

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 06/20/2013
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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: 06/20/13</p> <p>Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Markle Health & 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 hard wired smoke detection in the resident rooms on the 300 hall, in the corridors, and in areas open to the corridors. Battery operated smoke</p>	K010000	<p>K000Credible Allegation of Compliance & Request for Paper Compliance.The creation & submission of this 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 2567 plan of correction be considered the letter of credible allegation & requests a desk review certification of compliance.</p>	
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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>detectors were installed in the resident rooms on the 100 and 200 halls. The facility has a capacity of 86 and had a census of 71 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/27/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are 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 1 of 1 Social Services office corridor doors closed and latched into the door frame. This deficient practice affects 1 of 5 smoke compartments.</p> <p>Findings includes:</p> <p>Based on observation with the Environmental Supervisor on 06/20/13 at 1:25 p.m., the Social Services office was designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into</p>	K010018	K 0018It is the practice of this facility to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are 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.I. Corrective Action Taken: Contractor installed another latch. Both corridor doors now latch into the door frame.II. Identification of Other Residents:Contractor who installed the new corridor doors was notified about the	07/02/2013			

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	the door frame. This was acknowledged by the Environmental Supervisor at the time of observation. 3.1-19(b)		requirement to latch into the door frame.III. Measures Put In Place:Maintenance will monitor by visually inspecting all contractor work after installation of any more new doors.IV. Monitoring of Corrective Action:Compliance will be monitored by completion of an inspection log. Maintenance will complete this log after contractors install new doors & completed log will be presented to CQI committee for compliance.Completion Date: 7-2-13.		

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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 4 fire door sets were properly maintained and arranged to automatically close and latch. LSC 19.2.2.5 requires 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 positive latching is achieved on each door operation. NFPA 80, Section 15-2.5.4 requires when holes are left in a door or frame due to changes or removal of hardware or plant-ons, the holes shall be repaired by the following methods: install steel fasteners that adequately fill the holes or fill the screw or bolt holes with the same material as the door or frame. This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Environmental Supervisor on 06/20/13 at 12:55 p.m., the 200 hall fire doors failed to latch into the frame. Based on an interview with the Environmental</p>	K010044	<p>K0044It is the practice of this facility to ensure horizontal exits, if used, are in accordance with 7.2.4 19.2.2.5.I. Corrective Action Taken:a. The lower latches were removed & the doors now latch properly.b. The eight holes have been filled with hardware.II. Identification of Other Residents:a. Contractor who installed the new doors was notified about the requirement to latch properly.b. Contractor who installed the new doors was notified about the requirement to fill the holes.III. Measures Put In Place:a & b. Maintenance will monitor by visually inspecting all contractor work after installation of new fire doors.IV. Monitoring of Corrective Action:Compliance will be monitored by completion of an inspection log. Maintenance will complete this log after contractors install new fire doors & completed log will be presented to monthly Safety Committee for compliance review.Completion Date: 7-2-13.</p>	07/02/2013			

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	<p>Supervisor at the time of observation, the floor was recently replaced and latching hardware for the fire doors in the floor had not yet been reinstalled.</p> <p>b. Based on observation with the Environmental Supervisor on 06/20/13 at 12:40 p.m., the fire door set in the Cottage had eight holes measuring one half inch at the top of each door. Based on an interview with the Environmental Supervisor at the time of observation, the holes were from magnetic door locking hardware had been removed from this set of fire doors.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Fire Drill Report" with the Environmental Supervisor on 06/20/13 at 11:18 a.m., there was no record of a third shift fire drill for the fourth quarter of 2012. Based on an interview with the Environmental Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>K050It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. I. Corrective Action:Fire drills are being completed according to schedule.II. Identification of Other Residents:Maintenance has provided ED with a copy of the current Fire Drill Schedule. III. Measures Put In Place:ED will sign off on the monthly Fire Drill Schedule after comparing the time of the actual drill with the time scheduled.IV. Monitoring of Corrective Action:Compliance will be monitored by reviewing the fire drills & the schedule during the monthly Safety Committee meetings.Completion Date: 7-2-13</p>	07/02/2013	

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