STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155486	A. BUILDING -- B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

(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: 12/16/24 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 45 certified beds. At the time of the survey, the census was 13. Quality Review completed on 12/20/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to document exercises which tested the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	**Tag E 039** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were harmed during the actual fire event. The fire occurred in the kitchen, and all residents were	12/17/2024

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

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Plan" documentation dated 07/20/24 with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, documentation for an actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period was incomplete. Documentation for the actual kitchen fire incident which occurred on 05/03/24 with local fire department involvement		evacuated in a timely manner. The staff that were involved during the evacuation did everything exactly right, and no changes to our policy for evacuation was necessary. In the future whether it is an actual event or just training, the Administrator will conduct a short summary of the experience to ensure there is nothing needing to be changed. The facility will continue to do annual active shooter training, as well as tornado drills and table talk for potential chemical spills especially since we are in a rural area. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident could potentially be affected if training was never conducted in the facility. To ensure no residents are affected, training has been done every year. If there was ever a reason for concern with the staff being able to perform their duties to the fullest, the Administrator would ensure more training, even just individualized training is complete. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The deficient practice will not recur. A brief summary of any actual event	

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	did not include an after action report. Based on interview at the time of record review, the Administrator stated the facility also performs active shooter training but agreed that active shooter staff training documentation for the most recent twelve month period along with after action report documentation for the 05/03/23 fire incident was not available for review and agreed additional emergency preparedness testing documentation was not available for review at the time of the survey. These findings were reviewed with the Administrator and Maintenance during the exit conference.		will be conducted by the Administrator. During a table talk exercise all staff will be required to sign-in to show proof of training, and if there are any issues with the staff's responses they will be quickly identified. The Administrator will contact local fire department to do a community based exercise in the spring. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Administrator will conduct small quarterly audits during QAPI to ensure no "after action reports" are needed as well as any actually training needs to be conducted. **By what date the systemic changes for each deficiency will be completed:** Systemic changes for documentation was completed December 17, 2024.	
K 0000 Bldg. 02	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/16/24 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600	K 0000		

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	At this Life Safety Code survey, Middletown Nursing and Rehabilitation 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). Bldg. 02 was surveyed under Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, identified as Bldg. 02 and Bldg. 03, consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story wing determined to be Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing (Old Hall), and hard-wired smoke detectors in the fifteen resident rooms on the South Wing (New Hall) which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 13 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services except for two detached storage sheds were sprinkled. Quality Review completed on 12/20/24			
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of	K 0211	**Tag K 211** **What corrective action(s) will be accomplished for those residents found to have been**	12/16/2024

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	fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, two chairs were stored up against the wall in the exit access vestibule outside resident sleeping Room 12. The chairs were stored in the vestibule opposite an upright piano also stored in the vestibule which restricted the path of egress to four feet wide in the vestibule. Based on interview at the time of the observations, Maintenance agreed the storage in the exit access vestibule caused the aforementioned means of egress to not be continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)		**affected by the deficient practice:** Residents could be affected if that exit was needed and the means of egress was blocked substantially. Fortunately, no residents are located on that side of the fire door. The chairs have been moved just in case of such an event in order to continue to provide a safe environment for resident, staff and guests. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Fortunately, this occurred in a non-occupied resident area. Since the area is a very lightly travelled corridor, the facility staff under the direction of the Maintenance Director, will need to ensure such areas located throughout the building remain clear. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The areas in the facility that are more highly travelled will be monitored daily to ensure a means of egress. The Maintenance Director Assistant will conduct a weekly walk thru the building to ensure all means of egress are clear. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Monitoring means of egress will be done weekly by the Maintenance Director Assistant. **By what date the systemic changes for each deficiency will be completed:** The chairs were moved upon exit of the surveyor. December 16, 2024.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Report" documentation dated 11/26/24 with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, the results of main fire alarm system control panel battery inspection and testing was listed as "Fail". Review of the "Deficiency Summary" section of the 11/26/24 inspection report stated "Batteries dated 2019. Due for replacement due to age". Based on interview at the time of record review, Maintenance stated he did not change out the main fire alarm system	K 0345	**Tag K 345** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any resident has the potential to be affected when any system is not functioning properly. As a facility we always keep the safety of our residents first, so all systems whether mechanical or written in policy are maintained and operational. Batteries in the fire panel have been changed, but by not inspecting them annually there could be some flaws in the system. Gruneau does all of our fire system inspections. If there was ever a problem with anything they would alert us, and inform us of the specific issue(s). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All systems will be monitored by	12/30/2024

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	control batteries on or after 11/26/24 and agreed the batteries have not yet been replaced. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Report" documentation dated 02/19/24, 05/28/24, 10/23/24 and 11/26/ with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, semi-annual fire alarm system inspection documentation for visual inspections conducted		IDOH guidelines. Batteries in the fire panel will be checked annually to ensure functionality and expiration. Gruneau will also be instructed that our sensitivity testing needs to be more precise as well as the itemization of everything being inspected. This will allow us to better monitor the situation if one is ever presented. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** As stated previously, batteries will be checked annually and Gruneau will be instructed to give more detailed reports. Reports will be looked over by the Maintenance Director to ensure all tasks have been met, and if not Gruneau will have to come back out and redo inspections. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** During our quarterly QAPI meetings, all basic maintenance needs will be addressed. **By what date the systemic changes for each deficiency will be completed:** Batteries were replaced December 30, 2024, and Gruneau has been notified of the tags. We are waiting for them to contact us with a	

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	on 02/19/24 was not itemized by location. The "General Comments" section of the 02/19/24 documentation stated "Quarterly inspection. Visually inspected devices". Based on interview at the time of record review, Maintenance agreed semi-annual fire alarm system inspection documentation dated 02/19/24 was not itemized by device location. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include:		rescheduled inspection.	

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	Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Report" documentation with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, smoke detector sensitivity testing documentation within the most recent two year period was not available for review. Based on interview at the time of record review, Maintenance stated the fire alarm system inspection contractor's 08/30/23 "Fire Alarm Supplementary Form" was supposed to document sensitivity testing for the most recent two year period but agreed the 08/30/23 testing documentation did not include the sensitivity test point for each smoke detector which may have been sensitivity tested. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to provide written documentation or other evidence that the sprinkler system components had been inspected and tested for 1 of 4 quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but	K 0353	**Tag K 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any residents has the potential of being affected if systems are not checked properly. Containing smoke in the event of a fire is crucial to safety and well-being of everyone. If smoke can't be detained, residents and staff could suffer	12/20/2024

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	not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. NFPA, 25 Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Dry Sprinkler Inspection Report" documentation dated 05/28/24, 10/23/24 and 11/26/24 with Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, no third quarter (July, August, September) 2024 sprinkler system inspection documentation was available for review. Based on interview at the time of record review, Maintenance agreed no third quarter 2024 sprinkler system inspection documentation was available for review and agreed it had been greater than 120 days in between quarterly sprinkler system inspection and testing on 05/28/24 and on 10/23/24. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 freezer rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or		smoke inhalation. In the same not, sprinkler systems must be checked timely. If the sprinkler system does not work properly fire could spread rapidly making evacuation very difficult. Sprinkler systems will be checked quarterly as well as a weekly walk thru by the Assistant Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Sprinkler systems will be checked quarterly. Any building imperfections such as; ceiling tiles, broken outlets, door hinges, etc. will be correctly upon notification. All staff are well trained to point out issues and inform Maintenance Director of such flaws. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A weekly building walk-thru will be conducted by the Assistant Maintenance Director for any obvious flaws to the facility. All staff will continue to notify the Maintenance Director as well to ensure this deficient practice does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the freezer room by the Administrator's Office. Findings include: Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, one suspended ceiling tile was missing in the freezer room by the Administrator's Office. One sidewall sprinkler was installed in the room. Based on interview at the time of the observations, Maintenance agreed the missing ceiling tile would delay sprinkler activation in the room. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)		**recur, i.e., what quality assurance program will be put into place:** A quick Maintenance summary will be conducted during our quarterly QAPI meetings to discuss any issues involving the structure of the building. **By what date the systemic changes for each deficiency will be completed:** The tile was replaced December 20, 2024, and quarterly sprinkler inspections will continue as normal.	
K 0500 SS=F Bldg. 02	NFPA 101 Building Services - Other Based on record review, observation and interview; the facility failed to ensure all equipment which require inspection certificates from the State of Indiana had current inspection certificates to ensure the units were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the	K 0500	**Tag K 500** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Potentially all residents and staff could be affected in the event of an explosion. Inspections in the future will be done timely.	01/15/2025

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	evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Administrator and Maintenance from 10:20 a.m. to 1:10 p.m. on 12/16/24, current inspection certificates from the State of Indiana for all equipment which require inspection certificates from the State of Indiana were not available for review. Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the following equipment did not have current Certificate of Inspection documentation from the State of Indiana: a. the water heater identified as IN252553. b. the boiler identified as IN345853. c. the boiler identified as IN345854. Based on interview at the time of the observations, Maintenance agreed the aforementioned equipment did not have current Certificate of Inspection documentation from the State of Indiana. These findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		The Administrator has contacted the insurance agent to schedule a time for inspections and to get certifications on the water heater and boilers. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All systems will continue to stay up to code per IDOH guidelines. Although a certification can never prove 100% safety or reliability, it could potentially catch a preexisting problem that would otherwise go unnoticed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The facility's Administrator will stay in contact with the insurance company to ensure certification compliance with the boiler and water heater system. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any issues with the building will be reviewed during the facility's quarterly QAPI meetings. **By what date the systemic changes for each deficiency will be completed:** Inspections and permits printed January 15, 2025.	

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	155486	A. BUILDING 02 B. WING	12/16/2024

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K 0511 SS=D Bldg. 02	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to maintain electrical receptacles in wall mounted outlet boxes in 1 of 1 Shenandoah Dining Rooms in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, at Article 110.12 (B) Integrity of Electrical Equipment and Connections states internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. In addition, NFPA 70 requires electrical receptacles to be properly grounded in accordance with NFPA 70. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor.	K 0511	**Tag K 511** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** If there is a faulty outlet, it could potentially affect the person nearest the receptacle. All outlets in residents rooms have been replaced in the last 4 years, and any rooms outside of residents rooms that have been remodeled also have had outlets and covers replaced. That room is next on the list to be remodeled and has just been overlooked. Fortunately, for the safety of the resident's the outlet was in the Shenandoah Dining room, which is only used as a staff lounge. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** If there is a faulty outlet in a resident area, it could cause electric shock, death and the potential for fire in the building. The staff do a very good job to inform Maintenance of any issues especially those that pertain to the resident's areas. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The	12/18/2024

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	Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect one resident, staff or visitor in the Shenandoah Dining Room. Findings include: Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the top receptacle in the wall mounted outlet box installed in the support column at the center of the Shenandoah Dining Room was cracked. In addition, the receptacles in the outlet box were found to have an open ground when tested with an Ideal Industries GFCI testing device. Based on interview at the time of the observations, Maintenance agreed the aforementioned receptacles needed replacement. These findings were reviewed with the Administrator and Maintenance during the exit conference.		weekly walk-thru will also include outlets as that is a potential to be hazardous for both residents and staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any maintenance issues will be discussed during our quarterly QAPI meetings. This will ensure that if something has been missed is resolved in a timely manner. **By what date the systemic changes for each deficiency will be completed:** The outlet was fixed December 18, 2024.	

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K 0712 SS=C Bldg. 02	3.1-19(b) NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, third shift fire drills conducted within the most recent twelve month period on 12/14/23, 03/29/24, 06/28/24 and 09/18/24 were conducted at, respectively, 6:15 a.m., 6:00 a.m., 6:42 a.m. and 6:00 a.m. Based on interview at the time of record review, Maintenance stated the facility operates three shifts per day, additional third shift fire drill documentation was not available for review and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)	K 0712	**Tag K 712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All personnel could be affected in an actual event if proper evacuation procedures are not followed. This includes all staff to be knowledgeable of procedures for any event as well as how to actual execute. Fire drills are a common training done by the staff to ensure proper execution in the event of a fire. The facility preforms fire drills on a quarterly basis per shift as directed by Indiana Guidelines. This has been noticeably effective knowing that in May of 2024 the facility experienced an actual fire, and everyone evacuated out of the building safely. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** It is hard to say how the fire drills are not unexpected when 2 of 4 were different times and 2 drills happened to be the same time. The regulation states unexpected and expected times varying conditions. All staff are still trained	12/16/2024

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			properly per their quarterly fire drills. Resident could only be affected if no training is ever conducted, or staff are simply unaware of procedure. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will try and not do a fire drill within 30 minutes of the previous drill in order for it to be more unexpected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Fire drills will be discussed in necessary during our quarterly QAPI meetings. **By what date the systemic changes for each deficiency will be completed:** Systemic changes have been established following the exit survey; December 16, 2024.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states	K 0918	**Tag K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** In the event of an emergency the generator will operate the entire building. It is	12/30/2024

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	maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Maintenance from 10:20 a.m. to 1:10 p.m. on 12/16/24, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. Based on interview at the time of record review, Maintenance agreed documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. These findings were reviewed with the Administrator and Maintenance during the exit conference 3.1-19(b)		imperative that everything is in working order because loss of power in Middletown can happen on the nicest of days. We understand the simplest of issues to avoid in bad fuel. Bad fuel could keep the generator from running properly or run at all, which could cause a major issue in the event of power loss. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The generator fuel will be tested annually per the Indiana guidelines. This will ensure proper functionality of the generator and keep all residents safe in the event of power loss. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The generator fuel will be tested annually per the Indiana guidelines. This will ensure proper functionality of the generator and keep all residents safe in the event of power loss. Starting in the fall of 2025 the Administrator will stay in touch with the Maintenance Director to ensure fuel is tested because with winter coming up fuel is more likely to gel especially if it is bad fuel. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Any Maintenance issues will be discussed during quarterly QAPI meetings. **By what date the systemic changes for each deficiency will be completed:** The fuel sample was pulled December 30, 2024 by Shaeffer Oil.	
K 0000 Bldg. 03	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/16/24 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Life Safety Code survey, Middletown Nursing and Rehabilitation 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). Bldg 03 was surveyed under Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This facility, identified as Bldg 02 and Bldg 03, consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story wing determined to be Type II (222) construction	K 0000		

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	and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing (Old Hall), and hard-wired smoke detectors in the fifteen resident rooms on the South Wing (New Hall) which are electrically wired to an audible signal at the nurses' station. Bldg 03 consisted of the north dining room and adjoining support areas constructed in 2018. Bldg 03 was determined to be of Type V (111) construction and fully sprinklered. The facility has a capacity of 45 and had a census of 13 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services except for two detached storage sheds were sprinkled. Quality Review completed on 12/20/24			
K 0161 SS=E Bldg. 03	NFPA 101 Building Construction Type and Height Based on observation and interview, the facility failed to maintain the building construction type for new construction in the new dining room. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the new dining room. Findings include: Based on review of "Project Data" application information dated 08/23/17 with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, construction plans to add a new dining area to the north end of the facility was submitted to the Indiana Department	K 0161	**Tag K 161** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any resident has the potential to be affected in not all fire procedures are in place. Fire caulk is an easy fix to stop such a devastating event. Keeping the residents safe is top priority for the facility. The deficient area has been fire caulked and other potential areas have been checked to ensure the deficiency does not	01/02/2025

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	of Health by the facility. New construction plan documentation for the new dining room and adjoining areas was approved by the Indiana Department of Health in a letter to the facility dated 11/20/18. Based on interview at the time of record review, the Administrator and Maintenance stated the new dining room and adjoining areas were added to the facility in 2018. Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the annular space surrounding each of three separate black metal pipes which penetrated the new dining room wall above the suspended ceiling above the corridor door set serving as the entrance to the new dining room from the north hall was not firestopped. Each door in the corridor door set at the entrance to the new dining room was equipped with a 90-minute fire resistance rating label and was equipped with latching hardware which latched each door into the door frame when tested to close. The opening of the annular space exposed the wood frame studs of the load bearing wall. Based on interview at the time of the observations, Maintenance agreed the aforementioned openings did not maintain the building construction type. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)		occur elsewhere. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Fortunately, no new construction has occurred, so fire caulking is complete. It is odd that being new construction that it was not be noticed for the past few years. In the future if there is any new construction are procedures for fire safety will be completed according to Indiana Guidelines. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** This deficiency will most likely not recur due to the fact that no new construction is coming in the near future. Simple quarterly checks will solve the issue of any new or old imperfections to be fixed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any Maintenance issues will be discussed during quarterly QAPI meetings. Fire caulk should not be a future issue since there is not new construction in the works. **By what date the systemic changes for each deficiency will be completed:** The fire caulk	

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			was completed January 2, 2024.	
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Based on record review, observation and interview; the facility failed to ensure 2 of 2 hazardous areas in the new dining room such as fuel-fired heater rooms were enclosed with a 1-hour fire-rated barrier with a 3/4-hour fire-rated door. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the new dining room. Findings include: Based on review of "Project Data" application information dated 08/23/17 with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, construction plans to add a new dining area to the north end of the facility was submitted to the Indiana Department of Health by the facility. New construction plan documentation for the new dining room and adjoining areas was approved by the Indiana Department of Health in a letter to the facility dated 11/20/18. Based on interview at the time of record review, the Administrator and Maintenance stated the new dining room and adjoining areas were added to the facility in 2018. Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the door to each of two separate natural gas fired furnace rooms in the new dining room in Bldg. 03 was equipped with a self-closing device which self-closed and latched the door into the door frame when tested to close but each of the doors to the two separate furnace rooms were not	K 0321	**Tag K 321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any explosion or fire could potentially affect residents. Safety is top priority for the facility. We will continue to train for fire evacuation emergencies to ensure the safety of our residents and staff. We are not sure how these doors will be fixed yet because it is a part of our new addition that was approved by IDOH and Life Safety. Blueprints even indicated the type of doors being used, and the past before the construction of the new addition. The blueprints were available during the time of exit interview, but the surveyor refused to look at them because it would be difficult to read; or it would add more time to the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** In the future if there is any new construction we will work with an architect again and have IDOH look over the plans to ensure all	12/16/2025

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	equipped with a fire resistance rating label. Based on interview at the time of the observations, Maintenance stated no changes have been made to the doors after the rooms were constructed and agreed the doors were not equipped with fire resistance rating labels. Maintenance also stated facility blueprints or door schedule documentation might be available but was not available for review at the time of the survey. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)		codes are met per any new standard. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** In the future if there is any new construction we will work with an architect again and have IDOH look over the plans to ensure all codes are met per any new standard. The codes that were used in the blueprints were created in 2017, with final approval in 2018 are as followed: 1 Building: 2012 International building code effective December 1, 2014 w/ Indiana amendents 2 Electrical: 2009 I.E.C based on 2008 N.E.C with Indiana Amendments 3 Mechanical: 2012 International building code effective December 1, 2014 w/ Indiana amendents 4 Plumbing: 2006 I.P.C., w/ 2012 Indiana amendments 5 Energy: ASHRAE 90.1 2007 effective 2010 w/ Indiana Amendments 6 Fire Code: 2012 International building code effective December 1, 2014 w/ Indiana amendents **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place: Any new construction will be discussed during QAPI and with the owner to continue to ensure compliance. **By what date the systemic changes for each deficiency will be completed:** It is newer construction with blueprints and final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfathered in. I am asking that you look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs because of a misinterpretation of a regulation, so we will not be making any more changes. We are continuing our IDR of this tag since all plans and final construction was approved in 2022, but the contractor and architect that built the structure have been contacted. Contractor, who is a firefighter, evaluated and verified the doors are fire doors per his receipts. The doors are steel doors, but unsure why there is no fire rating. Trying to contact door company. In the meantime requesting a waiver until 12-16-25.	
K 0761 SS=E	NFPA 101 Maintenance, Inspection & Testing - Doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING 03 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

(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
Bldg. 03	Based on record review, observation and interview; the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel fire doors in accordance with NFPA 80, the Standard for Fire Doors and Other Opening Protectives. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states that after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 10 residents, staff and visitors in the new dining room. Findings include: Based on review of "Project Data" application information dated 08/23/17 with the Administrator and Maintenance during record review from 10:20 a.m. to 1:10 p.m. on 12/16/24, construction plans to add a new dining area to the north end of the facility was submitted to the Indiana Department of Health by the facility. New construction plan documentation for the new dining room and adjoining areas was approved by the Indiana Department of Health in a letter to the facility dated 11/20/18. Based on interview at the time of record review, the Administrator and Maintenance	K 0761	**Tag K 761** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any explosion or fire could potentially affect residents. Safety is top priority for the facility. We will continue to train for fire evacuation emergencies to ensure the safety of our residents and staff. To ensure the safety of our residents, the overhead door is always in the closed position unless in use. It remains closed even if residents are in the dining room, and meals have not yet started. The blueprints were available during the time of exit interview, but the surveyor refused to look at them because it would be difficult to read; or it would add more time to the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** In the future if there is any new construction we will work with an architect again and have IDOH look over the plans to ensure all codes are met per any new standard. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** In the	12/16/2025

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	stated the new dining room and adjoining areas were added to the facility in 2018. Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the metal rolling fire door between the kitchen and new dining room was not equipped with a fusible link and was not self-closing or automatic closing. Based on interview at the time of the observations, Maintenance stated no changes to the metal rolling fire door between the kitchen and new dining room have been made since the door was installed and agreed the rolling door was not equipped with a fusible link and was not self-closing or automatic closing. These findings were reviewed with the Administrator and Maintenance during the exit conference. 3.1-19(b)		future if there is any new construction we will work with an architect again and have IDOH look over the plans to ensure all codes are met per any new standard. The codes that were used in the blueprints were created in 2017, with final approval in 2018 are as followed: 1 Building: 2012 International building code effective December 1, 2014 w/ Indiana amendents 2 Electrical: 2009 I.E.C based on 2008 N.E.C with Indiana Amendments 3 Mechanical: 2012 International building code effective December 1, 2014 w/ Indiana amendents 4 Plumbing: 2006 I.P.C., w/ 2012 Indiana amendments 5 Energy: ASHRAE 90.1 2007 effective 2010 w/ Indiana Amendments 6 Fire Code: 2012 International building code effective December 1, 2014 w/ Indiana amendents **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any new construction will be discussed during QAPI and with the owner to continue to ensure compliance. **By what date the systemic changes for each deficiency will be completed:** It is newer	

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			construction with blueprints and final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfathered in. I am asking that you look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs because of a misinterpretation of a regulation, so we will not be making any more changes. The facility is continuing to IDR this tag since no changes or modifications were made since we got approval to use the dining room in 2022. However, we contacted A and R Garage Door on Thursday, January 9 about adding a fusible link. They did not give us a day of service, but said they would be out to look at the issue. We are requesting a 12 month waiver since we do not have a timetable, and per the actual fire event our method was proven to work and keep everyone safe. Waiver end date is requested for 12-16-25.	