STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING -- B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/22 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Emergency Preparedness survey, Cloverleaf of Knightsville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 77. Quality Review completed on 09/08/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contests the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 30, 2022 to the Life Safety survey completed on August 30, 2022. We respectfully request a paper review and will provide any additional information requested.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	155542	A. BUILDING -- B. WING	08/30/2022

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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/30/22 at 1:05 p.m. with the Maintenance Supervisor present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. Based on interview at the time of record review, the Maintenance Supervisor agreed there was no documentation provided on the monthly	E 0041	**It is the practice of the facility to assure our emergency generator inspections and testing meet federal life safety requirements.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The monthly generator inspection was completed and documented per Life Safety code. The transfer load percentage and the 10 sec transfer time was completed and documented for the month of September. **How the corrective action(s) will be monitored to ensure the**	09/30/2022

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	generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 2. Based on record review and interview, the facility failed to ensure the transfer time to the alternate power source on the monthly load test supplied service within 10 seconds to the alternate power supply for 1 of 1 emergency generator during the past 12 month period. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 08/30/22 at 1:05 p.m. with the Maintenance Supervisor present, the 2021 and 2022 generator log form documented the generator was tested monthly for at least 30 minutes under load with a five minute cool down time, however, the transfer time from normal power to emergency power was always listed as 30 seconds for the past 12 month period. When asked, the Maintenance Supervisor said he always put 30 seconds as the transfer time because that's the way it had always been documented. He further said he was not sure what the actual transfer time was. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		**deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect the generator under load monthly for three months. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/30/22 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Life Safety Code survey, Cloverleaf of Knightsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in resident rooms on the A wing. Resident rooms in the B and C wings were equipped with battery operated smoke alarms. The facility has a capacity of 102 and had a census of 77 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the detached laundry building. Quality Review completed on 09/08/22	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contests the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 30, 2022 to the Life Safety survey completed on August 30, 2022. We respectfully request a paper review and will provide any additional information requested.	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation, and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in 15 of 50 resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect at least 20 residents, staff and visitors on C Wing. Findings include: Based on record review on 08/30/22 at 10:45 a.m. with the Maintenance Supervisor present, there was documentation available that battery operated smoke alarms on the B Wing were tested monthly, however, the documentation provided did not include testing the battery operated smoke alarms on the C Wing. Based on observation of one battery operated smoke alarm from resident room 54 during a tour of the facility, the smoke alarm battery did have a replacement date of 06/20/22. The Maintenance Supervisor said all battery operated smoke alarms in the facility were replaced on 06/20/22. Based on interview at the	K 0300	**It is the practice of this facility to assure that all Battery-Operated Smoke detectors are inspected and maintained in accordance with federal life safety code.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All 15 Battery Operated smoke detectors have been inspected for the month of September with no issues noted.	09/30/2022

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	time of record review, the Maintenance Supervisor confirmed there was no documentation available to show resident room smoke alarms on the C Wing were tested monthly during the past 12 month period. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect ALL Battery-Operated Smoked Detectors monthly for three months. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 5 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions.	K 0331	**It is the practice of the facility to assure that all Interior wall and ceiling finishes, and or smoke compartments have a flame spread rating that meets the requirements of federal life safety code.**	09/30/2022

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	A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect up to 34 residents, staff, and visitors while in the same smoke compartment. Findings include: Based on observation on 08/30/22 at 12:21 p.m. during a tour of the facility with the Maintenance Supervisor, there was a one foot by one and a half foot plywood attic access panel in the Beauty Shop. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the plywood attic access panel did not have a flame spread rating as far as he knew. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An appropriate flame spread rated sheet of Drywall was installed for the pre-existing attic access panel in the Beauty Shop. An audit of the entire building was conducted, and all attic access panels met requirements. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect ALL attic access panels monthly for three months. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting.	

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			The date the systemic changes will be completed: September 30, 2022	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 4 of 57 smoke detectors that failed the sensitivity test was replaced or repaired. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument.	K 0345	**It is the practice of the facility to assure that all smoke detectors are tested and maintained in accordance with an approved program complying with the requirements of NFPA 70 and NFPA 72 National Fire Alarm and Signaling Code.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified.	09/30/2022

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	(3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 08/30/22 at 10:15 a.m. with the Maintenance Supervisor present, the smoke detector sensitivity test report dated 06/01/22 indicated four smoke detector (#4, #5, #37, and #39) had failed. There was no documentation available to show that the failed smoke detector had been replaced or repaired. Based on interview at the time of record review, the Maintenance Supervisor confirmed that there was no documentation available to show that the four smoke detector had been replaced or repaired since the 06/01/22 sensitivity test report. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Safe Care, Cloverleafs fire safety contractor, replace all four smoke detectors that had failed the previous inspection. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect All smoke detectors for three months to assure all the shifts match up with the correct time of day. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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Bldg. 01	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads covered with corrosion in 2 of 6 smoke compartments were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 30 resident, as well as staff and visitors within the smoke compartments. Findings include: Based on observations on 08/30/22 at 11:45 a.m.	K 0353	**It is the practice of the facility to assure that all sprinkler heads and pipes are inspected in accordance with NFPA 25 and federal life safety code.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic**	09/30/2022

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	155542	A. BUILDING 01 B. WING	08/30/2022

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	and again at 12:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was one sprinkler head in the A Wing Soiled Utility room covered with corrosion, furthermore, there was one sprinkler head in the B Wing Janitor's Closet also covered with corrosion. Based on interview at the time of each observation, the Maintenance Supervisor agreed the sprinkler heads in the Soiled Utility room and Janitor's Closet were covered with corrosion and needed to be replaced. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur:** Safe Care, Cloverleaf's fire safety contractor, provided an estimate to repair and fix the corrosive sprinkler heads. The quote was accepted and they plan to be onsite as soon as the ordered parts arrive. An audit of the entire building was conducted, and all additional sprinkler heads met requirements. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect All sprinkler heads monthly for three months to assure all the sprinklers meet life safety code standards. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick			

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	solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect up to 34 residents, as well as staff and visitors in the B Wing. Findings include: Based on observation on 08/30/22 at 12:12 p.m. during a tour of the facility with the Maintenance Supervisor, the set of smoke barrier doors in the B Wing did not close completely when tested. There was a two inch gap between the set of doors when closed fully. Based on interview at the time of observation, the Maintenance Supervisor agreed the set of smoke barrier doors in the B Wing did not close completely when tested. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	K 0374	**It is the practice of the facility to assure that all smoke barrier doors will close to form a smoke resistant barrier.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Safe Care, cloverleafs fire safety contractor, installed a device on the door closure system that allowed the door to properly close in accordance with federal life safety code.	09/30/2022

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	3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect All smoke barrier doors monthly for three months to assure all doors close and latch properly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 6 of 12 fire drills performed during the past 12 month period were listed as the correct designated shift time frame. This deficient practice could affect all residents in the facility.	K 0712	**It is the practice of the facility to assure Fire Drills are conducted in accordance with federal life safety code.** **The corrective action taken for those residents found to be**	09/30/2022

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	Findings include: Based on review of fire drill records on 08/30/22 at 10:00 a.m. with the Maintenance Supervisor present, there were no first shift fire drills listed during the past 12 month period. Based on interview at the time of record review, when asked, the Maintenance Supervisor said the first shift fire drills are performed between 6:00 a.m. and 2:00 p.m., second shift between 2:00 p.m. and 10:00 p.m., and third shift between 10:00 p.m. and 6:00 a.m. The following was noted: a. Fire drills performed on 08/10/21 at 12:00 p.m., 11/09/21 at 11:40 a.m., 02/03/22 at 10:00 a.m., and 05/09/22 at 2:00 p.m. were all listed as second shift fire drills, when they all fell under the first shift time frame. b. Fire drills performed on 09/13/21 at 8:00 p.m., and 12/05/21 at 6:00 p.m. were all listed as third shift fire drills, when they both fell under the second shift time frame. Based on interview at the time of record review, the dates and times of the previous fire drill reports were confirmed by the Maintenance Supervisor, who further said all the fire drills performed during the past 12 month period were performed during the correct shifts, but were documented incorrectly on the fire drill forms. These finding were reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A fire drill for the month of September was held on the first shift at the correct time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect All fire drills monthly for three months to assure there is a drill completed on each shift at least quarterly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	

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K 0761 SS=C Bldg. 01	1. Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.	K 0761	**It is the practice of the facility to assure all Fire Doors be inspected and tested in accordance with NFPA 80.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All fire doors have been inspected, tested, and documented in accordance with NFPA 80. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to inspect All fire doors monthly for three months. Any negative findings will be immediately remedied, and administrator	09/30/2022

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect at least least 20 residents, staff, and visitors on the C Wing. Findings include: Based on record review on 08/30/22 at 11:15 a.m. with the Maintenance Supervisor present, the facility was unable to provide documentation for an annual inspection of fire door assemblies, include, one oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Supervisor said he inspects all fire/smoke door assemblies on a regular basis but has no documentation available during the past 12 month period or prior. Based on observations during a tour of the facility with the Maintenance Supervisor at 1:30 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	

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	3.1-19(b) 2. Based on record review, observation and interview, the facility failed to maintain 1 of 1 rolling fire door in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants while in the dining room. Findings include: Based on record review on 08/30/22 at 10:35 a.m. with the Maintenance Supervisor present, there was no annual rolling fire door inspection to review. Based on observation with the Maintenance Supervisor at 12:00 p.m., the rolling fire door between the kitchen and dining room was not working properly. Based on interview at the time of observation, the Maintenance Supervisor said the rolling fire door will drop with the fire alarm but will not reset properly. He further said there is a work order with the vendor to get the problem corrected. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.			

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	3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

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	NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/30/22 at 1:05 p.m. with the Maintenance Supervisor present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. Based on interview at the time of record review, the Maintenance Supervisor agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the transfer time to the alternate power source on the monthly load test supplied service within 10 seconds to the	K 0918	**It is the practice of the facility to assure that our Generator is exercised in accordance with NFPA 101.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The generator has been exercised under load during the month of September and transferred the load within the 10-sec time frame. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to exercise the generator under load monthly for three months. Any negative findings will be immediately remedied, and administrator notified. The results	09/30/2022

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	alternate power supply for 1 of 1 emergency generator during the past 12 month period. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 08/30/22 at 1:05 p.m. with the Maintenance Supervisor present, the 2021 and 2022 generator log form documented the generator was tested monthly for at least 30 minutes under load with a five minute cool down time, however, the transfer time from normal power to emergency power was always listed as 30 seconds for the past 12 month period. When asked, the Maintenance Supervisor said he always put 30 seconds as the transfer time because that's the way it had always been documented. He further said he was not sure what the actual transfer time was. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 staff Conference room. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff only. Findings include: Based on observation on 08/30/22 at 11:02 a.m. during a tour of the facility with the Maintenance Supervisor, there was a microwave and toaster plugged into a power strip in the staff Conference Room. Based on interview at the time of	K 0920	**It is the practice of the facility to assure there are no power strips in the patient care vicinity.** **The corrective action taken for those residents found to be affected by the deficient practice include:** No residents were found to be affected by the deficient practice. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:** Potentially all residents could be affected but none were identified. **What measures will be put into place and what systemic**	09/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 01 B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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	observation, the Maintenance Supervisor acknowledged the use of the power strip in the staff Conference Room. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur:** The power strip was immediately removed from the patient care vicinity. All rooms in the facility have been audited for additional power strips with no findings. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** An audit will be completed by maintenance or designee to audit patient care vicinity of power strips for three months. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Meeting. **The date the systemic changes will be completed: September 30, 2022**	