Tracy Wells

PRINTED: 11/15/2023 FORM APPROVED OMB NO. 0938-039

11/03/2023

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295		JILDING ING	ONSTRUCTION	(X3) DATE COMPL 10/11/	ETED
NAME OF P	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD FREEMAN ST		
CLINTON	N HOUSE REHABIL	LITATION AND HEALTHCARE C	ENTE		FORT, IN 46041		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
E 0000							
Bldg			E 00	000	Each tag will have a plan of correction attached/submitted	i	
	Facility Number: 0 Provider Number: AIM Number: 100	155295					
	House Rehabilitation found in compliance Preparedness Requirements	Preparedness survey, Clinton on and Healthcare Center was e with Emergency irements for Medicare and ting Providers and Suppliers, 42					
	The facility has 88 the survey, the cens	certified beds. At the time of sus was 68.					
	Quality Review cor	mpleted on 10/19/23					
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR	K 0	000	Each tag will have a plan of correction attached/submitted	i	
	Facility Number: 0 Provider Number: AIM Number: 100	000192 155295 291120					
	At this Life Safety	Code survey, Clinton House					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

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.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' A. BUILDING 01 COMPLETE B. WING 10/11/202			ETED		
	PROVIDER OR SUPPLIER	LITATION AND HEALTHCARE CE	NTE	809 W F	DDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	Rehabilitation and I not in compliance w Participation in Med Subpart 483.90(a), 12012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one-story facil Type III (200) consisprinklered. The facility has a care of 68 at the time of All areas where resisted were sprinklered. A services were sprinklered. A services were sprinklered.	idents have customary access Il areas which provided facility klered except for one detached		TAG	DEFICIENCY)		DATE
K 0222 SS=F Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one lock permitted on each	ed means of egress shall not a latch or a lock that of a tool or key from the s using one of the following rangements: S OR SECURITY THREAT king arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155295	B. WI	NG		10/11/	/2023
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			FREEMAN ST		
CLINTO	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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	l of locks; keying of all					
	locks or keys carried by staff at all times; or						
		e means available to the					
	staff at all times.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	1.00(4)10					
	SPECIAL NEEDS						
	ARRANGEMENT	=					
	-	king arrangements for the					
		e 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						
	-	of power to the device; the					
		ed by a supervised					
	-	er system and the locked					
		d by a complete smoke					
	_	or is constantly monitored (or is constantly monitored)					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.	iged to dillock the doors					
	18.2.2.2.5.2, 19.2	2252 TIΔ 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
	_	lelayed-egress locking					
	• •	in accordance with					
	1 -	permitted on door					
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
	detection system or an approved, supervised						
	automatic sprinkler system.						
	18.2.2.2.4, 19.2.2	-					
	ACCESS-CONTR						
	LOCKING ARRANGEMENTS						
	Access-Controlled	d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 10/11/2023				ETED	
	PROVIDER OR SUPPLIER N HOUSE REHABIL	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an automatic fire dete approved, superv system. 18.2.2.2.4, 19.2.2 Based on observatifailed to ensure 5 o delayed egress was 7.2. LSC 7.2.1.6.1.d durable sign in lette high and not less th width on a contrast follows shall be loc to the release devic "PUSH UNTIL AL BE OPENED IN 13 This deficient pract staff, and visitors in Findings include: Based on observatifacility with the Ma from 11:30 a.m. to noted: a) the main entry de second delay egress signage for the doo b) the emergency e- signage for the doo c) the emergency e- rooms #418 and #4	it 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 2.4 on and interview, the facility ff 5 egress doors equipped for equipped as required by LSC (3) (4) states a readily visible, ers not less than 1 in. (25mm) an 1/8 in. (3.2mm) in stroke ing background that reads as eated on the door leaf adjacent e in the direction of egress: ARM SOUNDS. DOOR CAN 5 SECONDS". The could affect all residents, in the facility. The facility. The property of the stintenance Director on 10/11/23 (2:10 p.m. the following was poor to the facility had 15 is on it, but the required regimes on it, but the required	K 0	222	K222 – SS=F Egress Doors This Facility respectively requests a desk review for th 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 agreen by the provider of the truth of th facts alleged or conclusions se 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 affected by the findings. Egress Doors 1-8 has a code posted a four digit that is common knowledge. 15 second delay egress signage has been ordered as evidenced by attached order for	of t ment he et	10/31/2023

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not present.

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other residents:

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DEPARTMENT OF HEALTH AND HUN	MAN SERVICES	
CENTERS FOR MEDICARE & MEDIC	AID SERVICES	
CTATEMENT OF DEFICIENCIES	OVAL DE OVIDED (CLIDELIED /CLIA	α.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155295		r í	JILDING	nstruction 01	(X3) DATE : COMPL 10/11/	ETED	
	ROVIDER OR SUPPLIER I HOUSE REHABIL	ITATION AND HEALTHCARE CEI	NTE	809 W F	DDRESS, 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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	d) the emergency ex rooms #518 and #510 on it, but the requirement present. e) the emergency ex rooms #602 and #600 on it, but the requirement present. Based on interview Maintenance Direct noted egress doors with the delayed egress and because of the control o	tit doors nearest to resident 19 had 15 second delay egress 2d signage for the door was 2d had 15 second delay egress 2d had 15 second delay egress 2d signage for the door was 2d signage for the door was 2d the time of observation, the 2d or acknowledged the above 2d were equipped with 15 second 2d acked the proper signage. 2d viewed with the Administrator			Visitors, staff and resider that reside at the community he the potential to be affected by alleged deficient practice. 3) Measures put into place/ System changes: The Maintenance Director/ED/Designee will revie posted 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 f 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: 10/31/2023	ave the s or 6 oce er rns	
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, Ni Based on observation	n - Testing and n is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, n and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 on and interview, the facility	K 0	345	K345 SS = C Fire Alarm		10/24/2023
		e fire alarm system to assure time and date information in			System The facility requests paper		

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155295	B. W	ING		10/11	/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			FREEMAN ST		
CLINITON	N HOUSE DEHABI	LITATION AND HEALTHCARE O	ENITE		FORT, IN 46041		
CLINTOI	TIOUSE REHABII	ETTATION AND TIEAL THOAKE C	ZEINTE	FIVAINI			
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with the	e requirements of NFPA 101-			compliance for this citation.		
		ons 19.3.4 and 9.6 and NFPA 72			This plan of correction is the		
		tions 14.1, 14.1.1. This deficient			center's credible allegation of		
	practice could affect	et all residents, staff, and			compliance.		
	visitors.				Preparation and/or execution		
					this plan of correction does no		
	Findings include:				constitute admission or agree		
					by the provider of the truth of		
		ons made during a tour of the			facts alleged or conclusions se	et	
		aintenance Director on 10/11/23			forth in the statement of		
at 12:35 p.m., the time and date on the fire alarm control panel was incorrect. The display on the				deficiencies. The plan of			
				correction is prepared and/or			
	main fire alarm control panel indicated the date				executed solely because it is		
		25/23 at 10:47 p.m. when the			required by the provisions of		
		ne were 10/11/2023 at 12:36 p.m.			federal and state law.		
		at the time of observation, the			1) Immediate actions taken for	or	
		tor indicated he was unaware			those residents identified:		
		and would contact the alarm			No resident was found to		
		ne displayed date and time			affected by this alleged deficie	-	
		alarm control panel			Maintenance Director wa		
	immediately.				educated on fire alarm system	١,	
					testing and maintenance and		
		eviewed with the Administrator			documentation.		
	at the exit conferen	ice.			The Fire Alarm System I		
	2.1.10(1)				been updated for accurate tim	ie	
	3.1-19(b)				and date information in		
					accordance with NFPA.		
					2) How the facility identified		
					other residents:		
					Residents, staff, and vis		
					have the potential to be affect		
					by the alleged deficient practic	ce.	
					3) Measures put into place/		
					System changes:		
					The Maintenance Direct		
					will review fire panel to ensure		
					compliance. The Maintenance		
	ĺ				Director was re-educated on t	ne	I

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Preventative Maintenance Program and fire drill requirements by the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155295	B. W	ING		10/11/	2023
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CEI	NTE	809 W F	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST FORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II construction measure substituted for sprinklers where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and	Installation nd hospitals where required			Executive Director/designee The Maintenance Director responsible for compliance. 4) How the corrective actions will be monitored: An Environmental QAPI will be utilized monthly to mon compliance. The results of these aud will be reviewed in Quality Assurance Meetings monthly from months or until 100% compliant is achieved. The QA Committe will identify and trends or pattern and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10.24.2023	tool itor its for 6 nce ee	

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NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE PREFIX TAG SIMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Girden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler hall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Garden smoke compartment. Findings include: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 from 11:30 a.m. to 2:10 p.m. the following was noted: a) the four escutcheons in the "Miscellancous Gym were missing leaving agps around the sprinkler heads varying from 3/8 of an inch to 3/4 of an inch in diameter. b) the sprinkler head accerts to the dish washing machine in the kitchen had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheons was indeed missing in each of the aforementioned STREET ADDRESS. CITY, STATE, ZIP COD 809 WFREEMAN ST FRANKFORT, IN 46041 DD PREFIX TAG PREFIX T		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	ì í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 10/11/	ETED
CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SIMMARY STATEMENT OF DEFICIENCY REGULATORY OR ISE DENTIFYING INFORMATION Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Garden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler shall be compartment. Findings include: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 from 11:30 a.m. to 2:10 p.m. the following was noted: a) the four escutcheons in the "Miscellaneous Gym were missing leaving gaps around the sprinkler heads varying from 3/8 of an inch to 3/4 of an inch in diameter. b) the sprinkler head nearest to the dish washing machine in the kitchen had a missing escutcheons. Based on interview at the time of observation, the Maintenance Director on fired the secutcheons was indeed missing in each of the deforementationed a) the four escutcheons in the "Miscellaneous Gym were missing leaving gaps around the sprinkler head varying from 3/8 of an inch to 3/4 of an inch in diameter. b) the sprinkler head a mearest to the dish washing machine in the kitchen had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director on firmed the escutcheons was indeed missing in each of the deforementation of prepared and properties. The plan of correction to the center's credible allegation of correction is the center's credible allegation of correction does not constitute admission or agreement by the provider of the furth of the facility with the machine provider of the furth of the facility with the machine provider						ADDRESS, CITY, STATE, ZIP COD	. 5, . 1,	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) OR LSC IDENTIFYING INFORMATION Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.1, 19.3.5.1, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Garden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Garden smoke compartment. Findings include: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 from 11:30 a.m. to 2:10 p.m. the following was noted: a) the four escutcheons in the "Miscellaneous Gym were missing leaving gaps around the sprinkler heads varying from 3/8 of an inch to 3/4 of an inch in diameter. b) the sprinkler head nearest to the dish washing machine in the kitchen had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the secutcheons was indeed missing in each of the aforementioned Preparation and/or execution of this plan of correction 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: Inspections have been conducted of all four escutcheons noted in findings and all have been conducted of all four escutcheons noted in findings and all have been				809 W FREEMAN ST				
REGULATORY OR LSC IDENTIFYING INFORMATION Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Garden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Garden smoke compartment. Findings include: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 from 11:30 a.m. to 2:10 p.m. the following was noted: a) the four escutcheons in the "Miscellaneous Gym were missing leaving gaps around the sprinkler head acrease to the dish washing machine in the kitchen had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the seatcheons was indeed missing in each of the aforementioned COMPLETION TAG ROSS-REFERNATICACTION SHORD A TAGE ROSS-REFERNATICATION SHORD TAGE CROSS-REFERNATICATION A TAGE CROSS-REFERNATICATION A TO THE APPERIT TO THE APPERITE TO THE APPERI	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIS DI AN OF CORRECTION		(X5)
Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Garden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler than up to 43 residents in the Garden smoke compartment. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. 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. This Plan of Correction is the center's credible allegation of compliance. This Plan of correction 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. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of compliance. This Plan of Correction is the center's credible allegation of c	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the ceiling construction in 1 of 1 Garden Lounge was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Garden smoke compartment. Findings include: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 from 11:30 a.m. to 2:10 p.m. the following was noted: a) the four escutcheons in the "Miscellaneous Gym were missing leaving gaps around the sprinkler head nearest to the dish washing machine in the kitchen had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheons was indeed missing in each of the aforementioned System. INSTALLATION K 351 SS=E SPRINKLER SYSTEM-INSTALLATION 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: Inspections have been conducted of all four escutcheons noted in findings and all have been	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
areas. This finding was reviewed with the Administrator at the exit conference. This finding was reviewed with the Administrator at the exit conference. This finding was reviewed with the Administrator inspections in accordance with NFPA25 will be documented, recorded and available for review. This finding was reviewed with the Administrator inspections in accordance with NFPA25 will be documented, recorded and available for review.	TAG	Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure the Garden Lounge was Standard for the Instance of Ins	Illation of Sprinkler 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) 20 and interview, the facility ceiling construction in 1 of 1 is in accordance with NFPA 13, stallation of Sprinkler Systems. Ition, Section 6.2.7.1 states in or other devices used to eace around a sprinkler shall is be listed for use around a ceient practice could affect staff into in the Garden smoke 21.10 p.m. the following was been in the "Miscellaneous leaving gaps around the leaving from 3/8 of an inch to 3/4 iter. 22.10 an inch to 3/4 iter. 23.10 p.m. the following was been in the "Miscellaneous leaving gaps around the leaving from 3/8 of an inch to 3/4 iter. 23.11 device the dish washing then had a missing escutcheon. In at the time of observation, the cort confirmed the escutcheons is in each of the aforementioned in each of the Administrator	K 03		K351 SS=E SPRINKLER SYSTEM- INSTALLATION 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 not constitute admission or agree, by the provider of the truth of facts alleged or conclusions of 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 Inspections have been conducted of all four escutche noted in findings and all have repaired/corrected. As evident by attached photos. Continued system inspections in accordance with NFPA25 will be documented, recorded and available for rev	of ot ment the et cons been ced	10/30/2023

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

Event ID:

TZH221

Facility ID: 000192

92

other residents:

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PRINTED: 11/15/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295		UILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/11/2023		
	PROVIDER OR SUPPLIER N HOUSE REHABIL	ITATION AND HEALTHCARE C	STREET ADDRESS, CITY, STATE, ZIP COD 809 W FREEMAN ST ENTE FRANKFORT, 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 APPROPRI DEFICIENCY)	5.112		
					Visitors, staff and residents the reside at the community have potential to be affected by the alleged deficient practice.	e the		
					3)Measures put into place/ System changes: Maintenance director wi ensure through the TELS pro to have continued documenta of inspections per regulations	gram ation		
					4)How the corrective actions will be monitored:	s		
					The Maintenance Director/designee will present audits to the QAPI Committee during QAPI Meetings to ensu completion and compliance.	e		
					The results of these aud will be reviewed in Quality Assurance Meeting monthly fronths or until 100% complia is achieved times 3 months T QA Committee will identify and trends or patterns and make recommendations to revise the plan of correction as indicated	for 6 ance the ny		
					5) Date of compliance: 10/30/2023			
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the						

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

Event ID:

TZH221

Facility ID: 000192

If continuation sheet Page 9 of 24

DEPARTMENT OF H	EALTH AND HUMAN SERVICES	
CENTERS FOR MEDI	ICARE & MEDICAID SERVICES	

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ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. required by the provisions of federal and state law.			_					
(2) Openings in the mesh are equal to 70 percent or greater. federal and state law.		` '	••			_		
			mesh are equal to 70 percent					
		or greater.						
(3) The mesh extends a minimum of 22 inches 1 Immediate actions taken		(3) The mesh extend	ds a minimum of 22 inches			1 Immediate actions taken	ì	
down from the ceiling. for those residents identified:		down from the ceili	ng.			for those residents identified		

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

Event ID:

TZH221 Facility ID: 000192

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLI	ETED
		155295	B. W	ING		10/11/2	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			FREEMAN ST		
CLINTON	N HOUSE REHABIL	ITATION AND HEALTHCARE CEI	NTE		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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	tice could affect 18 residents			Inspection of privacy		
	and 4 staff.				curtains as identified in finding	ıs an	
				order has been placed as			
Finding includes:				evidenced on the attached PC			
					Order ensuring that at least 18		
		ons made during tour of the			inched is maintained below the		
		intenance Director on 10/11/23			level of the sprinkler deflectors	S.	
		vacy curtain in the shower			Continued system		
		l had a 9 inch mesh panel at the			inspections in accordance with	1	
	_	nd was hung on a horizontal			NFPA25 will be documented,	.	
	-	the curtain installed 8 inches			recorded and available for rev	iew.	
	_	ne shower area was not					
	-	inkler and the nearest sprinkler			2)How the facility identified		
		rom sprinkler coverage by the			other residents:		
		er room. Based on interview at			Visitors, staff and residents the		
		rvations, the Maintenance			reside at the community have	the	
		ged the aforementioned			potential to be affected by the		
		hung 8 inches from the ceiling mesh panel at the top of the			alleged deficient practice.		
		stended 17 inches from the			3)Measures put into place/		
		e required 22 inch minimum.			System changes:		
	C	•			Maintenance director wil	ı	
	This finding was re	viewed with the Administrator			ensure through the TELS prog		
	at the exit conference				to have continued documental		
					of inspections per regulations.		
	3.1-19(b)						
					4)How the corrective actions	,	
					will be monitored:		
					The Maintenance		
					Director/designee will present	the	
					audits to the QAPI Committee		
					during QAPI Meetings to ensu		
					completion and compliance.		
					Jampionali and Joinphallo.		
					The results of these aud	its	
					will be reviewed in Quality		
					Assurance Meeting monthly fo	or 6	
					months or until 100% complian		
					is achieved times 3 months Th		

PRINTED: 11/15/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/11/2023	
		ENTE	809 W	FREEMAN ST			
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	(X5) COMPLETION DATE	
				QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10.30.2023			
Portable Fire Extiner Portable fire extiner installed, inspected accordance with Nortable Fire Extiner 18.3.5.12, 19.3.5. Based on observating failed to ensure 1 of on the 500 hall were NFPA 10, Standard 2010 Edition. Sectif extinguishers shall where they will be immediately availate Preferable they shat paths of travel, include ficient practice will be laundry and serviced Findings include: Based on observating facility with the Material 1:36 p.m., the Allocated on the 500 for the standard provided in the standard	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility of 2 portable fire extinguishers e installed in accordance with I for Portable Fire Extinguishers, on 1-6.3 states Fire be conspicuously located readily accessible and ble in the event of a fire. Il be located along normal uding exits from areas. This rould affect all staff only in the e hall areas. ons made during a tour of the aintenance Director on 10/11/23 BC portable fire extinguisher Hall directly across from the	K 0	355	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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	nent ne t	10/11/2023	
	NFPA 101 Portable Fire Extinguishers shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall where they will be immediately availal Preferable they shall at 1:36 p.m., the Allocated on the 500 Nurses' station was	NFPA 101 Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas.	NFPA 101 Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 10/11/23 at 1:36 p.m., the ABC portable fire extinguisher located on the 500 Hall directly across from the Nurses' station was obstructed by a Hoyer lift.	NFPA 101 Portable Fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas. 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WING RECEIVED A SUPPLIER NHOUSE REHABILITATION AND HEALTHCARE CENTE REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers R. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable Fire extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas. R. 3.3 p.m., the ABC portable fire extinguisher located on the 500 Hall directly across from the Nurse' station was obstructed by a Hoyer lift.	DEFICIENCIES OF CORRECTION DENTIFICATION NUMBER 155295 PROVIDER OR SUPPLIER NOUSE REHABILITATION AND HEALTHCARE CENTE SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRICEDED BY PULL REGULATORY OR I.S. IDENTIFYING INFORMATION NFPA 101 Portable Fire Extinguishers Portable Fire extinguishers Portable Fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers on the 500 hall were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers and the conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 10/11/23 at 13:50 p.m., the ABC portable fire extinguisher located on the 500 Hall directly across from the Nurses' station was obstructed by a Hoyer lift.	

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Maintenance Director acknowledged the fire

extinguisher located on the 500 Hall directly

across from the nurses' station as being

Event ID:

TZH221

Facility ID: 000192

affected by the finding.

other residents:

2) How the facility identified

If continuation sheet

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PRINTED: 11/15/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155295	B. W	ING		10/11/	/2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			FREEMAN ST		
CLINTON	N HOUSE REHABII	LITATION AND HEALTHCARE C	ENTE		KFORT, IN 46041		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		hat he would speak with staff			Visitors, staff, and reside		
	about the issue.				have that reside at the commu	-	
This finding was reviewed with the Administrator				have the potential to be affect			
				by the alleged deficient practic	ce.		
	at the exit conferen	ce.			3) Measures put into place/		
	2.1.10(1-)				System changes:		
	3.1-19(b)				Facility has in serviced s		
					and removed the obstruction of ABC portable fire extinguisher		
					located on Hall 500. An Audit		
					completed throughout the who		
					house to ensure no other Fire		
					Extinguishers were obstructed		
					other were located.		
					4) How the corrective actions		
					will be monitored:		
					The Maintenance		
					Director/designee will audit the		
					whole house weekly to ensur		
					portable fire extinguishers are		
					from obstructions, for 6 month	ıs.	
					The audit will be reviewed pre	sent	
					in QAPI Meetings to ensure		
					completion and compliance.		
					The results of these aud	its	
					will be reviewed in Quality	_	1
					Assurance Meeting monthly for		
					months or until 100% complia		
					is achieved. The QA Committee		
					will identify any trends or patter		
					and make recommendations t		
					revise the plan of correction a indicated.	5	
					5) Date of compliance:		1
					10/11/2023		
					10/11/2023		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting	corridor openings in other					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	ì	JILDING	nstruction 01	(X3) DATE : COMPL 10/11/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 809 W FREEMAN ST ENTE FRANKFORT, IN 46041					
(X4) ID		ITATION AND HEALTHCARE CEN	NIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible materials and the door closed with a constant of t	osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its griff of at least 20 fully sprinklered smoke only required to resist the concrider doors and doors in its have positive latching atches are prohibited by these requirements do not espaces that do not contain bustible material. In bottom of door and floor deeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the res. Hold open devices that door is pushed or pulled are ded protective plates of the permitted. Dutch doors of are permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
	devices, etc.	on and interview, the facility	K 0	363	K363 SS= E Corridor -Doors	;	10/29/2023	

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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 10/11/2023			
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CE	NTE	809 W I	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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	failed to ensure 1 of completely resist the Life Safety Code 20 "Doors protecting of required enclosures hazardous areas shat passage of smoke at following: 1) 1 3/4 inch (44 mm 2) Materials that resiminates." This deficient pract residents, 4 staff and Findings include: Based on observation facility with the Mat 12:26 p.m., the detended the West Hall had a approximately 5/8th way through the doep passage of smoke the of a fire. Based on it observation, the Matheway acknowledged the factorial through the door ad hole fixed as soon as the safety of the s	F1 door to the corridor would be passage of smoke. NFPA 101 1012 edition at 19.3.6.3.1 states orridor openings in other than of vertical openings, exits, or all be constructed to resist the end shall be constructed of the object of the end shall be constructed of the object of the end shall be constructed of the end of the end of end of the end of the end of end of the end of end of the event end of end of end of the event end of e			The facility request 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 not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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 take for those residents identified. No resident was found the affected by the deficiency. The 5/8ths of an inch has been sealed. 2 How the facility identified other residents: Residents, staff, and visit have the potential to be affected by the alleged deficient practions. Measures put into place by the alleged deficient practions. Contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. Maintenance Director/designed will inspect for penetrations proper for completion. The Maintenance Director responsible for compliance. 4 How the corrective active acti	of ot ement the set n d: to be ble in om d ded sitors ted ce. el The ee rior tor is	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		A. BUILDING 01 B. WING		COMPLETED 10/11/2023	
	ROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CEI	809 W	FADDRESS, 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
K 0374 SS=E Bldg. 01	Barrie Subdivision of Buil Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that re Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, at in the direction of o provides a minimu for swinging or hot 19.3.7.6, 19.3.7.8, Based on observatio failed to ensure 1 of would restrict the minimum.	esists fire for 20 minutes. The plates of unlimited height one are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening m clear width of 32 inches rizontal doors.	K 0374	will be monitored: An Environmental QAPI will be utilized monthly to mon compliance with smoke barrie walls. The results of these aud will be reviewed in Quality Assurance Meeting Monthly for months or until 100% complia is achieved. The QA Committe will identify any trends or patte and make recommendations to revise the plan of correction a indicated 5 Date of compliance: 10.29/2023 K374 SS= E Subdivision of Building Spaces – Smoke Barrier Construction The facility request paper	aitor or lits or 6 nce ee eerns oo s

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/11/2023	
	PROVIDER OR SUPPLIEI N HOUSE REHABII	R LITATION AND HEALTHCARE C	ENTE	809 W	ADDRESS, CITY, STATE, ZIP COD FREEMAN ST (FORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF Barriers shall compound the opening leaving necessary for property of the proper	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ly with LSC Section 8.5.4. LSC ors in smoke barrier shall close g only the minimum clearance er operation. This deficient		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	DATE
	staff, and 2 visitors Findings include: Based on observati	ons made during tour of the			Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of	ot ment the
	from 11:30 a.m. to noted: a) the set of smoke	aintenance Director on 10/11/23 2:10 p.m. the following was barrier doors on the 200 Hall letely leaving a 4-inch gap or fullest.			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 take	n
	did not close comp when closed to thei Based on interview observations, the M acknowledged thes	during the time of faintenance Director e smoke barrier doors did not			for those residents identified No resident was found to affected by the deficiency. The set of smoke barried doors on the 200 hall have had closures adjusted to ensure	o be r d the
	looked at as soon a	dding that he would have them is he had time to work on them. Eviewed with the Administrator ce.			compliance of full closure with gaps. 2 How the facility identifice other residents: Residents, staff, and vision have the potential to be affect	e d itors
	3.1-19(b)				by the alleged deficient practic 3 Measures put into place System changes: Maintenance Director we educated about proper closure smoke barrier doors. The Maintenance Direct responsible for compliance. 4 How the corrective action will be monitored: An Environmental QAPI will be utilized monthly to more	as e of or is ons tool

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155295		A. BUILDING 01 B. WING		COMPLETED 10/11/2023	
	ROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CEN	809 W I	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 0712 SS=F Bldg. 01		he transmission of a fire		compliance with smoke barrier walls. The results of these aud will be reviewed in Quality Assurance Meeting Monthly for months or until 100% compliant 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: 10.11.2023	r 6 nce ee erns
	conditions. Fire dri and unexpected til conditions, at leas: The staff is familia aware that drills ar routine. Where dri 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record rev failed to ensure 12 overification of transi- to the monitoring sta quarters. LSC 19.7.1 care occupancies sha a fire alarm signal a conditions. This defi	t quarterly on each shift. r with procedures and is the part of established fills are conducted between AM, a coded by be used instead of	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 no constitute admission or agree by the provider of the truth of the	t ment

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	A. B	MULTIPLE CO FUILDING VING	ONSTRUCTION 01	(X3) DATE COMPI 10/11/	ETED
CLINTON	ROVIDER OR SUPPLIER	R LITATION AND HEALTHCARE CE	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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Findings include:				facts alleged or conclusions a forth in the statement of deficiencies. The plan of	set	
		view of the document titled ELS" with the Maintenance			correction is prepared and/or executed solely because it is		
	Director on 10/11/2				required by the provisions of		
		the drills for the past twelve			federal and state law.		
		fication of the transmission of			1) Immediate actions taken	for	
		. Based on interview at the time			those residents identified:		
	of record review, th	ne Maintenance Director stated			No resident was found	to be	
	that he was unawar	e of the need to verify the			affected by this alleged defic	iency.	
	transmission of the	fire alarm signal with the			Maintenance Director w	vas	
	monitoring compan	ny and would add it to his			educated on fire drills and		
	documentation as s	oon as he was able to do so.			verification of the transmission	n of	
					the signal for drills.		
		viewed with the Administrator			Monthly fire drill was		
	at the exit conferen	ce.			performed as evidenced by		
					attached drill documentation.		
	3.1-19(b)				2) How the facility identified	l	
	3.1-51(c)				other residents:		
					Residents, staff, and vi		
					have the potential to be affect		
					by the alleged deficient pract	ice.	
					3) Measures put into place/		
					System changes:	tor	
					The Maintenance Direct		
					will review fire drill log to ens compliance. The Maintenance		
					Director was re-educated on		
					Preventative Maintenance Pr		
					and fire drill requirements by	-	
					Executive Director/designee		
					The Maintenance Direct	tor is	
					responsible for compliance.		
					4) How the corrective action	าร	
					will be monitored:		
					An Environmental QAP	l tool	
					will be utilized monthly to mo	nitor	
					compliance.		
					The results of these au	dits	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155295	B. WI	NG		10/11/	2023
	PROVIDER OR SUPPLIER	ITATION AND HEALTHCARE CE	STREET ADDRESS, CITY, STATE, ZIP COD 809 W FREEMAN ST NTE FRANKFORT, IN 46041				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	will be reviewed in Quality		DATE
K 0753	NFPA 101				Assurance Meetings monthly from months or until 100% compliant is achieved. The QA Committed will identify and trends or patter and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 10/31/2023	nce ee erns o	
SS=E Bldg. 01	Combustible Deco Combustible Deco Combustible deco unless one of the o Flame retarda fire-retardant coati for product. o Decorations o Decorations o than 100 kilowatts 289. o Decorations, s paintings and othe walls, ceilings and accordance with 1 o The decoratio are in such limited fire development of 19.7.5.6	prations prations shall be prohibited following is met: ant or treated with approved ing that is listed and labeled meet NFPA 701. exhibit heat release less in accordance with NFPA such as photographs, er art are attached to the I non-fire-rated doors in 8.7.5.6(4) or 19.7.5.6(4). Ins in existing occupancies I quantities that a hazard of or spread is not present.					
	failed to ensure 10 c maintained in accor states combustible c in any health care of following criteria is (1) They are flame-	on and interview, the facility of over 41 rooms was dance with 18.7.5.6. 18.7.5.6 decorations shall be prohibited ccupancy, unless one of the met: retardant or are treated with lant coating that is listed and	K 0°	753	K753 SS = E Combustible Decorations 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	of	10/30/2023

labeled for application to the material to which it is

this plan of correction does not

CENTERSTON	t MEDICARE & MEDIC	THE SERVICES	_			0.11	B110.0700 007
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155295	B. W	ING		10/11/	/2023
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	-KOVIDEK OK SOFFLIEF			809 W I	FREEMAN ST		
CLINTON	N HOUSE REHABIL	LITATION AND HEALTHCARE CE	ENTE	FRANK	FORT, IN 46041		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	applied.				constitute admission or agreer	ment	
	(2) The decorations	s meet the requirements of			by the provider of the truth of t	:he	
	NFPA 701, Standar	rd Methods of Fire Tests for			facts alleged or conclusions se	et .	
	Flame Propagation	of Textiles and Films.			forth in the statement of		
	(3) The decorations	s exhibit a heat release rate not			deficiencies. The plan of		
	exceeding 100 kW	when tested in accordance with			correction is prepared and/or		
	NFPA 289, Standar	rd Method of Fire Test for			executed solely because it is		
	Individual Fuel Pac	kages, using the 20-kW			required by the provisions of		
	ignition source.				federal and state law.		
	(4)*The decoration	s, such as photographs,			1) Immediate actions taken fo	or	
		r art, are attached directly to			those residents identified:		
	the walls, ceiling, a	nd non-fire-rated doors in			No resident was found to	be	
	accordance with the				affected by this alleged deficie	encv.	
		non-fire-rated doors do not			The corridor door to residue	-	
		peration or any required			room #419 covered with holida		
		and do not exceed the area		wrap was removed and disposed			
	limitations of 18.7.			of.			
		not exceed 20 percent of the			The corridor door to residue	dent	
		oor areas inside any room or			room #706, #707, #708, #709,		
	_	ompartment that is not			#710, #711, #712.#713, and #		
	_	ut by an approved automatic			on "The Garden Unit" have be		
	_	accordance with Section 9.7.			determined per the attached	OII	
		not exceed 30 percent of the			documentation to comply with		
	` '	oor areas inside any room or			NFPA 701 and NFPA 289.		
	_	ompartment that is protected			2) How the facility identified		
	_	opproved supervised automatic			other residents:		
		accordance with Section 9.7.			Residents, staff, and visi	itors	
		not exceed 50 percent of the			have the potential to be affected		
	` '	oor areas inside patient			by the alleged deficient practic		
	_	ring a capacity not exceeding			3) Measures put into place/	<i>.</i> C.	
		moke compartment that is			_ · · · · · · · · · · · · · · · · · · ·		
	_	ut by an approved, supervised			System changes: Contractors will be		
	-	system in accordance with					
	Section 9.7.	system in accordance with			educated, prior to completing	+	
		ice could affect 14 residents, 4			services on the building, about		
	•				proper combustible decoration	15.	
	staff, and 2 visitors	•			The Maintenance	£	
	E' 1' ' 1 1				Director/designee will inspect	ior	
	Findings include:				compliance prior to job		
					completion.		
	Based on observation	ons made during tour of the	1		The Maintenance Director	or is	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155295	B. W	ING		10/11/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				FREEMAN ST		
CLINTON	I HOUSE REHABIL	ITATION AND HEALTHCARE CE	NTE		FORT, IN 46041		
(X4) ID		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
	_	intenance Director on 10/11/23			responsible for compliance.		
		2:10 p.m. the following was			4) How the corrective actions	S	
	noted:				will be monitored:		
	· ·	to resident room #419 was			An Environmental QAPI		
	-	t with holiday wrapping paper.			will be utilized monthly to mon	itor	
		to resident room #706, #707,			compliance.		
		711, #712, #713, and #715 on			The results of these aud	its	
		vere all covered 100 percent			will be reviewed in Quality	f O	
	doors.	rap covering the resident room			Assurance Meetings monthly		
	Based on interview	at the time of each			months or until 100% compliants		
		intenance Director advised			is achieved. The QA Committe will identify and trends or patte		
		what the flame spread rating			and make recommendations to		
		gs were and agreed the surface			revise the plan of correction as		
	of each door was en	-			indicated.	5	
	or cach addr was en	kinery covered.			5) Date of compliance:		
	This finding was rev	viewed with the Administrator			10.30.2023		
	at the exit conference				10.00.2020		
	3.1-19(b)						
K 0920	NFPA 101						
SS=E	Electrical Equipme	ent - Power Cords and					
Bldg. 01	Extens						
		ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
	·	ed electrical equipment					
	, ,	les that have been					
		alified personnel and meet					
		0.2.3.6. Power strips in					
	· ·	cinity may not be used for					
	, -	personal electronics),					
		n care resident rooms that					
		E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
	· ·) meet UL 1363. In					
	non-patient care re	ooms, power strips meet	1				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	ON (X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPLETED		
		155295	B. WING		10/11/2023			
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			FREEMAN ST			
CLINTON HOUSE REHABILITATION AND HEALTHCARE CEN								
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL						COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION						DATE	
		ls. All power strips are						
	used with general precautions. Extension							
	cords are not used as a substitute for fixed							
	wiring of a structure. Extension cords used							
	temporarily are removed immediately upon							
	completion of the purpose for which it was							
	installed and meets the conditions of 10.2.4.							
	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility		K 0920					
					K920 SS = E Electrical Equipment – Power Cords and		10/11/2023	
	failed to ensure 1 of 1 Medical Records office did						10/11/2023	
		ords as a substitute for fixed			Extens			
	wiring. LSC 9.1.2 requires electrical wiring and				The facility requests paper	ests paper		
	equipment shall be in accordance with NFPA 70,				compliance for this citation.			
		Code. NFPA 70, 2011 Edition,			This plan of correction is the			
		res that, unless specifically			center's credible allegation of			
	_	cords and cables shall not be			compliance.			
	1 ~	for fixed wiring of a structure.			Preparation and/or execution	of		
	This deficient practice affects 14 residents. 4 staff				this plan of correction does no			
	and 2 visitors.				constitute admission or agree			
					by the provider of the truth of			
	Findings include:				facts alleged or conclusions s	et		
					forth in the statement of			
		ons made during tour of the			deficiencies. The plan of			
	facility with the Maintenance Director on 10/11/23				correction is prepared and/or			
		2:10 p.m., a power strip was			executed solely because it is			
	piggybacked into another power strip that was				required by the provisions of			
	then plugged into a short 12-inch extension cord				federal and state law.			
	located in the Medical Records office. These then				1) Immediate actions taken for			
	had a small mini-fridge and a Keurig coffee maker				those residents identified:			
	plugged into them. Based on interview at the time				No resident was found to be			
		the Director of Maintenance			affected by this alleged deficie	ency.		
	acknowledged the piggybacked power strips and the short extension cord as being used as a				The power strip			
					piggybacked into another pow			
	substitute for fixed wiring and stated that he would take care of the issue as soon as possible.				strip that was then plugged into a			
	would take care of t	me issue as soon as possible.			short 12 inch extension cord	fice		
	This finding was	viewed with the Administrator			located in Medical Records of has been removed.	lice		
	This finding was reviewed with the Administrator at the exit conference.					s been removed. The Maintenance Director		
	at the exit connectent				and Staff have been educated			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155295	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/11/2023				
NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE REHABILITATION AND HEALTHCARE CEN				STREET ADDRESS, CITY, STATE, ZIP COD 809 W FREEMAN ST NTE FRANKFORT, IN 46041						
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE			
	3.1-19(b)	ASC IDENTIFIEND BY ORWINITION		1.00	the use of power strips as per attached in-service. 2) How the facility identified other residents: Visitors, Residents, and Staff, have the potential to be affected by the alleged deficie practice. 3) Measures put into place/System changes: The Maintenance Direct was re-educated on the use of power cords. The Maintenance Direct of the monitored will be monitored: The Maintenance Director/Designee will ensure inspection of rooms/offices are completed weekly. 4) How the corrective actions will be monitored: The Maintenance Director/designee will present electrical equipment audits to QAPI Committee during QAPI Meetings to ensure completion and compliance The results of these aud will be reviewed in Quality Assurance Meetings monthly months or until 100% complian is achieved. The QA Committee will identify and trends or patter and make recommendations to revise the plan of correction actindicated. 5) Date of compliance: 10.11.2023	nt or f e s the n its for 6 nce ee eens	DAIL			

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