

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 05/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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: 05/19/16</p> <p>Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340</p> <p>At this Life Safety Code survey, Markle Health and 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the resident rooms on the 300 hall, in the corridors, areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms on the 100 and 200 halls. The facility has a capacity</p>	K 0000	<p>K000Credible Allegation of Compliance & Request for Desk ReviewThe 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 compliance and also requests a desk review certification of compliance.</p>	
------------------------	--	--------	---	--

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.

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 05/19/2016	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K 0025 SS=E Bldg. 01	<p>of 86 and had a census of 70 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had two detached sheds providing facility services including activity and therapy supplies that were not sprinklered.</p> <p>Quality Review completed on 05/20/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 18 residents in one of 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of</p>	K 0025	<p>K025 I. Correction Action Taken 1. The penetrations in the ceiling of the Med-room were sealed around the wires. 2. The area above the ceiling tiles of the 100 hall smoke barrier wall have been sealed. Also, the two inch penetration through a pipe sleeve above the ceiling tiles of the 200 hall smoke barrier wall has been sealed with fire caulk. II. Identification of Other Residents Affected All residents had the potential to be affected by this deficient practice. Maintenance supervisor visually inspected all other smoke barrier walls &</p>	06/13/2016			

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 05/19/2016	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>the facility with the Environmental Services Director on 05/19/16 at 11:11 a.m., the ceiling of the Med-room contained three unsealed half inch penetrations around wires. Based on interview at the time of observation, the Environmental Services Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 45 residents in 3 of 6 smoke compartments.</p> <p>Findings include:</p>		<p>ceilings for compliance. All other affected areas have been sealed with fire caulk. III. Measures Put Into Place Maintenance will visually check for smoke barrier penetration compliance. Maintenance will perform the check once per month and results will be documented on a CQI audit tool. IV. Monitoring of Corrective Action Maintenance will present findings at the monthly CQI meetings x 6 months & then re-evaluate the need for further monitoring.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0029 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Environmental Services Director on 05/19/16 between 12:00 p.m. and 12:35 p.m., above the ceiling tiles of the 100 hall smoke barrier wall were two unsealed two inch penetrations through a pipe sleeve. Also, above the ceiling tiles of the 200 hall smoke barrier wall was one unsealed two inch penetration through a pipe sleeve. Based on interview at the time of observation, the Environmental Services Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 2 of 4 hazardous areas were smoke resistive. This deficient practice could affect 30 residents in 2 of 6 smoke</p>	K 0029	K029 I. Corrective Action a.) The half inch gap penetration around the wires and the fourth inch gap along a drywall patch have been sealed. b.) All five	06/13/2016

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 05/19/2016	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K 0044 SS=E Bldg. 01	<p>compartments.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Environmental Services Director on 5/19/16 between 10:00 a.m. and 12:00 p.m. the following hazardous areas had unsealed penetrations:</p> <p>(a) In the mechanical room on the 300 hall which contained a fuel fired water heater had a half inch penetration around wires and a fourth inch gap along a drywall patch.</p> <p>(b) In the mechanical room on the service hall which contained a fuel fired water heater had five unsealed one and a half inch penetrations around wires.</p> <p>Based on interview at the time of observation, the Environmental Services Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires</p>	K 0044	<p>penetrations around the wires have been sealed with fire caulk.</p> <p>II. Identification of Other Hazardous Areas Affected All other hazardous areas have the potential to be affected. Maintenance supervisor visually inspected all other hazardous areas for compliance & all other affected areas have been sealed.</p> <p>III. Measures Put In Place Maintenance will visually check for unsealed penetrations in all hazardous areas of the facility. Maintenance will perform the check once per month and results will be documented on a CQI audit tool. IV. Monitoring of Corrective Action Taken Maintenance will present findings at the monthly CQI meetings x 6 months and then CQI committee will re-evaluate the need for further monitoring.</p> <p>I. Corrective Action Taken</p> <p>The fire door on 200 hall has been</p>	06/13/2016			

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 05/19/2016
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 0076 SS=E Bldg. 01	<p>horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 25 residents in 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Service Director on 09/19/16 at 11:35 a.m., the fire door set to the 200 hall failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed these were fire doors by the Environmental Service Director.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p>		<p>repaired and now latches correctly.</p> <p>II. Identification of Other Residents Affected</p> <p>Maintenance has checked all fire doors to check for proper closure. No other areas of non-compliance were identified.</p> <p>III. Measures Put In Place</p> <p>Maintenance will check all doors for proper latching once per month x 6. Findings will be documented on a CQI audit tool.</p> <p>IV. Monitoring of Corrective Action</p> <p>Maintenance will present findings at the monthly CQI meetings x 6 months & then the CQI committee will re-evaluate the need for further monitoring.</p>		

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 05/19/2016	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 oxygen cylinders in the oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect 25 resident in 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Environmental Services Director on 05/19/16 at 11:15 a.m., there was an unsupported "E" cylinder of compressed oxygen in the oxygen storage room. Based on interview, this was acknowledged by the Environmental Services Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0076	<p>I. Corrective Action Taken The "E" cylinder of compressed oxygen in the oxygen storage room has been chained to the wall. II. Identification of Other Residents Maintenance has visually inspected the oxygen storage room and all other oxygen tanks are secured as required. Staff were educated by the Clinical Education Coordinator on the requirement that all freestanding cylinders must be chained or supported in a cylinder stand or cart. This education was completed by June 13th. III. Measures Put in Place Maintenance supervisor/designee will visually inspect the oxygen storage room weekly during facility rounds & observe for compliance. Findings will be documented on a CQI audit tool. Any issues involving non-compliance will be immediately addressed by the Maintenance supervisor/designee. IV. Monitoring of Corrective Action Taken Maintenance will present findings at the monthly CQI meetings x 6 months & then the CQI committee will re-evaluate the need for further monitoring.</p>	06/13/2016			

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 05/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 25 resident in 1 of 6 smoke compartments.</p> <p>Findings include: Based on an observation during a tour of</p>	K 0143	<p>I. Corrective Action The four half inch holes in the walls in the oxygen storage/trans-filling room have been fire caulked. II. Identification of Other Residents Maintenance has visually checked the oxygen storage/trans-filling room to observe for any other holes. The room was found to be in compliance. III. Measures Put In Place Maintenance will visually inspect the oxygen storage/trans-filling room walls for any damage to walls monthly x 6 and document on a CQI audit</p>	06/13/2016
----------------------------	--	--------	--	------------

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 05/19/2016
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN 46770		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	the facility with the Environmental Services Director on 05/19/16 at 11:15 a.m., the oxygen storage/trans-filling room contained four half inch holes in the walls. Based on interview at the time of observation, the Environmental Services Director confirmed the holes in the walls. 3.1-19(b)		tool. Any identified areas of concern will immediately be repaired by maintenance. IV. Monitoring of Corrective Action Maintenance will present CQI audit tool findings each month at the CQI meetings x 6 & then CQI committee will re-evaluate the need for further monitoring.		