STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155295	A. BUILDING -- B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE	809 W FREEMAN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/26/22 Facility Number: 000192 Provider Number: 155295 AIM Number: 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 certified beds. At the time of the survey, the census was 77. Quality Review completed on 09/29/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 482.15(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/26/22 at 10:34 a.m., the facility could not provide weekly or monthly generator testing for October, November, or December of 2021. Based on interview at the time of record review, the Maintenance Director acknowledged that the facility could not provide the aforementioned documentation stating that the previous Maintenance Director was terminated and threw away his records for that time period. Because he began in his position on January 1st, he had no access to the other Maintenance Directors documents. 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 finding.	E 0041	**E041 – SS=C Hospital CAH and 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 not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set 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 to be affected by the finding. · Generator Service was completed January 2022 forward and will continue to be documented per regulations. **2.) How the facility identified other residents:** · Visitors, staff and residents that reside at the community have the potential to be affected by the	09/29/2022

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			alleged deficient practice. **3.) Measures put into place/ System changes:** · Weekly inspections log to be maintained per regulations. **4.) How the corrective actions will be monitored:** · Generator inspection will be monitored by Maintenance Director/ED/designee weekly for six months. · The results of these audits 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. · The Executive Director will review the Preventative Maintenance Worksheets monthly. **5.) Date of compliance: 09/29/2022**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/26/22 Facility Number: 000192	K 0000		

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	Provider Number: 155295 AIM Number: 100291120 At this Life Safety Code survey, Clinton House Rehabilitation and Healthcare Centerwas found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 88 and had a census of 77 at the time of this visit. All areas where residents have customary access were sprinklered. All areas which provided facility services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 09/29/22			
K 0222 SS=B Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are			

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	used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable 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 ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies			

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	installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50 residents, staff and visitors if needing to exit the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 09/26/22 at 1:08 p.m., the main entry / exit to the facility was magnetically locked and could be opened by entering a four-digit code but the code posted at the door read "* address" whereas the facility address is not common knowledge. Based on an interview at the time of the observation, the Maintenance Director stated the code posted in such a way as to prevent residents from eloping. On 09/26/22 at 2:30 p.m. it was noted that the facility had changed the posting at the front door	K 0222	**K222 – SS=B Egress Doors** **This Facility respectively requests a desk review for this citation.** *This Plan of Correction is the centers credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident was found to be affected by the findings. · Egress Doors 1-8 has a code posted a four digit that is common knowledge. **2) How the facility identified other residents:**	09/29/2022

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	to read that the door code was * 8 0 9 and therefore this deficiency was fixed prior to my exiting of the facility. 3.1-19(b)		· Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director/ED/Designee will review posted door codes monthly to ensure compliance. **4) How the corrective actions will be monitored:** · The results of these tests will be reviewed in Quality Assurance Meetings 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. **5) Date of compliance: 09/29/2022**	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure of 12 of 12 battery backup lights were tested monthly for 30 seconds for three of the last twelve months to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5	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

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	weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Maintenance Director on 09/26/22 at 10:28 a.m., the facility could not provide monthly testing the battery-operated emergency lights for October, November, or December of 2021. Based on an interview at the time of record review, the Maintenance Director indicated the facility has battery operated emergency exit lights throughout the facility were tested monthly but the previous Maintenance Director was terminated 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 Maintenance Directors documents. 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 finding. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** **Issue #1-facilty testing has been completed to ensure that emergency illumination is provided to identified areas by the facility generator. No residents identified as being affected.** **Issue#2-Emergency power light has been tested for functionality. No resident identified as being affected** **2) How the facility identified other residents:** **No residents identified as being affected** **3) Measures put into place/ System changes:**	

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			Issue #1 , Issue #2- added to preventative maintenance program for annual testing and results to be recorded. **4) How the corrective actions will be monitored:** **Maintenance Supervisor/designee will monitor through facility preventative maintenance manual annually any identified issues will be immediately corrected to ensure compliance.** **The results of these audits 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.** **5) Date of compliance: 10/12/2022**	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	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 failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review of the facility's sprinkler	K 0353	**K353 SS=C SPRINKLER 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 of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken**	09/29/2022

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	system inspection documentation for the most recent twelve-month period with the Maintenance Director during record review from 9:15 a.m. to 1:05 p.m. on 09/26/22, weekly dry sprinkler system gauge inspection documentation for 14 weeks of the most recent 52-week period was not available for review. (October, November, or December of 2021) In addition, monthly inspection documentation for all sprinkler system control valves for 3 months of the most recent 12-month period was not available for review either. Based on an interview at the time of record review, the Maintenance Director indicated the facility did inspect the sprinkler system control valves and gauges as the code requires, but the previous Maintenance Director was terminated 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 Maintenance Directors documents. 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 finding. 3.1-19(b)		**for those residents identified:** · Inspections have been conducted January to present per regulations · Continued system inspections in accordance with NFPA25 will be documented, recorded and available for review. **2)How the facility identified other residents:** Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3)Measures put into place/ System changes:** · Maintenance director will ensure through the TELS program to have continued documentation of inspections per regulations. **4)How the corrective actions will be monitored:** · The Maintenance Director/designee will present the audits to the QAPI Committee during QAPI Meetings to ensure completion and compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 months The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	155295	A. BUILDING 01 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1) Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Director on 09/26/22 at 10:10 a.m., the facility could not provide fire drills for the fourth quarter (October, November, or December) of 2021. Based on an interview at the time of record review, the Maintenance Director indicated the facility did conduct fire drills as the code requires, but the previous Maintenance Director was terminated 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	K 0712	**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 of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident was found to	10/12/2022

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	Maintenance Directors documents. 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 finding. 3.1-19(b) 3.1-51(c) 2) Based on record review and interview, the facility failed to ensure 8 of 9 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the documentation entitled "Fire Drill Report" with the Maintenance Director on 09/26/22 at 10:13 a.m., only one of the fire drills conducted within the last nine-month period (October, November, and December's drills were not available for review) documented the transmission of the fire alarm signal with the alarm monitoring company. Based on interview at the time of record review, the Maintenance Director indicated that he was unaware the necessity to 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		be affected by this alleged deficiency. · Maintenance Director was educated on fire drills, timings, and documentation. · The fourth quarter documents lost prior to current directors employment all other documents are in place and will continue per regulations **2) How the facility identified other residents:** · Residents, staff, and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director will review fire drill log to ensure compliance. The Maintenance Director was re-educated on the Preventative Maintenance Program and fire drill requirements by the Executive Director/designee · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance. · The results of these audits will be reviewed in Quality Assurance Meetings monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify and trends or patterns and make recommendations to revise the plan of correction as	

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	finding. 3.1-19(b) 3.1-51(c)		indicated. **5) Date of compliance:** **10.12.2022**	
K 0761 SS=F Bldg. 01	Based on observation, record review and interview, the facility failed to ensure annual inspection and testing of 2 of 2 door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:	K 0761	**K761 SS = F Maintenance, Inspection & Testing - Doors** **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 not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident or staff were found to be affected by the deficiency. **2) How the facility identified other residents:** · Residents that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/**	10/12/2022

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	(1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/26/22 at 10:24 a.m., the facility could not provide an annual inspection of the fire door assemblies for review. Based on observation 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		**System Changes:** · The Maintenance Director/designee will ensure annual door assembly inspections are completed and documentation of inspection is in the facility according to LSC. · Maintenance Director/designee will door assemblies monthly to ensure no holes or breaks exist in surfaces of either the door or frame. **4) How the corrective actions will be monitored:** · The Maintenance Director/designee will present the Door inspections to the QAPI Committee during QAPI Meetings to ensure completion and compliance. · The results of these audits 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. **5) Date of compliance:** **10.12.2022**	

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	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 finding. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure approximately 270 of 270 nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health	K 0914	**K914 SS = F Electrical Systems Maintenance and Testing** **The facility requests paper compliance for this citation.**	10/12/2022

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	Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 09/26/22 at 10:44 a.m., the facility could not provide an annual inspection of the resident room electric receptacles for review. Based on interview at the time of record review, the Maintenance Director indicated there was no documentation receptacle testing and that he was unaware of the need for them to be tested. Based on observations made during a tour of the facility, it was determined that the resident rooms did not have hospital grade receptacles. 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 finding. 3.1-19(b)		*This plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · No resident or staff were found to be affected by the deficiency. **2) How the facility identified other residents:** · Residents that reside at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System Changes:** · The Maintenance Director/designee will ensure annual resident room electrical receptacle inspections are completed and documentation of inspection is in the facility according to LSC. · Maintenance Director/designee will ensure electrical resident room receptacle inspections are completed	

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			monthly to ensure visual and physical compliance NFPA99. **4) How the corrective actions will be monitored:** · The Maintenance Director/designee will present the receptacle inspections to the QAPI Committee during QAPI Meetings to ensure completion and compliance. · The results of these audits 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. **5) Date of compliance: 10.12.2022**	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 14 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. Findings include:	K 0918	**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 of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	09/29/2022

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	Based on record review of the facility's generator inspection documentation for the most recent twelve-month period with the Maintenance Director during record review at 10:34 a.m. weekly generator inspection documentation for 14 weeks of the most recent 52-week period was not available for review. (October, November, or December of 2021) Based on an interview at the time of record review, the Maintenance Director indicated the facility did test the facility generator as the code requires, but the previous Maintenance Director was terminated and threw away his records for that time period. Because he began in his position of January 1st of 2022, he had no access to the other Maintenance Directors documents. 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 finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in 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		*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. · Generator inspected and service completed January through Current · Generator inspection from previous director for fourth quarter were thrown away **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 deficient practice. **3) Measures put into place/ System changes:** · Maintenance Director re-educated on preventative maintenance program and Maintenance Director/designee will ensure inspection of generator is completed weekly. **4) How the corrective actions will be monitored:** · The Maintenance Director/designee will present electrical systems to the QAPI Committee during QAPI Meetings to ensure completion and compliance. · The Executive Director will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality	

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	occupants. Findings include: Based on record review of the facility's generator inspection documentation for the most recent twelve-month period with the Maintenance Director during record review at 10:34 a.m. monthly generator inspection documentation for 3 months of the most recent 12-month period was not available for review. (October, November, or December of 2021) Based on an interview at the time of record review, the Maintenance Director indicated the facility did test the facility generator as the code requires, but the previous Maintenance Director was terminated and threw away his records for that time period. Because he began in his position of January 1st of 2022, he had no access to the other Maintenance Directors documents. 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 finding. 3.1-19(b)		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. **5) Date of compliance: 09/29/2022**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible			

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CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE	809 W FREEMAN ST FRANKFORT, IN 46041

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	construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 8 of 8 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states	K 0923	**K923 SS = E Gas Equipment – 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 01 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE	809 W FREEMAN ST FRANKFORT, IN 46041

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	cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect as many as 4 staff in or near the oxygen transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 09/26/22 at 2:19 p.m., eight 'E' type oxygen cylinders was standing upright on the floor of the oxygen storage and transfilling room immediately behind the entry door. Based on interview at the time of observation, the Maintenance Director acknowledged the eight 'E' type oxygen cylinders in the aforementioned oxygen storage and transfilling room was not properly chained or supported in a proper cylinder stand or cart. 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 finding. 3.1-19(b)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **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 deficient practice. **3) Measures put into place/ System changes:** · Facility has removed the 1 oxygen cylinder. An Audit was completed throughout the whole house to ensure no other oxygen cylinders have been stored improperly. No other were located. **4) How the corrective actions will be monitored:** · The Maintenance Director/designee will audit 5 random Resident rooms weekly to ensure oxygen cylinders if present are stored correctly for 6 months. The audit will be reviewed present in QAPI Meetings to ensure completion and compliance. · The results of these audits	

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			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. **5) Date of compliance: 9/29/2022**	