

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 04/22/2015
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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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K 000 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: 04/22/15</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 000	<p>K000Credible 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 compliance and also 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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K 025 SS=F Bldg. 01	<p>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>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations through 3 of 4 smoke barrier walls was 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</p>	K 025	K 025I. Corrective Action Taken:It is the practice of this facility to ensure all smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier & ceiling smoke barriers provide a one hour fire resistance rating.1. a.) The pipes and wires in the 200 hall smoke wall above the ceiling tiles has been sealed. b.) The pipes and wires in the 300 hall smoke wall above the ceiling tiles has been sealed. c.) The pipe in the service hall smoke wall above the ceiling tile has been sealed.2. a.) The	05/18/2015			

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	<p>resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 4 of 5 smoke compartments of the facility.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Environmental Supervisor on 04/2/15 between 11:16 a.m. and 11:43 a.m. the following unsealed smoke barrier penetrations were noted:</p> <p>a.) Three penetrations three fourth of an inch in size around pipes and wires in the 200 hall smoke wall above the ceiling tiles.</p> <p>b.) Two penetrations one fourth of an inch in size around pipes and wires in the 300 hall smoke wall above the ceiling tiles.</p> <p>c.) One penetration one half inch in size around a pipe in the service hall smoke wall above the ceiling tile</p> <p>Based on interview at the time of observation, the Director of Maintenance 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 1 of 1 ceiling</p>		<p>penetrations through the ceiling around the sprinkler heads of room 215 have been sealed. b.) The penetrations through the ceiling around the sprinkler heads of room 216 have been sealed. c.) The penetrations through the ceiling around the sprinkler heads in the maintenance shop have been sealed. d.) The penetrations through the ceiling around the sprinkler heads in the kitchen have been sealed. e.) The penetrations through the ceiling around the sprinkler heads in the supply closet of the service hall have been sealed. f.) The penetrations through the ceiling around the sprinkler heads in the men's restroom in the service hall have been sealed. g.) The penetrations through the ceiling around the sprinkler heads in the therapy room have been sealed. h.) The penetrations through the ceiling around the sprinkler heads in room 103 have been sealed.II. Identification of Other Residents:All other rooms have the potential to be affected. Maintenance supervisor visually inspected all other smoke barrier walls & ceilings for compliance. No others areas were affected.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 the</p>	

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	<p>smoke barriers was maintained to provide a one 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 can affect all residents of the facility</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Environmental Supervisor on 04/22/15 between 10:25 a.m. and 11:20 a.m., the following ceiling penetrations were noted:</p> <p>a.) Three unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads of room 215.</p> <p>b.) Two unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads of room 216.</p> <p>c.) Two unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in the maintenance shop.</p> <p>d.) Two unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in the kitchen.</p> <p>e.) One unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in the supply closet of the service hall.</p> <p>f.) One unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in the men's</p>		<p>Corrective Action Taken: Maintenance will present findings at the monthly CQI meetings x 6 months. Completion Date: 5/18/15</p>				

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K 029 SS=E Bldg. 01	<p>rest room in the service hall.</p> <p>g.) One unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in the therapy room.</p> <p>h.) One unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads in room 103. Based on interview at the time of observation, the Environmental Supervisor 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 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 Based on observation and interview, the facility failed to ensure 3 of 4 furnace/boiler rooms, a hazardous area, was smoke resistive and provided one hour fire rated construction. This</p>	K 029	K029I. Corrective Action Taken:It is the practice of this facility to ensure one hour fire rated construction or an approved automatic fire extinguishing system protects hazardous areas.a.) The holes around pipes	05/18/2015	

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K 038 SS=B Bldg. 01	<p>deficient practice could affect 4 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Environmental Supervisor on 04/22/15 between 10:30 a.m. 11:01 a.m., the following hazardous areas containing a hot water heater had unsealed penetrations.</p> <p>a.) Two holes around pipes one to one and a half inch in size in the service hall furnace room.</p> <p>b.) Three holes around pipes one to two inches in size in the 300 hall furnace room.</p> <p>c.) One hole half inch in size in the 200 hall furnace room.</p> <p>Based on interview at the time of observation, the Environmental Supervisor acknowledged and provided the measurement of the penetrations.</p> <p>3.1-19(b)</p> <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 6 exit doors</p>	K 038	<p>in the service hall furnace room have been sealed.b.) The holes around pipes in the 300 hall furnace room have been sealed.c.) The hole in the 200 hall furnace room have been sealed.II. Identification of Other Residents:All other hazardous areas have the potential to be affected.Maintenance supervisor visually inspected all other hazardous areas for compliance. No other areas were affected.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.Completion Date: 5/18/15</p> <p>K038I. Corrective Action Taken:It is the practice of the facility to ensure exits are readily</p>	05/15/2015			

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	<p>was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " This deficient practice could affect 31 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Environmental Supervisor on 04/22/15 at 10:30 a.m., the exit doors on the 200 hall were equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked proper signage regarding pushing the door to open. There was a sign posted, but the sign was printed on paper, was taped to the wall near the top of the wall, and was not immediately noticeable. Based on interview at the time of observation, the Environmental Supervisor acknowledged this was not proper signage regarding pushing the door to open.</p> <p>3.1-15(b)</p>		<p>accessible at all times in accordance with section 7.1. 19.2.1.A professionally manufactured sign was obtained and affixed to the 200 hall exit door.II. Identification of Other Residents:All residents have the potential to be affected.Professionally manufactured signage was obtained & affixed to the exit doors on 200 hall, 300 hall and the front door.III. Measures Put In Place:Maintenance will visually check for proper signage on 200 hall, 300 hall & the front exit doors in the facility. Maintenance will perform the visual audit once per month and the 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.Correction Date: 5/15/15</p>		

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