

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155673	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/10/2014
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NAME OF PROVIDER OR SUPPLIER  MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/10/14</p> <p>Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Markle Health &amp; Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors with hard wired smoke detectors in resident rooms 302, 303, 304, 305, 306,</p>	K010000	Credible Allegation of Compliance and Request for Desk Review. The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be considered the letter of credible allegation and also requests a Desk Review certification of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K010018 SS=E	<p>307, 308, 309, 310, 311, 312, 313, 314, 315 and battery operated smoke detectors in resident rooms 101,102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218. The facility has a capacity of 86 and had a census of 82 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two wooden detached storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are</p>			

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	<p>only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 4 of 47 resident room corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects 8 residents who reside in resident rooms 103, 105, 109, and 309.</p> <p>Findings include:</p> <p>Based on observations on 06/10/14 during a tour of the facility from 8:30 a.m. to 11:00 a.m. with the maintenance supervisor, resident rooms 103, 105, 109 and 309 each had between a three quarter inch and one inch gap along the top and latching sides of the doors with the doors closed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 11:00 p.m. exit conference on 06/10/14.</p> <p>3.1-19(b)</p>	K010018	<p>K018 I. Corrective Action Taken: It is the practice of this facility to ensure all resident room corridor doors latch and resist the passage of smoke with no impediments to closing the doors. Weather stripping was installed around the doors of rooms 103, 105, 109, and 309. II. Identification of Other Residents: Maintenance supervisor visually inspected all other resident room doors. No other doors were found to be out of compliance. III. Measures Put In Place: Maintenance will visually check proper latching of resident room corridor doors to resist the passage of smoke. This will be completed once per month and will be documented on the CQI Tool titled "Environmental Safety-Resident Area". The form was revised to include this information. IV. Monitoring of Corrective Action: Maintenance will present findings once per month during the CQI meetings. Completion Date: 6-10-14</p>	06/10/2014			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 2 hazardous areas, such as storage room for combustibles over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 34 residents who reside on the 200 Hall, near the medical records storage room.</p> <p>Findings include:</p> <p>Based on observation on 06/10/14 at 10:20 a.m. with the maintenance supervisor, the 200 Hall medical records storage room which measured two hundred thirty four square feet and stored thirty one cardboard boxes of plastic adult briefs and plastic toner cartridges lacked a self closing device on the door.</p>	K010029	<p>I. Corrective Action Taken:It is the practice of this facility to ensure all storage rooms for combustibles are provided with a self closing device which causes the door to automatically close &amp; latch into the door frame. A self closing device was installed on the medical records storage room 6/12/14.II. Identification of Other Residents:All combustible storage rooms were checked for the presence of self closing devices &amp; none were found to be out of compliance. III. Measures Put In Place:Maintenance will visually monitor for the presence of a self closing device on all combustible storage rooms during monthly safety rounds. This will be documented on the CQI Tool titled "Environmental Safety-Resident Area". The form has been revised to include this information.IV. Monitoring of Corrective Action: Maintenance will present findings</p>	06/10/2014			

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K010147 SS=E	<p>This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/10/14 at 11:00 a.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 65 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 15</p>	K010147	<p>once per month x 6 months during the CQI meetings.</p> <p>At the end of the 6 month period, CQI committee will determine the need to continue monitoring this each month.</p> <p>Completion Date: 6-12-14</p> <p>K147I. Corrective Action Taken:It is the practice of this facility to ensure all electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code.9.1.2.A GFCI device was installed by the activity sink on 6/10/14.II. Identification of Other Residents:Maintenance supervisor visually checked all other sink areas and none were found to be out of compliance.III. Measures Put In Place:Maintenance will monitor for the presence of ground fault receptors during monthly safety rounds and will document the findings on the CQI tool titled "Environmental Safety-Resident Area". IV. Monitoring of Corrective Action:Maintenance will present findings once per month during the CQI meetings.Completion Date: 6/10/14</p>	06/10/2014

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	<p>residents at a time who would use the activity room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/10/14 at 9:45 a.m., the activity room had an electric receptacle on the wall within two feet of the handwash sink. Based on interview with the maintenance supervisor at the time of observation, neither the electrical outlet nor the circuit breaker for this electric outlet was provided with GFCI protection. The lack of GFCI protection for the electric receptacle near the activity room handwash sink was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at exit conference on 06/10/14 at 11:00 a.m.</p> <p>3.1-19(b)</p>						