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	10/11/2023

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: 10/11/23 Facility Number: 000192 Provider Number: 155295 AIM Number: 100291120 At this Emergency Preparedness survey, Clinton House Rehabilitation and Healthcare Center was found in 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 68. Quality Review completed on 10/19/23	E 0000	Each tag will have a plan of correction attached/submitted	
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: 10/11/23 Facility Number: 000192 Provider Number: 155295 AIM Number: 100291120 At this Life Safety Code survey, Clinton House	K 0000	Each tag will have a plan of correction attached/submitted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Wells	HFA	11/03/2023

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	10/11/2023

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
	Rehabilitation and Healthcare Center was 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 68 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 used for storage which was not sprinklered. Quality Review completed on 10/19/23			
K 0222 SS=F 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 used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	10/11/2023

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
	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 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	10/11/2023

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
	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 5 of 5 egress doors equipped for delayed egress was equipped as required by LSC 7.2. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect all residents, staff, and visitors in the facility. 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 main entry door to the facility had 15 second delay egress on it, but the required signage for the door was not present. b) the emergency exit door near the Therapy room had 15 second delay egress on it, but the required signage for the door was not present. c) the emergency exit doors nearest to resident rooms #418 and #419 had 15 second delay egress on it, but the required signage for the door was not present.	K 0222	**K222 – SS=F 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. 15 second delay egress signage has been ordered as evidenced by attached order form **2) How the facility identified other residents:**	10/31/2023

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	10/11/2023

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
	d) the emergency exit doors nearest to resident rooms #518 and #519 had 15 second delay egress on it, but the required signage for the door was not present. e) the emergency exit doors nearest to resident rooms #602 and #604 had 15 second delay egress on it, but the required signage for the door was not present. Based on interview at the time of observation, the Maintenance Director acknowledged the above noted egress doors were equipped with 15 second delayed egress and lacked the proper signage. This finding was reviewed with the Administrator at the exit conference. 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: 10/31/2023**	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in	K 0345	**K345 SS = C Fire Alarm System** **The facility requests paper**	10/24/2023

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	10/11/2023

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
	accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 10/11/23 at 12:35 p.m., the time and date on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date and time to be 12/25/23 at 10:47 p.m. when the current date and time were 10/11/2023 at 12:36 p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel immediately. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**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 be affected by this alleged deficiency. Maintenance Director was educated on fire alarm system, testing and maintenance and documentation. The Fire Alarm System has been updated for accurate time and date information in accordance with NFPA. **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 panel to ensure compliance. The Maintenance Director was re-educated on the Preventative Maintenance Program and fire drill requirements by the	

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	10/11/2023

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
			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 indicated. **5) Date of compliance:** **10.24.2023**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13,			

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	10/11/2023

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
	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 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 escutcheons was indeed missing in each of the aforementioned areas. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0351	**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 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 repaired/corrected. As evidenced by attached photos. Continued system inspections in accordance with NFPA25 will be documented, recorded and available for review. **2)How the facility identified other residents:**	10/30/2023

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	10/11/2023

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
			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 plan of correction as indicated. **5) Date of compliance: 10/30/2023**	
K 0353 SS=E 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 accordance with NFPA 25, Standard for the			

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	10/11/2023

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
	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 observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of over 60 rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling.	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 for those residents identified:**	10/30/2023

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	10/11/2023

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
	This deficient practice could affect 18 residents and 4 staff. Finding includes: Based on observations made during tour of the facility with the Maintenance Director on 10/11/23 at 1:35 p.m., the privacy curtain in the shower room of the 500 hall had a 9 inch mesh panel at the top or the curtain and was hung on a horizontal rod with the top of the curtain installed 8 inches from the ceiling. The shower area was not provided with a sprinkler and the nearest sprinkler head was blocked from sprinkler coverage by the curtain in the shower room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned privacy curtain was hung 8 inches from the ceiling and with the 9 inch mesh panel at the top of the curtain, the mesh extended 17 inches from the ceiling instead of the required 22 inch minimum. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		Inspection of privacy curtains as identified in findings an order has been placed as evidenced on the attached PO Order ensuring that at least 18 inched is maintained below the level of the sprinkler deflectors. 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	

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	10/11/2023

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
			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**	
K 0355 SS=E Bldg. 01	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. 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. Based on interview at the time of observation, the Maintenance Director acknowledged the fire extinguisher located on the 500 Hall directly across from the nurses' station as being	K 0355	**K355 SS = E Portable Fire Extinguishers** **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 be affected by the finding. **2) How the facility identified other residents:**	10/11/2023

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	10/11/2023

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
	obstructed stating that he would speak with staff about the issue. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		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 in serviced staff and removed the obstruction of the ABC portable fire extinguisher located on Hall 500. An Audit was completed throughout the whole house to ensure no other Fire Extinguishers were obstructed. No other were located. **4) How the corrective actions will be monitored:** The Maintenance Director/designee will audit the whole house weekly to ensure portable fire extinguishers are free from obstructions. for 6 months. The audit will be reviewed present in 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: 10/11/2023**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other			

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	10/11/2023

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
	than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility	K 0363	**K363 SS= E Corridor -Doors**	10/29/2023

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	10/11/2023

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
	failed to ensure 1 of 1 door to the corridor would completely resist the passage of smoke. NFPA 101 Life Safety Code 2012 edition at 19.3.6.3.1 states "Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be constructed to resist the passage of smoke and shall be constructed of the following: 1) 1 ¾ inch (44 mm) thick, solid-bonded core wood 2) Materials that resist fire for a minimum of 20 minutes." This deficient practice could affect as many as 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 10/11/23 at 12:26 p.m., the door to the clean utility room on the West Hall had a hold in the door approximately 5/8ths of an inch in diameter all the way through the door. This hole would allow the passage of smoke through the door in the event of a fire. Based on interview at the time of observation, the Maintenance Director acknowledged the hole passed completely through the door adding that he would have the hole fixed as soon as possible. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**The facility request 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 be affected by the deficiency. The 5/8ths of an inch hole in the door to the clean utility room on West Hall has been sealed **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:** Contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director/designee will inspect for penetrations prior to job completion. The Maintenance Director is responsible for compliance. **4 How the corrective actions**	

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	10/11/2023

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
			will be monitored: An Environmental QAPI tool will be utilized monthly to monitor compliance with smoke barrier walls. 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: 10.29/2023**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke	K 0374	**K374 SS= E Subdivision of Building Spaces – Smoke Barrier Construction** **The facility request paper**	10/11/2023

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	10/11/2023

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
	barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 18 residents, 4 staff, and 2 visitors. 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 set of smoke barrier doors on the 200 Hall did not close completely leaving a 4-inch gap when closed to their fullest. b) the set of smoke barrier doors on the 600 Hall did not close completely leaving a 3-inch gap when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged these smoke barrier doors did not close completely adding that he would have them looked at as soon as he had time to work on them. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**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 be affected by the deficiency. The set of smoke barrier doors on the 200 hall have had the closures adjusted to ensure compliance of full closure with no gaps. **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:** Maintenance Director was educated about proper closure of smoke barrier doors. 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	

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	10/11/2023

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
			compliance with smoke barrier walls. 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: 10.11.2023**	
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 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills 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.	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*	10/31/2023

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	10/11/2023

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
	Findings include: Based on record review of the document titled "Direct Supply - TELS" with the Maintenance Director on 10/11/23 at 9:41 a.m., the documentation for the drills for the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Maintenance Director stated that he was unaware of the need to verify the transmission of the fire alarm signal with the monitoring company and would add it to his documentation as soon as he was able to do so. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 3.1-51(c)		*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 this alleged deficiency. Maintenance Director was educated on fire drills and verification of the transmission of the signal for drills. Monthly fire drill was performed as evidenced by attached drill documentation. **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	

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	10/11/2023

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
			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 indicated. **5) Date of compliance: 10/31/2023**	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 10 of over 41 rooms was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is	K 0753	**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 this plan of correction does not*	10/30/2023

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	10/11/2023

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
	applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20-kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during tour of the		*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 this alleged deficiency. The corridor door to resident room #419 covered with holiday wrap was removed and disposed of. The corridor door to resident room #706, #707, #708, #709, #710, #711, #712.#713, and #715 on “The Garden Unit” have been determined per the attached documentation to comply with NFPA 701 and NFPA 289. **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:** Contractors will be educated, prior to completing services on the building, about proper combustible decorations. The Maintenance Director/designee will inspect for compliance prior to job completion. The Maintenance Director is	

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	10/11/2023

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
	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 corridor door to resident room #419 was covered 100 percent with holiday wrapping paper. b) the corridor door to resident room #706, #707, #708, #709, #710, #711, #712, #713, and #715 on 'The Garden unit" were all covered 100 percent with a vinyl type wrap covering the resident room doors. Based on interview at the time of each observation, the Maintenance Director advised that he had no idea what the flame spread rating of the door coverings were and agreed the surface of each door was entirely covered. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		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 indicated. **5) Date of compliance:** **10.30.2023**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet			

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	10/11/2023

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
	other UL standards. 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 failed to ensure 1 of 1 Medical Records office did not used flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 14 residents. 4 staff and 2 visitors. 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., a power strip was piggybacked into another power strip that was then plugged into a short 12-inch extension cord located in the Medical Records office. These then had a small mini-fridge and a Keurig coffee maker plugged into them. Based on interview at the time of the observation, the Director of Maintenance acknowledged the piggybacked power strips and the short extension cord as being used as a substitute for fixed wiring and stated that he would take care of the issue as soon as possible. This finding was reviewed with the Administrator at the exit conference.	K 0920	**K920 SS = E Electrical Equipment – Power Cords and Extens** **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 be affected by this alleged deficiency. The power strip piggybacked into another power strip that was then plugged into a short 12 inch extension cord located in Medical Records office has been removed. The Maintenance Director and Staff have been educated on	10/11/2023

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	10/11/2023

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
	3.1-19(b)		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 deficient practice. **3) Measures put into place/ System changes:** The Maintenance Director was re-educated on the use of power cords. 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 the QAPI Committee during QAPI Meetings to ensure completion and 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 indicated. **5) Date of compliance: 10.11.2023**	