

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2013
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NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857
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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: 03/06/13</p> <p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cloverleaf of Knightsville 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), and 410 IAC 16.2. The original facility and two additions constructed prior to March 1, 2003 were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as two separate buildings due to the construction dates of the facility. The original facility and two additions constructed prior to March 1,</p>	K010000	This plan of correction is submitted as required by law. By submitting this plan of correction Cloverleaf Healthcare does not admit that the citations listed on the CMS 2567 exist nor does it admit to any statement, finding, facts or conclusion that forms the basis of alleged citations.	

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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	<p>2003 were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors, spaces open to the corridors and resident rooms on A wing. B and C Wing resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 102 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The detached laundry is not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 locked emergency exits equipped with a magnetic lock unlocked upon activation of the fire alarm system. LSC 7.2.1.6.1 allows buildings protected throughout by an approved supervised automatic fire alarm system to have doors equipped with approved, listed, delayed-egress locks which shall automatically unlock upon actuation of an approved supervised automatic fire alarm system, loss of power controlling the lock, and an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 42 residents on C Wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/06/13 at 3:00 p.m., the west exit door from C Wing was equipped with a magnetic delayed egress lock. Upon activation of the fire alarm at</p>	K010038	<p>K038</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p>Maintenance Director has checked wiring on the c wing west exit door and door automatically opens now upon activation of fire alarm.</p> <p>Maintenance Director has checked all doors to assure that all doors automatically open upon activation of fire alarm.</p> <p>Maintenance Director will do tests 3 times weekly for 1 month, 1 test weekly for 1 month and 1 test bi weekly for 2 months and monthly thereafter.</p> <p>Administrator to monitor</p>	04/05/2013			

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	3:00 p.m., the door failed to unlock and remain unlocked when the alarm was silenced prior to resetting. The door was tested twice with the maintenance director who confirmed at the time of observations, the door did not unlock upon activation of the fire alarm. 3.1-19(b)						

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K010048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to ensure an interim fire safety plan addressing the response to alarms was followed. NFPA 101, 2000 edition, Section 19.7.2.2. requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan for response to alarms was modified.</p> <p>Findings include:</p> <p>Based on interview on 03/06/13 at 12:30 p.m. with the maintenance director and administrator, the fire alarm system was not capable of transmitting an alarm to the fire department or a monitoring station</p>	K010048	<p>the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 048 fire safety plan</p> <ol style="list-style-type: none"> 1. A new fire safety plan has been written to include. <ol style="list-style-type: none"> a.) Use of alarms. b.) Transmission of alarm to fire department. c.) Response to alarms. d.) Isolation of fire. e.) Evacuation of immediate area. f.) Evacuation of smoke compartment. g.) Preparation of floors and building for evacuation. h.) Extinguishment of fire. 2.)Any resident, vender, employee or visitor has the potential to be affected, but none were identified. 3.)The importance of these regulations have been reviewed and in-serviced to the staff and maintenance 	04/05/2013			

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	<p>due to work being done on the remote monitoring system. The administrator said at the time of interview, staff had been notified of the interruption of this service and they were instructed to call 911 in the event of fire or an activated alarm. There was no written documentation of the staff notification. On 03/06/13 at 2:55 p.m. the maintenance director announced an impending test of the fire alarm system from the B wing nurses station. He was asked, and he confirmed at the time, if his announcement would be heard in all parts of the facility. Following activation of the fire alarm on 03/06/13 at 3:00 p.m., the facility was checked for proper function of doors in all areas. Upon entering C wing, staff had removed residents to their rooms and were overheard commenting to one another they didn't know where the fire was. These staff were immediately informed the alarm was being tested. Staff # 1, the day shift charge nurse was asked if she had called 911 to report the alarm. She had not. She admitted she had been instructed to call 911 in the event of fire or an alarm by the maintenance director earlier in the day. She could provide no explanation for her failure to do so. A second shift nurse was on hand at the time of the alarm and subsequent interview. He commented, "what if someone already called? Who</p>		<p>pertaining to the new fire safety plan to include:</p> <p>a.) Use of alarms. b.) Transmission of alarm to fire department. c.) Response to alarms. d.) Isolation of fire. e.) Evacuation of immediate area. f.) Evacuation of smoke compartment. g.) Preparation of floors and building for evacuation. h.) Extinguishment of fire.</p> <p>4.)The monitoring of this will be a joint effort between the NHA/Designee and the maintenance director as they do their daily rounds which will include checking staff at random on the new fire safety plan. A quarterly monitoring by the Director of plant ops/Designee will be conducted. A report of their findings will be reviewed at the monthly risk management/QA meeting to determine that the new fire safety plan remains in compliance.</p>				

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	<p>knew who was going to call 911?" The administrator was notified of the exchange on 03/06/13 at 3:25 p.m. and conceded the staff had not responded to the fire alarm based on the notice of the fire alarm monitoring status, may not have a clear understanding of their role in the event of fire or alarm and, since they were unaware of the test, should have called 911.</p> <p>3.1-19(b)</p>			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <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. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 cylinders of nonflammable gases, such as oxygen were chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be chained or supported in a proper cylinder stand or cart. This deficient practice affects visitors, staff and 20 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/06/13 at 1:30 p.m., two oxygen B-cylinders were standing upright on a shelf without support. The maintenance director said at the time of observation, this practice was not allowed.</p>	K010076	<p>K076</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p>The two oxygen cylinders were properly placed in supported stand. Hospice company was educated and reminded that B-cylinders were not to be placed in oxygen room without support.</p> <p>This is the only oxygen room within the facility.</p> <p>Maintenance Director or his designee will audit oxygen room 3 times weekly for 1 month, 1 time weekly for 1 month and then 1 time bi weekly for 2 months and monthly thereafter.</p> <p>Administrator and Maintenance Director to monitor</p> <p>Completed 04/05/2013</p>	04/05/2013			

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain 2 of 2 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 10 or more residents in the dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/06/13 at 12:15 p.m., two vertical rolling fire doors protected the service windows between the kitchen and adjacent dining room. One door was wide open, the second was open six inches. The maintenance director said at the time of observation, one door was newly "installed three months ago" and operation was tested upon installation by the fire system</p>	K010130	<p>K0130Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue Door 1 of 2 of the rolling fire doors was recently installed, a sticker was placed stating that it was properly installed and had been tested. The rolling fire door was placed on yearly inspection list and will be inspected by contracted company Safe Care. Door 2 of 2 was locked in place therefore it can't be opened. This rolling fire door will remain closed at all times and staff have been educated. These are the only two rolling fire doors within the facilityMaintenance Director or his designee will audit rolling fire doors 3 times weekly for 1 month, 1 time weekly for 1 month and then 1 time bi weekly for 2 months and monthly thereafter. Administrator and Maintenance Director to monitor Completed 04/05/2013</p>	04/05/2013			

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	<p>contractor. He said the second door had not been tested because it was going to be replaced and it was always kept closed. A review of fire equipment inspection and testing reports on 03/06/13 at 11:30 a.m. with the administrator, did not include a report of the recent installation and testing for the rolling fire doors.</p> <p>3.1-19(b)</p>			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside. This deficient practice affects visitors, staff and 20 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/06/13 at 1:30 p.m., the oxygen transfer and storage room was identified by signage on the door and this was confirmed by the maintenance director. When the door was opened to the room, the mechanical vent was not running. A switch in the room was flipped, and the vent could then be</p>	K010143	Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue The mechanical vent in the oxygen room was re wired and placed on its own electrical switch. This switch was placed on the back wall which isn't easily accesible from doorway. Employees were educated on leaving switch in on position at all times for ventilation.This is the only oxygen room within the facility. Maintenance Director or his designee will audit oxygen room 3 times weekly for 1 month, 1 time weekly for 1 month and then 1 time bi weekly for 2 months and monthly thereafter. Administrator and Maintenance Director to monitor	04/05/2013			

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	heard running. The maintenance director acknowledged at the time of observation, turning the vent off did not provide the continuous mechanical ventilation required for the oxygen transfilling room. 3.1-19(b)				

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	<p>smoke detectors in the resident rooms (C Wing.) The facility has the capacity for 102 and had a census of 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The detached laundry is not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K040038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 locked emergency exits equipped with a magnetic lock unlocked upon activation of the fire alarm system. LSC 7.2.1.6.1 allows buildings protected throughout by an approved supervised automatic fire alarm system to have doors equipped with approved, listed, delayed-egress locks which shall automatically unlock upon actuation of an approved supervised automatic fire alarm system, loss of power controlling the lock, and an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 25 residents on C Wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/06/13 at 3:00 p.m., the south exit door from C Wing was equipped with a magnetic delayed egress lock. Upon activation of the fire</p>	K040038	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue</p> <p>Maintenance Director has checked wiring on the c wing west exit door and door automatically opens now upon activation of fire alarm.</p> <p>Maintenance Director has checked all doors to assure that all doors automatically open upon activation of fire alarm.</p> <p>Maintenance Director will do tests 3 times weekly for 1 month, 1 test weekly for 1 month and 1 test bi weekly for 2 months and monthly thereafter.</p> <p>Administrator to monitor</p>	04/05/2013			

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	<p>alarm at 3:00 p.m., the door failed to unlock and remain unlocked when the alarm was silenced prior to resetting. The door was tested twice with the maintenance director who confirmed at the time of observations, the door did not unlock upon activation of the fire alarm.</p> <p>3.1-19(b)</p>				

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K040048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review, observation and interview; the facility failed to ensure an interim fire safety plan addressing the response to alarms was followed. NFPA 101, 2000 edition, Section 19.7.2.2. requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan for response to alarms was modified.</p> <p>Findings include:</p> <p>Based on interview on 03/06/13 at 12:30 p.m. with the maintenance director and administrator, the fire alarm system was not capable of transmitting an alarm to the fire department or a monitoring station</p>	K040048	<p>the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 048 fire safety plan</p> <ol style="list-style-type: none"> 1. A new fire safety plan has been written to include. <ol style="list-style-type: none"> a.) Use of alarms. b.) Transmission of alarm to fire department. c.) Response to alarms. d.) Isolation of fire. e.) Evacuation of immediate area. f.) Evacuation of smoke compartment. g.) Preparation of floors and building for evacuation. h.) Extinguishment of fire. 2.)Any resident, vender, employee or visitor has the potential to be affected, but none were identified. 3.)The importance of these regulations have been reviewed and in-serviced to the staff and maintenance 	04/05/2013			

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	<p>due to work being done on the remote monitoring system. The administrator said at the time of interview, staff had been notified of the interruption of this service and they were instructed to call 911 in the event of fire or an activated alarm. There was no written documentation of the staff notification. On 03/06/13 at 2:55 p.m. the maintenance director announced an impending test of the fire alarm system from the B wing nurses station. He was asked, and he confirmed at the time, if his announcement would be heard in all parts of the facility. Following activation of the fire alarm on 03/06/13 at 3:00 p.m., the facility was checked for proper function of doors in all areas. Upon entering C wing, staff had removed residents to their rooms and were overheard commenting to one another they didn't know where the fire was. These staff were immediately informed the alarm was being tested. Staff # 1, the day shift charge nurse was asked if she had called 911 to report the alarm. She had not. She admitted she had been instructed to call 911 in the event of fire or an alarm by the maintenance director earlier in the day. She could provide no explanation for her failure to do so. A second shift nurse was on hand at the time of the alarm and subsequent interview. He commented, "what if someone already called? Who</p>		<p>pertaining to the new fire safety plan to include:</p> <p>a.) Use of alarms. b.) Transmission of alarm to fire department. c.) Response to alarms. d.) Isolation of fire. e.) Evacuation of immediate area. f.) Evacuation of smoke compartment. g.) Preparation of floors and building for evacuation. h.) Extinguishment of fire.</p> <p>4.)The monitoring of this will be a joint effort between the NHA/Designee and the maintenance director as they do their daily rounds which will include checking staff at random on the new fire safety plan. A quarterly monitoring by the Director of plant ops/Designee will be conducted. A report of their findings will be reviewed at the monthly risk management/QA meeting to determine that the new fire safety plan remains in compliance.</p>				

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	<p>knew who was going to call 911?" The administrator was notified of the exchange on 03/06/13 at 3:25 p.m. and conceded the staff had not responded to the fire alarm based on the notice of the fire alarm monitoring status, may not have a clear understanding of their role in the event of fire or alarm and, since they were unaware of the test, should have called 911.</p> <p>3.1-19(b)</p>			