mpleted on 09/29/22					
	The requirement at MET as evidenced	42 CFR, Subpart 483.73 is NOT by:					
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power sys emergency plan s this section and in	LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1)					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.73(e), §485.625(e)

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DCHE21 Facility ID: 000192 If continuation sheet Page 1 of 26

PRINTED: 10/19/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	ИВ NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>		LETED
		155295	B. W	'ING		09/26	6/2022
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					FREEMAN ST		
CLINTO	N HOUSE REHABII	LITATION AND HEALTHCARE (	CENTE	FRANK	FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(e) Emergency ar						
		and the CAH] must					
	1 '	ency and standby power					
	1 7	n the emergency plan set					
	forth in paragraph	n (a) of this section.					
	\$492.15(0)(1).84	92 72(0)(1) \$495 625(0)(1)					
	- , , , , -	.83.73(e)(1), §485.625(e)(1) rator location. The					
		e located in accordance with					
		rements found in the Health					
	· ·	ode (NFPA 99 and Tentative					
		ents TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
		and Tentative Interim					
	,	12-1, TIA 12-2, TIA 12-3,					
		id NFPA 110, when a new					
		or when an existing					
	structure or buildi	ng is renovated.					
	482.15(e)(2), §48	3.73(e)(2), §485.625(e)(2)					
	Emergency gener	rator inspection and testing.					
		H and LTC facility] must					
		nergency power system					
		g, and [maintenance]					
	'	nd in the Health Care					
		IFPA 110, and Life Safety					
	Code.						
	482 15(e)(3) 848	3.73(e)(3), §485.625(e)(3)					
	, , , , -	rator fuel. [Hospitals, CAHs					
		] that maintain an onsite fuel					
		emergency generators must					
	•	ow it will keep emergency					
		perational during the					
	emergency, unles	<del>-</del>					
		§482.15(h), LTC at					
	§483.73(g), and 0	CAHs §485.625(g):]					1

FORM CMS-2567(02-99) Previous Versions Obsolete

The standards incorporated by reference in this section are approved for incorporation by

Event ID:

DCHE21

Facility ID: 000192

If continuation sheet

Page 2 of 26

STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMP	LETED
		155295	B. W	ING _		09/26	5/2022
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			FREEMAN ST		
CLINITO	N HOUSE REHARII	LITATION AND HEALTHCARE CE	NTF		FORT, IN 46041		
OLINIO	T TOOOL NETIABII	LITTION AND HEALTHOANE OF	-: N : L	III			•
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	Director of the Office of the					
	1	in accordance with 5 U.S.C.					
	1 ' '	R part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
	· ·	ore, MD or at the National					
		cords Administration					
		mation on the availability of					
	go to:	ARA, call 202-741-6030, or					
	1 ~	es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		Federal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 0216						
	1.617.770.3000.						
	(i) NFPA 99, Heal	lth Care Facilities Code,					
	2012 edition, issu	ed August 11, 2011.					
	(ii) Technical inter	rim amendment (TIA) 12-2 to					
	NFPA 99, issued	August 11, 2011.					
	(iii) TIA 12-3 to NI	FPA 99, issued August 9,					
	2012.						
	, ,	FPA 99, issued March 7,					
	2013.						
	1 ' '	FPA 99, issued August 1,					
	2013.						
	` '	FPA 99, issued March 3,					
	2014.						
	. ,	ife Safety Code, 2012					
	edition, issued Au						
	1 ' '	NFPA 101, issued August					
	11, 2011.	CDA 101 issued October					
	1 ' '	FPA 101, issued October					
	30, 2012.	FPA 101, issued October					
	1 (X) 11A 12-3 (0 N)	TA TOT. ISSUEU OCIODEL	1		l		i .

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet Page 3 of 26

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<del></del>	COMPL	
		155295	B. WI	NG		09/26/	2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD FREEMAN ST		
CLINTON	N HOUSE REHABIL	ITATION AND HEALTHCARE CE	NTE		FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
TAG	22, 2013.  (xi) TIA 12-4 to NF 22, 2013.  (xii) NFPA 110, S' Standby Power Sy including TIAs to 2009.  Based on record reversal failed to implement inspection, testing, a found in the Health 110, and Life Safety CFR 482.15(e)(2). The safety CFR 482	EPA 101, issued October  tandard for Emergency and vetems, 2010 edition, chapter 7, issued August 6, riew and interview, the facility the emergency power system and maintenance requirements  Care Facilities Code, NFPA or Code in accordance with 42  This deficient practice could riew with the Maintenance 2 at 10:34 a.m., the facility reekly or monthly generator November, or December of rview at the time of record rance Director acknowledged	E 00	TAG	E041 – SS=C Hospital CAH a LTC Emergency Power The Facility requests paper compliance for this citation. This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreer by the provider of the truth of the facts alleged or conclusions se forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1.) Immediate actions taken for those residents identified  No resident was found the affected by the finding. Generator Service was completed January 2022 forwa and will continue to be documented per regulations.  2.) How the facility identifie	and  of t ment the et	09/29/2022
					other residents:  Visitors, staff and reside that reside at the community he potential to be affected by	ave	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155295	A. BUILDING  B. WING	onstruction 	COMPLETED 09/26/2022
	ROVIDER OR SUPPLIER I HOUSE REHABIL	ITATION AND HEALTHCARE CEN	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST (FORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000				alleged deficient practice.  3.) Measures put into place System changes:  Weekly inspections log be maintained per regulations 4.) How the corrective action will be monitored:  Generator inspection will monitored by Maintenance Director/ED/designee weekly six months.  The results of these aud will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliates achieved. The QA committed will identify any trends or patter and make recommendations to revise the plan of correction a indicated.  The Executive Director review the Preventative Maintenance Worksheets monthly.  5.) Date of compliance: 09/29/2022	to . ons ill be for dits or 6 nce ee eerns o
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000		
	Survey Date: 09/26	/22			
	Facility Number: 00	00192			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	A. E	MULTIPLE CO BUILDING WING	nstruction 01	CON	TE SURVEY MPLETED 26/2022
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE C	ENTE	809 W F	DDRESS, CITY, STATE, ZIP ( FREEMAN ST FORT, IN 46041	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Provider Number: AIM Number: 100						
	Rehabilitation and I not in compliance v Participation in Me Subpart 483.90(a), 2012 edition of the Association (NFPA	Code survey, Clinton House Healthcare Centerwas found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire, and the National Fire Protection ) 101, Life Safety Code (LSC), g Health Care Occupancies and					
	Type III (200) cons sprinklered. The fact with smoke detection sleeping rooms and	ity was determined to be of truction and was fully cility has a fire alarm system on in the corridors, resident spaces open to the corridors. apacity of 88 and had a census this visit.					
	were sprinklered. A	idents have customary access Il areas which provided facility klered except for one detached tot sprinklered.					
	Quality Review cor	npleted on 09/29/22					
K 0222 SS=B Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING	d means of egress shall not a latch or a lock that if a tool or key from the susing one of the following rangements: SOR SECURITY THREAT king arrangements for the eeds of the patient are					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet

Page 6 of 26

PRINTED: 10/19/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			O!	MB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMI	PLETED	
		155295	B. W	ING		09/26	6/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			FREEMAN ST			
CLINTO	N HOUSE REHABII	LITATION AND HEALTHCARE (	CENTE	FRANK	FORT, IN 46041			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	· ·	cking device shall be						
		n door and provisions shall						
	be made for the ra	apid removal of occupants						
	by: remote contro	l of locks; keying of all						
	locks or keys carr	ied by staff at all times; or						
	other such reliable	e means available to the						
	staff at all times.							
	18.2.2.2.5.1, 18.2	.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6							
	SPECIAL NEEDS	LOCKING						
	ARRANGEMENT	S						
	Where special loc	king arrangements for the						
		ne patient are used, all of						
		curity Locking requirements						
		addition, the locks must be						
	_	at fail safely so as to						
		of power to the device; the						
		ed by a supervised						
		er system and the locked						
	1	d by a complete smoke						
		(or is constantly monitored						
		cation within the locked						
		the sprinkler and detection						
		nged to unlock the doors						
	upon activation.							
	18.2.2.2.5.2, 19.2	.2.2.5.2. TIA 12-4						
	DELAYED-EGRE							
	ARRANGEMENT							
		delayed-egress locking						
	• •	in accordance with						
	1 *	permitted on door						
		ng low and ordinary hazard						
		ngs protected throughout by						
		ervised automatic fire						
		or an approved, supervised						
	automatic sprinkle							
	18.2.2.2.4, 19.2.2							
	I ACCESS-CONTR	ROLLED EGRESS	I		I		I	

FORM CMS-2567(02-99) Previous Versions Obsolete

LOCKING ARRANGEMENTS

Access-Controlled Egress Door assemblies

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet

Page 7 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155295	B. W	ING		09/26/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<b>C</b>			FREEMAN ST		
	N HOUSE REHABIL	LITATION AND HEALTHCARE CE	NTE		FORT, IN 46041		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC! )		DATE
		lance with 7.2.1.6.2 shall					
	be permitted.	2.4					
	18.2.2.2.4, 19.2.2.	.2.4 BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2.	.2.4					
		on and interview, the facility	K	222	K222 – SS=B Egress Doors		09/29/2022
	failed to ensure the	means of egress through 1 of			This Facility respectively		
	8 exits were readily	accessible for residents			requests a desk review for th	nis	
	without a clinical di	iagnosis requiring specialized			citation.		
	security measures. I	Doors within a required means			This Plan of Correction is the		
	-	be equipped with a latch or			centers credible allegation of		
	_	ne use of a tool or key from the			compliance.		
	-	therwise permitted by LSC			Preparation and/or execution		
		cking arrangements shall be			this plan of correction does no	ot	
	•	ance with 19.2.2.2.5.2. This			constitute admission or agree		
	-	ould affect over 50 residents,			by the provider of the truth of t		
	staff and visitors if	needing to exit the facility.			facts alleged or conclusions so	et	
					forth in the statement of		
	Findings include:				deficiencies. The plan of		
	Rosed on observation	on with the Maintenance			correction is prepared and/or		
		on with the Maintenance our of the facility on 09/26/22 at			executed solely because it is		
	_	entry / exit to the facility was			required by the provisions of federal and state law.		
	-	d and could be opened by			1) Immediate actions taken for	or	
		t code but the code posted at			those residents identified:	O1	
		dress" whereas the facility			No resident was found to	to	
		non knowledge. Based on an			be affected by the findings.		
		e of the observation, the			Egress Doors 1-8 has a	ì	
		tor stated the code posted in			code posted a four digit that is		
		event residents from eloping.			common knowledge.	-	
		) p.m. it was noted that the			2) How the facility identified		
		d the posting at the front door			other residents:		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet Page 8 of 26

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155295		A. BUILDING B. WING	01	COMPLETED 09/26/2022	
	PROVIDER OR SUPPLIER N HOUSE REHABIL	ITATION AND HEALTHCARE CE	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST KFORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		code was * 8 0 9 and ency was fixed prior to my y.		that reside at the community if the potential to be affected by alleged deficient practice.  3) Measures put into place/ System changes:  The Maintenance Director/ED/Designee will reviposted door codes monthly to ensure compliance.  4) How the corrective actions will be monitored:  The results of these test will be reviewed in Quality Assurance Meetings monthly months or until 100% compliating achieved. The QA Committed will identify any trends or pattern and make recommendations to revise the plan of correction a indicated.  5) Date of compliance: 09/29/2022	nave the sew ss sts for 6 nace eee eerns o
K 0291 SS=C Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observation failed to ensure of were tested monthly the last twelve month provide lighting durand a written record tests was provided. functional testing sh	ng g of at least 1-1/2-hour d automatically in	K 0291	K291 SS=C Emergency Lighting The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.	10/12/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet

Page 9 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155295	B. WI	NG		09/26/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.			FREEMAN ST		
CLINTON	I HOUSE REHABIL	ITATION AND HEALTHCARE CEN	NTE		FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s, for not less than 30			B	- <b>f</b>	
	seconds, (3) Function	_			Preparation and/or execution		
	-	for a minimum of 1 1/2 hours			this plan of correction does no		
		thting system is battery ritten records of visual			constitute admission or agree		
		s shall be kept by the owner			by the provider of the truth of t		
	for inspection by th				facts alleged or conclusions so forth in the statement of	<b>5</b> ι	
		eficient practice could affect all			deficiencies. The plan of		
	residents in the faci	-			correction is prepared and/or		
	residents in the fact	nty.			executed solely because it is		
	Findings include:				required by the provisions of		
	i manigs merade.				federal and state law.		
	Based on record rev	view with the Maintenance			reactar and state law.		
		2 at 10:28 a.m., the facility			1) Immediate actions take	n	
	could not provide m				for those residents identified		
	_	nergency lights for October,				-	
		mber of 2021. Based on an					
	·	e of record review, the			Issue #1-facilty testing has b	een	
		or indicated the facility has			completed to ensure that		
		ergency exit lights throughout			emergency illumination is		
	the facility were tes	ted monthly but the previous			provided to identified areas I	οу	
	Maintenance Direct	or was terminated and threw			the facility generator. No	-	
	away his records for	r that time period. Because he			residents identified as being		
	began in his position	n on January 1st of 2022, he			affected.		
		other Maintenance Directors			Issue#2-Emergency power li	ght	
		26/22 at 2:38 p.m., during the			has been tested for		
		n the facility Maintenance			functionality. No resident		
		ecutive Director, no additional			identified as being affected		
		ence could be provided					
	contrary to this defi	cient finding.			2) How the facility identification	ed	
					other residents:		
	3.1-19(b)						
					No residents identified as		
					being affected		
					2) Magazines mut into miss	o./	
					3) Measures put into place	<del>U</del> I	

PRINTED: 10/19/2022

	TERS FOR MEDICARE & MEDICAID SERVICES								
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	A. B	MULTIPLE CO UILDING VING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2022			
	PROVIDER OR SUPPLIER	R LITATION AND HEALTHCARE C	ENTE	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST (FORT, IN 46041				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE		
					Issue #1 , Issue #2- added preventative maintenance program for annual testing and results to be recorde				
					4) How the corrective actions will be monitored:				
					Maintenance Supervisor/designee will monitor through facility preventative maintenance manual annually any identific issues will be immediately corrected to ensure compliance.	ed			
					The results of these audits we be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify at trends or patterns and make recommendations to revise the plan of correction as indicated.	for ny he			
					5) Date of compliance: 10/12/2022				
K 0353 SS=C	NFPA 101 Sprinkler System	- Maintenance and Testing							

FORM CMS-2567(02-99) Previous Versions Obsolete

Bldg. 01

Sprinkler System - Maintenance and Testing

Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in

Event ID:

DCHE21

Facility ID: 000192

If continuation sheet

Page 11 of 26

10/19/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2022 155295 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility K 0353 K353 SS=C SPRINKLER 09/29/2022 failed to document sprinkler system inspections in SYSTEM- MAINTENANCE AND accordance with NFPA 25. NFPA 25, Standard for **TESTING** the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 The facility requests paper Edition, Section 5.2.4.2 states gauges on dry pipe compliance for this citation. sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are This Plan of Correction is the being maintained. Section 5.1.2 states valves and center's credible allegation of fire department connections shall be inspected, compliance. tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be Preparation and/or execution of utilized for inspection, testing and maintenance of this plan of correction does not valves, valve components and trim. Section 4.3.1 constitute admission or agreement states records shall be made for all inspections, by the provider of the truth of the tests, and maintenance of the system and its facts alleged or conclusions set components and shall be made available to the forth in the statement of authority having jurisdiction upon request. This deficiencies. The plan of deficient practice could affect all residents, staff, correction is prepared and/or

FORM CMS-2567(02-99) Previous Versions Obsolete

and visitors.

Findings include:

Based on record review of the facility's sprinkler

Event ID:

DCHE21

Facility ID: 000192

If continuation sheet

executed solely because it is required by the provisions of

Immediate actions taken

federal and state law.

Page 12 of 26

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/26/2022		
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CE	NTE	809 W F	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	system inspection derecent twelve-month Director during recent 1:05 p.m. on 09/26/gauge inspection derecent 52-for review. (Octobe 2021) In addition, in documentation for a valves for 3 months period was not avaired on an interview at the Maintenance Direct inspect the sprinkle gauges as the code in Maintenance Direct away his records for began in his position had no access to the documents. On 09/2 exit conference with Director and the Ex	ocumentation for the most h period with the Maintenance ord review from 9:15 a.m. to 22, weekly dry sprinkler system ocumentation for 14 weeks of week period was not available r, November, or December of monthly inspection all sprinkler system control of the most recent 12-month lable for review either. Based the time of record review, the for indicated the facility did r system control valves and requires, but the previous or was terminated and threw r that time period. Because he n on January 1st of 2022, he to other Maintenance Directors 26/22 at 2:38 p.m., during the n the facility Maintenance ecutive Director, no additional ence could be provided			for those residents identified Inspections have been conducted January to present regulations Continued system inspections in accordance with NFPA25 will be documented, recorded and available for rev  2)How the facility identified other residents: Visitors, staff and residents the reside at the community have potential to be affected by the alleged deficient practice.  3)Measures put into place/ System changes: Maintenance director wiensure through the TELS progoto have continued documentate of inspections per regulations.  4)How the corrective actions will be monitored: The Maintenance Director/designee will present audits to the QAPI Committee during QAPI Meetings to ensure completion and compliance. The results of these audition will be reviewed in Quality Assurance Meeting monthly formonths or until 100% compliant is achieved times 3 months Treat QA Committee will identify any trends or patterns and make	per iew.  at the iill gram tion  the or 6 once ne	

recommendations to revise the

PRINTED: 10/19/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/26/2022	
	PROVIDER OR SUPPLIEI N HOUSE REHABII	LITATION AND HEALTHCARE C	ENTE	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST KFORT, IN 46041			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		E	(X5) COMPLETION DATE	
					plan of correction as indicated.  5) Date of compliance: 09/29/2022			
K 0712 SS=F Bldg. 01	alarm signal and a conditions. Fire di and unexpected to conditions, at leas The staff is familia aware that drills a routine. Where do 9:00 PM and 6:00 announcement maudible alarms. 19.7.1.4 through 1) Based on record facility failed to coof 4 quarters. LSC conducted quarterly conditions. This deand residents.  Findings include:  Based on record red Director on 09/26/2 could not provide for staff and residents.	ay be used instead of	K 0	712	K712 SS = F Fire Drills The facility requests paper compliance for this citation. This plan of correction is the center's credible allegation of compliance. Preparation and/or execution o this plan of correction does not constitute admission or agreem by the provider of the truth of th facts alleged or conclusions set forth in the statement of	nent ne	10/12/2022	
	Maintenance Direc	he time of record review, the tor indicated the facility did s the code requires, but the nce Director was terminated			correction is prepared and/or executed solely because it is required by the provisions of federal and state law.			

FORM CMS-2567(02-99) Previous Versions Obsolete

and threw away his records for that time period.

Because he began in his position on January 1st

of 2022, he had no access to the other

Event ID:

DCHE21 Facility ID: 000192

1) Immediate actions taken for

No resident was found to

those residents identified:

If continuation sheet

Page 14 of 26

PRINTED: 10/19/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155295 B. WING 09/26/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Maintenance Directors documents. On 09/26/22 at be affected by this alleged 2:38 p.m., during the exit conference with the deficiency. facility Maintenance Director and the Executive Maintenance Director was Director, no additional information or evidence educated on fire drills, timings, could be provided contrary to this deficient and documentation. finding. The fourth quarter documents lost prior to current 3.1-19(b) directors employment all other 3.1-51(c)documents are in place and will continue per regulations 2) Based on record review and interview, the 2) How the facility identified facility failed to ensure 8 of 9 fire drills included other residents: the verification of transmission of the fire alarm Residents, staff, and signal to the monitoring station in fire drills visitors have the potential to be conducted between 6:00 a.m. and 9:00 p.m. for the affected by the alleged deficient last 4 quarters. LSC 19.7.1.4 requires fire drills in practice. health care occupancies shall include the 3) Measures put into place/ transmission of a fire alarm signal and simulation System changes: of emergency fire conditions. This deficient The Maintenance Director practice affects all residents in the facility as well will review fire drill log to ensure as staff and visitors. compliance. The Maintenance Director was re-educated on the Findings include: Preventative Maintenance Program and fire drill requirements by the Based on record review of the documentation Executive Director/designee entitled "Fire Drill Report" with the Maintenance The Maintenance Director Director on 09/26/22 at 10:13 a.m., only one of the is responsible for compliance. fire drills conducted within the last nine-month 4) How the corrective actions period (October, November, and December's drills will be monitored: were not available for review) documented the An Environmental QAPI

FORM CMS-2567(02-99) Previous Versions Obsolete

DCHE21

Facility ID: 000192

If continuation sheet

tool will be utilized monthly to

will be reviewed in Quality

The results of these audits

Assurance Meetings monthly for 6

months or until 100% compliance

will identify and trends or patterns

is achieved. The QA Committee

and make recommendations to

revise the plan of correction as

monitor compliance.

transmission of the fire alarm signal with the alarm

monitoring company. Based on interview at the

time of record review, the Maintenance Director

document the transmission of the fire alarm signal

with the alarm monitoring company. On 09/26/22

at 2:38 p.m., during the exit conference with the

facility Maintenance Director and the Executive

Director, no additional information or evidence

could be provided contrary to this deficient

indicated that he was unaware the necessity to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	STRUCTION (X3) DATE S		SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED 09/26/2022	
		155295	B. WI	NG			
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				FREEMAN ST		
CLINTON	I HOUSE REHABIL	ITATION AND HEALTHCARE CEI			(FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	finding.				indicated.		
	2.1.10(1)				5) Date of compliance:		
	3.1-19(b)				10.12.2022		
	3.1-51(c)						
K 0761							
SS=F							
Bldg. 01							
		on, record review and	K 0'	761	K761 SS = F Maintenance,		10/12/2022
		ty failed to ensure annual			Inspection & Testing - Doors		
		ng of 2 of 2 door assemblies			The facility requests paper		
	-	accordance with LSC unicating openings in dividing			compliance for this citation.		
		d by 19.1.1.4.1 shall be			This plan of Correction is the center's credible allegation of		
	-	orridors and shall be protected			compliance.		
		osing fire door assemblies.			Preparation and/or execution of	of	
		3.) LSC 8.3.3.1 Openings			this plan of correction does no		
	•	ire protection rating by Table			constitute admission or agreer		
	-	ected by approved, listed,			by the provider of the truth of t		
	-	semblies and fire window			facts alleged or conclusions se		
	assemblies and their	r accompanying hardware,			forth in the statement of		
		, closing devices, anchorage,			deficiencies. The plan of		
		nce with the requirements of			correction is prepared and/or		
		for Fire Doors and Other			executed solely because it is		
		s, except as otherwise			required by the provisions of		
	-	de. NFPA 80 5.2.1 states fire			federal and state law.		
		all be inspected and tested not a written record of the			1) Immediate actions take		
	-	signed and kept for inspection			for those residents identified  No resident or staff were		
	-	80, 5.2.3.1 states functional			found to be affected by the	5	
	-	and window assemblies shall			deficiency.		
	-	lividuals with knowledge and					
		e operating components of			2) How the facility identific	ed	
		ng subject to testing. NFPA			other residents:		
		e door assemblies shall be			· Residents that reside at	the	
		rom both sides to assess the			community have the potential		
	overall condition of	door assembly.			be affected by the alleged defi	cient	
					practice.		
		ates as a minimum, the					
	following items sha	Il be verified:			3) Measures put into place	<del>)</del> /	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet Page 16 of 26

PRINTED: 10/19/2022

DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES			OM	B NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED		
		155295	B. WING			09/26/2022			
				STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF P	ROVIDER OR SUPPLIER		809 W FREEMAN ST						
CLINTON	I HOUSE REHABIL	ITATION AND HEALTHCARE CEN	NTE	FRANK	FORT, IN 46041				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	l I	ID			(X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO			COMPLETION			
m	DECLII LEODII OD	LCC IDENTIFYING DIFFORM ATION	T. C		CROSS-REFERENCED TO THE APPROPRIA	.IE	D. A. WIE		

X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	(1) No open holes or breaks exist in surfaces of		System Changes:	
	either the door or frame.		· The Maintenance	
	(2) Glazing, vision light frames, and glazing beads		Director/designee will ensure	
	are intact and securely fastened in place, if so		annual door assembly inspections	
	equipped.		are completed and documentation	
	(3) The door, frame, hinges, hardware, and		of inspection is in the facility	
	noncombustible threshold are secured, aligned,		according to LSC.	
	and in working order with no visible signs of		· Maintenance	
	damage.		Director/designee will door	
	(4) No parts are missing or broken.		assemblies monthly to ensure no	
	(5) Door clearances do not exceed clearances		holes or breaks exist in surfaces	
	listed in 4.8.4 and 6.3.1.7.		of either the door or frame.	
	(6) The self-closing device is operational; that is,		or other the door of frame.	
	the active door completely closes when operated		4) How the corrective	
	from the fully open position.		actions will be monitored:	
	(7) If a coordinator is installed, the inactive leaf		· The Maintenance	
	closes before the active leaf.		Director/designee will present the	
	(8) Latching hardware operates and secures the		Door inspections to the QAPI	
	door when it is in the closed position.		Committee during QAPI Meetings	
	(9) Auxiliary hardware items that interfere or		to ensure completion and	
	prohibit operation are not installed on the door or		compliance.	
	frame.		The results of these audits	
	(10) No field modifications to the door assembly		will be reviewed in Quality	
	have been performed that void the label.		Assurance Meeting monthly for 6	
	(11) Gasketing and edge seals, where required, are		months or until 100% compliance	
	inspected to verify their presence and integrity.		is achieved. The QA Committee	
	This deficient practice could affect all occupants.		will identify any trends or patterns	
	This deficient practice could arrest air occupants.		and make recommendations to	
	Findings include:		revise the plan of correction as	
	Thiangs metade.		indicated.	
	Based on record review with the Maintenance		maioatou.	
	Director on 09/26/22 at 10:24 a.m., the facility		5) Date of compliance:	
	could not provide an annual inspection of the fire		10.12.2022	
	door assemblies for review. Based on observation		10.12.2022	
	during the tour between 12:30 a.m. and 2:00 p.m.,			
	there were two fire door assemblies noted in the			
	building. Based on interview at the time of records			
	review, the Maintenance Director stated an annual			
	inspection was not conducted for the fire door			
	assemblies in the last year. On 09/26/22 at 2:38			1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192 If continuation sheet Page 17 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	COMPLETED	
		155295	B. W	B. WING 09/26/2022				
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>		
NAME OF P	ROVIDER OR SUPPLIER	₹			FREEMAN ST			
CLINTON	I HOUSE REHABII	ITATION AND HEALTHCARE C	ENTE		FORT, IN 46041			
OLINTOI	THOUGH REHABIL	THATION AND HEALTHOAKE O	LINIL	TIVAINI				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		it conference with the facility						
		tor and the Executive Director,						
		nation or evidence could be						
	provided contrary to	o this deficient finding.						
	3.1-19(b)							
V 0014	NEDA 404							
K 0914 SS=F	NFPA 101	- Maintananaa and						
Bldg. 01	-	s - Maintenance and						
Diug. 01	Testing	. Maintananaa and						
	Testing	s - Maintenance and						
	•	ceptacles at patient bed						
	. •	ere deep sedation or general						
		ninistered, are tested after						
		replacement or servicing.						
		is performed at intervals						
	_	ented performance data.						
	_	isted as hospital-grade at						
	-	re tested at intervals not						
		nths. Line isolation monitors						
		are tested at intervals of						
	, ,	to 1 month by actuating						
	-	h per 6.3.2.6.3.6, which						
		ual and audible alarm. For						
		automated self-testing, this						
		formed at intervals less						
	-	2 months. LIM circuits are						
	•	.2 after any repair or						
	-	electric distribution system.						
		tained of required tests and						
	associated repairs	*						
	-	oom or area tested, and						
	results.	•						
	6.3.4 (NFPA 99)							
		on, record review and	K 0	914	K914 SS = F Electrical		10/12/2022	
	interview, the facili	ty failed to ensure			Systems Maintenance and			
	approximately 270	of 270 nonhospital-grade			Testing			
		es at resident room locations			The facility requests paper			
	_	annually. NFPA 99, Health			compliance for this citation.			

10/19/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2022 155295 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Care Facilities Code 2012 Edition, Section 6.3.4.1.3 This plan of Correction is the states receptacles not listed as hospital-grade, at center's credible allegation of patient bed locations and in locations where deep compliance. sedation or general anesthesia is administered, Preparation and/or execution of shall be tested at intervals not exceeding 12 this plan of correction does not months. Additionally, Section 6.3.3.2, Receptacle constitute admission or agreement Testing in Patient Care Rooms requires the by the provider of the truth of the physical integrity of each receptacle shall be facts alleged or conclusions set confirmed by visual inspection. The continuity of forth in the statement of the grounding circuit in each electrical receptacle deficiencies. The plan of shall be verified. Correct polarity of the hot and correction is prepared and/or neutral connections in each electrical receptacle executed solely because it is shall be confirmed; and retention force of the required by the provisions of grounding blade of each electrical receptacle federal and state law. (except locking-type receptacles) shall be not less Immediate actions taken than 115 grams (4 ounces). This deficient practice for those residents identified: could affect all residents. No resident or staff were found to be affected by the Findings include: deficiency. Based on record review with the Maintenance How the facility identified Director on 09/26/22 at 10:44 a.m., the facility other residents: could not provide an annual inspection of the Residents that reside at the resident room electric receptacles for review. community have the potential to Based on interview at the time of record review, be affected by the alleged deficient the Maintenance Director indicated there was no practice. documentation receptacle testing and that he was unaware of the need for them to be tested. Based Measures put into place/ **System Changes:** on observations made during a tour of the facility, it was determined that the resident rooms did not The Maintenance have hospital grade receptacles. On 09/26/22 at Director/designee will ensure annual resident room electrical 2:38 p.m., during the exit conference with the facility Maintenance Director and the Executive receptacle inspections are Director, no additional information or evidence completed and documentation of

FORM CMS-2567(02-99) Previous Versions Obsolete

finding.

3.1-19(b)

could be provided contrary to this deficient

Event ID: DCHE21

Facility ID: 000192

inspection is in the facility

Director/designee will ensure electrical resident room receptacle

inspections are completed

according to LSC. Maintenance

If continuation sheet

Page 19 of 26

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295		JILDING	nstruction 01	(X3) DATE COMPL 09/26/	ETED
	ROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CE	NTE	809 W F	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	: NATE	(X5) COMPLETION DATE
K 0918	NFPA 101				monthly to ensure visual and physical compliance NFPA9:  4) How the corrective actions will be monitored:  The Maintenance Director/designee will preser receptacle inspections to the QAPI Committee during QAF Meetings to ensure completi and compliance.  The results of these awill be reviewed in Quality Assurance Meeting monthly months or until 100% compli is achieved. The QA Commiwill identify any trends or pat and make recommendations revise the plan of correction indicated.  5) Date of compliance: 10.12.2022	g.  Int the second or seco	
SS=C Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfo NFPA 110. Generator sets are	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to nis capability for the life branches. Maintenance generator and transfer loces are transfer loces in accordance with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet

Page 20 of 26

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		A. BUILDING <u>01</u> COMP			(X3) DATE COMPL 09/26/	ETED	
	PROVIDER OR SUPPLIED N HOUSE REHABII	LITATION AND HEALTHCARE CEI	NTE	809 W I	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041	<u>,                                      </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION intervals, and exercised		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	once every 36 mc Scheduled test ur a complete simula automatic or man loads, and are copersonnel. Mainte energy power sou accordance with licircuit breakers a program for periocomponents is esmanufacturer req of maintenance a and readily availa and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1 1) Based on record facility failed to en inspections for the 14 of 52 weeks. Nigenerators shall be NFPA 110, Standar Power Systems. NI Emergency Power including all appur inspected weekly a 99, 6.4.4.2 requires performance, exercing generator to be reg for inspection by the simulation of the simulation of the second control of the sec	anths for 4 continuous hours. Inder load conditions include ated cold start and ual transfer of all EES Inducted by competent enance and testing of stored arces (Type 3 EES) are in INFPA 111. Main and feeder re inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels earked, readily identifiable, in normal power circuits. In a dissibility of damage of the resource is a design mew installations.  In (NFPA 99), NFPA 110, in (NFPA 70) In review and interview, the source a written record of weekly generator was maintained for in accordance with red for Emergency and Standby items of the emaintained in accordance with red for Emergency and Standby items of the emaintained in the emaintained in the emaintained in accordance with red for Emergency and Standby items of the emaintained in the emaintained in the emaintained in the emaintained in the emaintained and available are authority having efficient practice could affect all	K 09	918	K918 SS = C Electrical Systems – Essential Electric System Maintenance and Testing The facility requests paper compliance for this citation. This plan of correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	of ot ement the	09/29/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet Page 21 of 26

10/19/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2022 155295 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE required by the provisions of Based on record review of the facility's generator federal and state law. inspection documentation for the most recent 1) Immediate actions taken for twelve-month period with the Maintenance those residents identified: Director during record review at 10:34 a.m. weekly No resident was found to generator inspection documentation for 14 weeks be affected by the finding. of the most recent 52-week period was not Generator inspected and available for review. (October, November, or service completed January through December of 2021) Based on an interview at the Current time of record review, the Maintenance Director Generator inspection from indicated the facility did test the facility generator previous director for fourth quarter as the code requires, but the previous were thrown away Maintenance Director was terminated and threw 2) How the facility identified away his records for that time period. Because he other residents: began in his position of January 1st of 2022, he Visitors, staff and residents had no access to the other Maintenance Directors have that reside at the community documents. On 09/26/22 at 2:38 p.m., during the have the potential to be affected exit conference with the facility Maintenance by the alleged deficient practice. Director and the Executive Director, no additional 3) Measures put into place/ information or evidence could be provided System changes: contrary to this deficient finding. Maintenance Director re-educated on preventative 3.1-19(b) maintenance program and Maintenance Director/designee 2) Based on record review and interview, the will ensure inspection of generator facility failed to maintain a complete written record is completed weekly. of monthly generator load testing for 3 of the last 4) How the corrective actions 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 will be monitored: requires monthly testing of the generator serving The Maintenance the emergency electrical system to be in Director/designee will present electrical systems to the QAPI

accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all

to ensure completion and compliance. The Executive Director will review the Preventative Maintenance Worksheets monthly.

Committee during QAPI Meetings

The results of these audits will be reviewed in Quality

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		r í	JILDING	onstruction  01	(X3) DATE : COMPL 09/26/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD FREEMAN ST		
CLINTON	N HOUSE REHABIL	ITATION AND HEALTHCARE CE	NTE		FORT, IN 46041		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	inspection document twelve-month period Director during recommonthly generator is months of the most not available for review indicated the facility as the code requires Maintenance Direct away his records for began in his position had no access to the documents. On 09/2 exit conference with Director and the Ex	for was terminated and threw r that time period. Because he n of January 1st of 2022, he e other Maintenance Directors 26/22 at 2:38 p.m., during the h the facility Maintenance ecutive Director, no additional ence could be provided			Assurance Meeting monthly for months or until 100% compliar is achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as indicated.  5) Date of compliance: 09/29/2022	nce ee rns	
	3.1-19(b)						
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ecceptors Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 cc Storage locations enclosure or within	Cylinder and Container  Cylinder and Container  qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2  cubic feet are outdoors in an an enclosed interior mited- combustible					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192

If continuation sheet Page 23 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING			COMPLETED	
		155295	B. WI	NG		09/26/	2022	
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CE	NTE	809 W F	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.C.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE	
	that can be secure stored with flamms from combustibles sprinklered) or end noncombustible or minimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas of less than or equivalent or equivalent care areas of less than or equivalent cylinders must be as specified in 11. A precautionary significant on each door or groom, where the saminimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with interestablished. Empty contact the stablished.	ign readable from 5 feet is ate of a cylinder storage sign includes the wording as FION: OXIDIZING GAS(ES) I NO SMOKING." Id so cylinders are used in y are received from the cylinders are segregated. When facility employs gral pressure gauge, a e considered empty is ty cylinders are marked to Cylinders stored in the open						
	11.3.1, 11.3.2, 11. 99)	.3.3, 11.3.4, 11.6.5 (NFPA	L O	022	K022 SS = E Coo Emiliamon	4	00/20/2022	
	failed to ensure 8 of gases such as oxyge falling. NFPA 99, I 2012 Edition, Section nonflammable gase (300 cubic feet) but (3000 cubic feet) sh	on and interview, the facility of 8 cylinders of nonflammable en were properly secured from Health Care Facilities Code, on 11.3.2 states storage for s greater than 8.5 cubic meters eless than 85 cubic meters hall comply with 11.3.2.1 UFPA 99. Section 11.3.2.6 states	K 09	923	K923 SS = E Gas Equipmen Cylinder and Container Storage The facility requests paper compliance for this citation. This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of		09/29/2022	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DCHE21 Facility ID: 000192 If continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		A. B	A. BUILDING <u>01</u> CO			DATE SURVEY OMPLETED 9/26/2022	
	PROVIDER OR SUPPLIEI N HOUSE REHABII	LITATION AND HEALTHCARE C	ENTE	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST (FORT, IN 46041		
	SUMMARY (EACH DEFICIENT REGULATORY OF Cylinder or contains 11.6.2.3. Section 1 cylinders shall be pring a proper cylinder practice could affect the oxygen transfill Findings include:  Based on observation Director during a to 2:19 p.m., eight 'E' standing upright on storage and transfill the entry door. Base observation, the Macknowledged the control of transfilling room with the aforemention transfilling room with the facility Macknowledged the control of the contro	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION er restraints shall comply with 1.6.2.3(11) states freestanding roperly chained or supported er stand or cart. This deficient ext as many as 4 staff in or near ing room.  on with the Maintenance our of the facility on 09/26/22 at type oxygen cylinders was the floor of the oxygen ling room immediately behind ed on interview at the time of	ENTE	809 W	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  this plan of correction does not constitute admission or agreed 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.  1) Immediate actions taken for those residents identified:  No resident was found to be affected by the finding.  2) How the facility identified other residents:  Visitors, staff, and residents have that reside at the community have the potential to be affected by the alleged deficience.  3) Measures put into place/System changes:  Facility has removed the oxygen cylinder. An Audit was completed throughout the who house to ensure no other oxyge cylinders have been stored improperly. No other were local	t ment he et  or o ne to ccient le le en	(X5) COMPLETION DATE
					4) How the corrective actions will be monitored:  The Maintenance Director/designee will audit 5 random Resident rooms weekl ensure oxygen cylinders if presare stored correctly for 6 montl The audit will be reviewed presin QAPI Meetings to ensure completion and compliance.	y to sent hs.	

The results of these audits

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/19/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED <u>01</u> 155295 B. WING 09/26/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE FRANKFORT, IN 46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as

indicated.

9/29/2022

5) Date of compliance:

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DCHE21 Facility ID: 000192 If continuation sheet Page 26 of 26