STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. BUILDING -- B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAROLETON HEALTHCARE CENTER	2500 IOWA AVE CONNERSVILLE, IN 47331

(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: 03/19/24 Facility Number: 000318 Provider Number: 155387 AIM Number: 100266550 At this Emergency Preparedness survey, Caroleton 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 50 certified beds. At the time of the survey, the census was 48. Quality Review completed on 03/21/24	E 0000	K000 Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the on-site Life-Safety survey/quality review/licensure review conducted 03/19/2024. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review. Tonya James, LHFA	
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: 03/19/24 Facility Number: 000318 Provider Number: 155387	K 0000	K000 Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tonya James., LHFA	Executive Director	04/02/2024

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.

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	AIM Number: 100266550 At this Life Safety Code survey, Caroleton 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, and spaces open to the corridors. The facility has a capacity of 50 and had a census of 48 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached laundry building, the detached Administration annex building, the detached twenty-four foot by twenty-foot garage, and the two detached twelve foot by six-foot metal storage sheds which were not sprinklered. Quality Review completed on 03/21/24		required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the on-site Life-Safety survey/quality review/licensure review conducted 03/19/2024. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to respectfully request a desk review. Tonya James, LHFA	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egress was continuously maintained free of obstructions. This deficient practice could affect 12 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Administrator on 03/19/24 between 12:05 p.m. and 2:10 p.m., in the corridor near the service exit door there were two wooden nightstands and a wooden dresser being used for storage of light bulbs and other miscellaneous parts. The aforementioned furniture was being stored in the corridor and protruded into the corridor about 2 feet. Based on interview the MD stated that he would remove the furniture from the corridor. This deficiency was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)	K 0211	K0211 Means of Egress - General CFR(s): NFPA 101 1. The corridor/service exit corridor/door was immediately cleared of any/all obstructions.2. All residents have the potential to be affected by the issues cited in the statement of deficiencies.3. Maintenance Director or designee will provide education related to “Means of Egress” and that all corridors are free of obstruction.4. The Maintenance Director and/or designee will complete weekly audits of “Means of Egress” (1x) times per week for four (4) weeks, then (1x) time every other week for four (4) weeks, and then 1x per month thereafter.5. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	03/20/2024
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system			

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	option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous storage room in the kitchen area was not obstructed from closing. This deficient practice could affect 6 staff in the kitchen area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Administrator on 03/19/24 between 12:05 p.m. and 2:10 p.m., the dry storage room in the kitchen area, greater than 50 square feet, contained combustible material and supplies	K 0321	K 0321--Hazardous Areas - Enclosure CFR(s): NFPA 101 1. The dry storage room/dry pantry room door was immediately cleared of any/all tape/obstructions preventing the door latch from properly closing. 2. All residents have the potential to be affected by the issues cited in the statement of deficiencies. 3. Maintenance Director and/or designee will provide education	03/19/2024

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	making this a hazardous area. The door to the storage room was equipped with a self-closing device, however tape had been placed over the latch preventing the door from latching into the door frame when closed. The MD stated that staff apparently do this when they get deliveries in addition to facilitating faster and easier access to the storage room during the day. This deficiency was acknowledged by the MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		related to “Hazardous Areas - Enclosure” and that all required enclosures/doors are free of closure obstructions. 4. The Maintenance Director and/or designee will complete weekly audits of “Hazardous Areas - Enclosure” (1x) times per week for four (4) weeks, then (1x) time every other week for four (4) weeks, and then 1x per month thereafter. 5. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be			

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	posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 1. Based on observation and interview, the facility failed to ensure combustible gases were not stored in 1 of 2 smoking areas. This deficient practice could affect 12 residents in the smoking area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Administrator on 03/19/24 between 12:05 p.m. and 2:10 p.m., in the resident smoking area, a propane tank was sitting next to a gas grill inside the designated smoking area. This deficiency was acknowledged by the Administrator and MD at the time of observation and again at the exit conference with the MD and Administrator present.	K 0741	K 0741 Smoking Regulations CFR(s): NFPA 101 1. The gas grill propane tanks were immediately disconnected from the gas grill and placed in appropriate/proper storage location. 2. The employee observed smoking in a prohibited location was immediately redirected and removed from smoking in a prohibited area. 3. All residents have the potential to be affected by the issues cited in the statement of deficiencies. 4. Maintenance Director and/or designee will provide education	03/19/2024

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	3.1-19(b) 2. Based on observation, records review, and interview; the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect 3 staff around the service exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Administrator on 03/19/24 at approximately 12:10 p.m., smoking on property was evident due to an employee smoking near the service hall exit door and the exterior freezer/cooler. The Administrator was asked if that was one of the two designated smoking areas, and she stated that no it was not. Based on records review the smoking policy stated smoking is allowed "only in designated smoking areas." This deficiency was acknowledged by the Administrator and MD at the time of observation and again at the exit conference with the MD and Administrator present. 3.1-19(b)		related to “Smoking Regulations CFR(s): NFPA 101” to ensure that all designated smoking areas are free of prohibited combustible gasses and/or chemicals. 5. Maintenance Director and/or designee will provide education related to “Smoking Regulations CFR(s): NFPA 101” to ensure that smoking is prohibited in all areas, with exception to identified designated smoking areas. 6. The Maintenance Director and/or designee will complete weekly audits of “Smoking Regulations CFR(s): NFPA 101”” (1x) times per week for four (4) weeks, then (1x) time every other week for four (4) weeks, and then 1x per month thereafter. 7. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated after review of Quality Assurance/Performance Improvement Committee.	