

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 12/19/2011
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NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN47857
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K0000	<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: 12/19/11</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>	K0000	<p>This plan of correction is to serve as Cloverleaf Of Knightsville's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Cloverleaf Of Knightsville or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We are in full compliance as of 01/18/2012</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.

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	<p>This facility 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, 2003 were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Wing A has smoke detectors in every resident room. The facility has the capacity for 102 and had a census of 83 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K0017 SS=E	<p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure an open use area in 1 of 6 smoke compartments was separated from the corridor by smoke resistant walls, extending from the floor to the roof above, or met an exception. LSC 19.3.6.1, Exception # 6: Spaces other than patient sleeping rooms, treatment rooms and hazardous areas may be open to the corridor and may be unlimited in area provided: (a) The space and corridors which the space opens into in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, or the</p>	K0017	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Contracted company Safe Care installed a electrically supervised automatic smoke detector on 1-6-12 2.) Maintenance director discovered there to be no other open use area compartments within the facility.3.) Electrically supervised smoke detector was added to annual test and inspection list.4.) Administrator to monitor</p>	01/18/2012

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	<p>furnishings and furniture within the area, in combination with all other combustibles within the area, are of such minimum quality and arrangement that a fully developed fire is unlikely to occur, and (c) The space does not obstruct access to required exits. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment housing the main sitting area and dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 12:40 p.m., the human resources office had a 24 inch by 36 inch opening with two sliding glass smoke tight panels. The panels had no latch and the office was not continuously occupied. Additionally, the office was not protected by an electrically supervised automatic smoke detection system or located to permit direct supervision by the facility staff from a nurse's station or similar space when unoccupied. The maintenance director acknowledged at the time of</p>			

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K0038 SS=E	<p>observation, the window could be open to the corridor without the benefit of a latch.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure a handrail was provided for 1 of 2 exits with a ramp. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4, Exception #3, allows existing ramps shall be permitted to have handrails on one side only. This deficient practice could affect 6 staff, visitors and any resident in the south offices.</p> <p>Findings include:</p> <p>Based on observation on 12/19/11 at 10:15 a.m. with the maintenance director, the east exit</p>	K0038	<p>K038 Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue Maintenance Director has installed hand rails along the east exit ramp from the south offices. Maintenance Director has poured concrete and made the section of the exit discharge to be level. Maintenance Director has checked all other exits to assure ramps have hand rails and also that the walking surfaces in the means of egress are nominally level. Maintenance Director will do semi yearly checks to assure levels and hand rails are in proper condition. Administrator to monitor</p>	01/18/2012	

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	<p>from the south offices exit corridor had a ten foot long ramp with a grade change of at least twelve inches from top to bottom. The ramp was not provided with a handrail. The maintenance director said at the time of observation, the railing had become unsafe and had been removed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 11 exits was arranged to minimize tripping hazards. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect staff, visitors, and 40 residents on B hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 2:05 p.m., the concrete exit discharge surface for the center exit from B hall had an abrupt</p>				

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K0046 SS=D	<p>level change of one and three quarters inches at the expansion joint between the concrete pad outside the exit door and the next section of the concrete walking surface. The maintenance director acknowledged at the time of observation, the surface was irregular across the width of the sidewalk.</p> <p>3.1-19(b)</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure emergency lighting was provided in the basement. LSC 7.9.2.1 requires emergency lighting shall be provided for not less than one and one half hours in the event of failure of normal lighting. This deficient practice affects visitors and maintenance staff in the basement.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11</p>	K0046	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.)Maintenance Director installed an emergency light down in the basement and also outside the building in the center of B wing.2.) Maintenance Director has checked all alcoves to assure emergency lighting was provided3.) Maintenance Director will audit emergency lighting quarterly 4.) Administrator to monitor</p>	01/18/2012	

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	<p>at 10:40 a.m., emergency lighting was not provided for the basement level and access stairway. The maintenance director said at the time of observation, he carried a flashlight when he went into the basement for sprinkler riser, storage and any other issues in case the normal lighting failed.</p> <p>3.1-19 (b)</p> <p>2. Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 1 of 11 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 40 residents on B hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 2:10 p.m., the exit discharge path from the center B wing exit to the street evacuation point was not provided with the emergency</p>						

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K0047 SS=E	<p>lighting along its entire length. The maintenance director agreed at the time of observation, the center exit discharge lighting provided could not illuminate more than the exit alcove.</p> <p>3.1-19(b)</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 paths in the exit means of egress from the south offices was clearly identified. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects 6 staff, visitors and any resident in the south offices.</p> <p>Findings include:</p>	K0047	<p>K047Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Maintenance Director installed an exit sign above the west exit doorway from the south offices corridor.2.) Mainteance Director has assured all other exit doors are marked with an exit sign.3.) Maintenance Director audits exit door signs weekly to assure proper function.4.) Administrator to monitor</p>	01/18/2012			

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K0048 SS=E	<p>Based on observation with the maintenance director on 12/19/11 at 10:10 a.m., exit signs were not posted for the corridor doorway leading to the west exit from the south offices. The maintenance director acknowledged an exit sign above the west exit doorway was not visible from the south offices corridor.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(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</p>	K0048	<p>K048Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.)Administrator has added the use of the K class fire extinguisher located in the kitchen to the Fire Action Plan Policy and included it on the fire extinguisher locations page in the disaster plan book.2.) Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.) Emergency/Disaster Plan Policy book will be audited and updated yearly4.) Administrator to monitor</p>	01/18/2012

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	<p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility Fire Action Plan with the maintenance director and administrator on 12/19/11 at 10:20 a.m., the Fire Action Plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The administrator said at the time of record review, training was conducted annually for the use of each fire extinguisher type despite the omission in the fire plan.</p> <p>3.1-19(b)</p>				

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K0051 SS=E	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 2 of 6 smoke compartments were properly separated from an air supply. LSC 9.6 refers to NFPA 72. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. A-2-3.5.1 explains detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice</p>	K0051	<p>K051Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Maintenance Director and contracted company Safe Care relocated the smoke detectors near the HR office, dining room, entry foyer and near room 23. The smoke detectors were moved the appropriate distant away from the supply and/or return air vents.2.) Maintenance Director has assured that all smoke detectors throughout building are at an appropriate distance away from supply and/or return air vents.3.) Maintenance Director to audit all smoke detectors to assure distance is appropriate.4.) Administrator to monitor</p>	01/18/2012

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	<p>could affect visitors, staff, and 50 or more residents in the center and B hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 between 12:40 p.m. and 2:15 p.m., smoke detectors in the corridor were located less than the minimum distance from supply and/or return air vents near the human resources office (one foot), the dining room (two feet), the entry foyer (eight inches) and near room 23 (two feet). The maintenance director confirmed the distance measurements and agreed at the time of observations, the air flow could impede the function of the smoke detectors.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 combustable exterior emergency exit canopies from the service corridor discharge and 1 of 1 adjacent roof overhangs with the attached combustable canopy. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustable exterior roofs or canopies exceeding four feet in width. This deficient practice affects visitors, staff, and any resident who might be in the vicinity.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 12:05 p.m., a six by six foot</p>	K0056	<p>K056Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Contracted company Safe Care installed sprinkler coverage under exit canopies from the service corridor discharge and adjacent roof overhang with the attached combustable canopy. Sprinkler coverage was also added to the alcove in the HR office. Safe Care also relocatd the sprinkler heads in the scheduling office, storage closet next to room 23 and the linen closet next to room 22 that were located to close to the wall Maintenance Director installed a pipe arm to support each six foot long, one inch steel prinkler pipes in rooms 12, 13, 14 and 15.2.)Mainteance Director checked all sprinkler heads for there location and the distance between the wall and sprinkler head. All sprinkler heads were at correct distance. All overhangs</p>	01/18/2012

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	<p>wooden overhead canopy was constructed above the service corridor exit discharge. A two by 53 foot roof overhang was located adjacent to the exit discharge with a two foot wide canvas canopy attached to the roof along the length of the roof overhang. The covered areas were not sprinklered. The maintenance director said at the times of observation, he was unaware these outdoor areas required sprinkler protection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide complete sprinkler coverage for all areas in 1 of 6 smoke compartments. LSC 19.1.6.2 requires facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects visitors, staff, and 10 or more residents in the center smoke compartment which includes a main sitting area and dining room.</p> <p>Findings include:</p>		<p>were checked to determine width and assure sprinkler coverage was provided if needed. sprinkler pipes were checked to assure all were appropriately supported.3.) Maintenance Director to audit sprinkler heads annually4.) Administrator to monitor</p>		

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	<p>Based on observation with the maintenance director on 12/19/11 at 12:35 p.m., a four by eight foot alcove was located in the human resources office separated by an eighteen inch by eight foot bulk head. There was no sprinkler in the alcove. The maintenance director agreed the single sprinkler provided in the human resources office would not provide coverage for the alcove.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to install sprinkler systems in accordance with NFPA 13. NFPA 13, 1999 Edition at 5-6.3.3 requires sprinklers shall be located a minimum distance of four inches from a wall. This deficient practice affects visitors, staff, and 40 residents in the northwest B hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11</p>			

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	<p>between 12:50 a.m. and 2:10 p.m., sprinkler heads were located less than four inches from walls in the scheduling office near the B hall nurses station (three inches); in the corridor storage closet near room 23 (two inches), and corridor linen storage closet near room 22 (two inches). The maintenance director confirmed the measurements at the times of observation and said he was unaware of the wall separation requirement for the sprinkler heads.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to install sprinkler systems in accordance with NFPA 13. NFPA 13, 1999 Edition at 6-2.3.4 requires the cumulative horizontal length of an unsupported armover to a sprinkler shall not exceed 24 inches for steel pipe. This deficient practice affects visitors, staff, and 40 residents in the northwest B hall smoke compartment.</p> <p>Findings include:</p>						

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K0069 SS=E	<p>Based on observation with the maintenance director on 12/19/11 between 12:50 a.m. and 2:10 p.m., a six foot long unsupported one inch steel sprinkler pipe arm exceeded the maximum of 24 inches allowed in resident room 15 and in rooms 14, 13, and 12 where the unsupported lengths were measured at five feet. The maintenance director said at the times of observation, he had not realized the unsupported lengths exceeded the maximum length permitted.</p> <p>3.1-19(b)</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to ensure the grease filters on 1 of 1 kitchen stove hoods was properly positioned to drain the grease into the containers. NFPA 96, Standard for Ventilation Control and Fire</p>	K0069	<p>K069Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Maintenance Director changed the orientation of the grease filter baffles from horizontally to vertical2.) Maintenance Director educated</p>	01/18/2012

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K0147 SS=E	<p>Protection of Commercial Cooking Operations, 1998 Edition, at 3.2.7 says grease filters requiring a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so filters cannot be installed in the wrong orientation. This deficient practice could affect kitchen staff and any residents or visitors in the adjoining dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 11:50 a.m., grease filter baffles were installed horizontally to drain grease from the exhaust hood. The maintenance supervisor said at the time of observation, he was not sure of the correct orientation for the grease filters.</p> <p>3.1-19(b)</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>		<p>on the requirements of the specific orientation of grease filters3.) Maintenance Director to do quarterly audits to assure the orientation of grease filter baffles are correct.4.) Administrator to monitor</p>		

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	<p>Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 6 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects 3 visitors, 2 staff and 10 residents in the assisted dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/19/11 at 12:10 p.m., a mechanical/electrical room housing electrical circuit panels was accessed through a door in the assisted dining room. The room was filled with dining room</p>	K0147	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) The mechanical room where the electrical circuit panels are on C wing was cleared of extra dining room chairs.2.) Two other mechanical rooms were checked to assure electrical panels were easily accessible3.) Maintenance director to monitor monthly and bring issues to administrator if furniture is put back into mechanical rooms.4.) Administrator to monitor</p>	01/18/2012

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K0154 SS=F	<p>chairs stacked two and three high which had to be removed before the electrical panels could be accessed. The maintenance director said at the time of observation, he had asked staff repeatedly to keep the room free of storage.</p> <p>3.1-19(b)</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 83 of 83 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's</p>	K0154	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Verbiage was changed on the Fire Watch Policy and Procedure in the disaster plan poly book to consist of " It is the policy of Cloverleaf Healthcare to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24 hour period."2.)Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.)</p>	01/18/2012	

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K0155 SS=F	<p>Fire Watch Policy and Procedure with the administrator and maintenance director on 12/19/11 at 1:40 p.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedures did not include the requirement for initiating a fire watch when the sprinkler system was out of service for four hours in 24 hours. The administrator acknowledged this element of the fire watch requirement was omitted.</p> <p>3.1-19(b)</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on observation and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 83 of 83 residents in the event the fire</p>	K0155	<p>Emergency/Disaster Plan Policy book will be audited and updated yearly4.) Administrator to monitor</p> <p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Verbiage was changed on the Fire Watch Policy and Procedure in the disaster plan polyi book to consist of " It is the policy of</p>	01/18/2012	

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	<p>alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy and Procedure provided as evidence of procedures to follow in the event the fire alarm system was out of service with the administrator and maintenance director on 12/19/11 at 1:40 p.m., the policy and procedure was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period. The administrator acknowledged at the time of record review, this element of the fire watch requirement was omitted.</p> <p>3.1-19(b)</p>		<p>Cloverleaf Healthcare to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24 hour period."2.)Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.) Emergency/Disaster Plan Policy book will be audited and updated yearly4.) Administrator to monitor</p>		

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K0000	<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: 12/19/11</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 2006 addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The 2006 addition was determined to be of Type V (111) construction</p>	K0000	<p>This plan of correction is to serve as Cloverleaf Of Knightsville's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Cloverleaf Of Knightsville or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We are in full compliance as of 01/18/2012</p>	

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K0048 SS=E	<p>and fully sprinklered. The 2006 addition has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 102 and had a census of 83 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>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</p> <p>Based on record review and interview the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <p>(1) Use of alarms</p> <p>(2) Transmission of alarm to the fire department</p>	K0048	<p>K048Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.)Administrator has added the use of the K class fire extinguisher located in the kitchen to the Fire Action Plan Policy and included it on the fire extinguisher locations page in the disaster plan book.2.) Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.) Emergency/Disaster Plan Policy book will be audited and updated</p>	01/18/2012

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	<p>(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 This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility Fire Action Plan with the maintenance director and administrator on 12/19/11 at 10:20 a.m., the Fire Action Plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The administrator said at the time of record review, training was conducted annually for the use of each fire extinguisher type despite the omission in the fire plan.</p> <p>3.1-19(b)</p>		yearly.) Administrator to monitor		

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K0154 SS=F	<p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 83 of 83 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy and Procedure with the administrator and maintenance director on 12/19/11 at 1:40 p.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedures did not include the requirement for initiating a fire watch when the sprinkler system was out of</p>	K0154	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Verbiage was changed on the Fire Watch Policy and Procedure in the disaster plan poly book to consist of " It is the policy of Cloverleaf Healthcare to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24 hour period."2.)Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.) Emergency/Disaster Plan Policy book will be audited and updated yearly4.) Administrator to monitor</p>	01/18/2012

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K0155 SS=F	<p>service for four hours in 24 hours. The administrator acknowledged this element of the fire watch requirement was omitted.</p> <p>3.1-19(b)</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on observation and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 83 of 83 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Policy and Procedure provided as evidence of</p>	K0155	<p>Our facility strives to provide the best care possible. Consistent with this practice we have addressed the following issue 1.) Verbiage was changed on the Fire Watch Policy and Procedure in the disaster plan poliy book to consist of " It is the policy of Cloverleaf Healthcare to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24 hour period."2.)Emergency/Disaster Plan Policy book was reviewed and updated to assure policies met standard code3.) Emergency/Disaster Plan Policy book will be audited and updated yearly4.) Administrator to monitor</p>	01/18/2012

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	<p>procedures to follow in the event the fire alarm system was out of service with the administrator and maintenance director on 12/19/11 at 1:40 p.m., the policy and procedure was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period. The administrator acknowledged at the time of record review, this element of the fire watch requirement was omitted.</p> <p>3.1-19(b)</p>				