PRINTED: 09/23/2022
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155542	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
E 0000			E 00	000	By submitting the enclosed materials, we are not admittin truth or accuracy of any specifindings or allegations. We retained to contests the findings.	ific serve	
	Facility Number: (Provider Number: 100 AIM Number: 100 At this Emergency Cloverleaf of Knig	000296 155542	proceedings and submit the responses pursuant to our regulatory obligations. The requests that the plan of correction be considered or conside		or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The far requests that the plan of correction be considered our allegation of compliance effects	e cility ctive	
	Requirements for M Participating Provid 483.73	Medicare and Medicaid ders and Suppliers, 42 CFR 2 certified beds. At the time of			Safety survey completed on August 30, 2022. We respect request a paper review and w provide any additional informatequested.	fully vill	
		mpleted on 09/08/22 42 CFR, Subpart 483.73 is NOT by:					
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital musi standby power sy emergency plan s this section and ir	I LTC Emergency Power tion for Participation: and standby power systems. I implement emergency and stems based on the set forth in paragraph (a) of a the policies and set forth in paragraphs (b)(1)					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.73(e), §485.625(e)

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLE B. WING 08/30/2			LETED	
	PROVIDER OR SUPPLIE		•	9325 N	DDRESS, CITY, STATE, ZIP COD CRAWFORD ST SVILLE, IN 47857	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	INATE	DATE
	(e) Emergency ar The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency gener generator must be the location required Care Facilities Counterim Amendment 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an	and standby power systems. and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The ise located in accordance with rements found in the Health inde (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim in 12-1, TIA 12-2, TIA 12-3, ind NFPA 110, when a new or when an existing					
	Emergency generation The [hospital, CA implement the eminspection, testing requirements four	3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] and in the Health Care IFPA 110, and Life Safety					
	Emergency generand LTC facilities source to power en have a plan for he power systems of emergency, unless	3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the ss it evacuates.					
	§483.73(g), and 0 The standards inc	CAHs §485.625(g):] corporated by reference in					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155542	B. WING		08/30/2022
		<u>-</u>	STREE	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹	9325	N CRAWFORD ST	
CLOVER	RLEAF OF KNIGHTS	SVILLE	KNIG	HTSVILLE, IN 47857	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	RIATE
TAG	†	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	1	Director of the Office of the			
		in accordance with 5 U.S.C.			
	552(a) and 1 CFR part 51. You may obtain				
	the material from the sources listed below.				
		a copy at the CMS			
		urce Center, 7500 Security			
		ore, MD or at the National ords Administration			
		mation 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				
		eference, CMS will publish a			
		ederal Register to			
	announce the cha	•			
		Protection Association, 1			
	Batterymarch Par	k,			
	Quincy, MA 02169	9, www.nfpa.org,			
	1.617.770.3000.				
	(i) NFPA 99, Heal	th Care Facilities Code,			
		ed August 11, 2011.			
		im amendment (TIA) 12-2 to			
	NFPA 99, issued	•			
	` '	FPA 99, issued August 9,			
	2012.				
	1 ' '	FPA 99, issued March 7,			
	2013.				
	` '	FPA 99, issued August 1,			
	2013.				
	l \ '	FPA 99, issued March 3,			
	2014.	fo Safaty Codo, 2012			
	edition, issued Au	fe Safety Code, 2012			
		gust 11, 2011. IFPA 101, issued August			
	11, 2011.	IFFA 101, ISSUEU AUGUSI			
		FPA 101, issued October			
	30, 2012.	TA 101, ISSUEU OCIODEI			
		FPA 101, issued October			
	1 (A) 11A 12-0 10 NE	1 / 10 1, 133ucu Octobel	1		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION (X3) DATE		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		155542	B. W	NG	08/30/2022		/2022
				·			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
01.01/50		0.4.1.5			CRAWFORD ST		
CLOVER	LEAF OF KNIGHTS	SVILLE		KNIGH	TSVILLE, IN 47857		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	22, 2013.						
	(xi) TIA 12-4 to NI	FPA 101, issued October					
	22, 2013.	ŕ					
	(xiii) NFPA 110, S	Standard for Emergency and					
	1 ' '	ystems, 2010 edition,					
		chapter 7, issued August 6,					
	2009						
	Based on record rev	view and interview, the facility	E 0	041	It is the practice of the facilit	y	09/30/2022
	failed to implement the emergency power system inspection, testing, and maintenance requirements				to assure our emergency	-	
					generator inspections and		
	found in the Health Care Facilities Code, NFPA			testing meet federal life safe	ty		
	110, and Life Safety Code in accordance with 42				requirements.		
	CFR 483.73(e)(2).				The corrective action taken f	or	
					those residents found to be		
	1. Based on record review and interview, the				affected by the deficient		
	facility failed to ma	nintain a complete written record			practice include: No resident	S	
	of monthly generate	or load testing for 1 of 1			were found to be affected by t	he	
	generator during the	e past 12 months. Chapter			deficient practice.		
	6.4.4.1.1.4(a) of 20	12 NFPA 99 requires monthly			How other residents that have	re	
		ator serving the emergency			the potential to be affected b	у	
		be in accordance with NFPA			the same defective practice		
		or Emergency and Standby			will be identified and what		
	I -	hapter 8. Chapter 6.4.4.2 of			corrective action(s) will be		
	_	a written record of inspection,			taken:		
	1 ~	ising period, and repairs for the			Potentially all residents could		
		ularly maintained and available			affected but none were identifi		
	for inspection by th				What measures will be put in	ito	
	l -	leficient practice could affect all			place and what systemic		
	residents, staff and	visitors.			changes will be made to		
					ensure that the deficient		
	Findings include:				practice does not recur:		
	D 1 1				The monthly generator inspec		
		view on 08/30/22 at 1:05 p.m.			was completed and document		
		ce Supervisor present, there			per Life Safety code. The trans		
		ion on the emergency			load percentage and the 10 se		
	, .	test form for percentage of load			transfer time was completed a	ın a	
		load tests during the past 12 interview at the time of record			documented for the month of		
					September.		
		nance Supervisor agreed there			How the corrective action(s)		
	was no documentat	ion provided on the monthly	1		will be monitored to ensure t	ne	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 08/30/2022				
	OF PROVIDER OR SUPPLIE ERLEAF OF KNIGHT		-	9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST TSVILLE, IN 47857	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
	generator load test during the past 12 mand Maintenance Sconference. 2. Based on record facility failed to en alternate power surgenerator during the Chapter 6.4.4.1.1.4 monthly testing of emergency electric with NFPA 110, the Standby Powers Sydeficient practice cas staff and visitors. Findings include: Based on record rewith the Maintenar 2021 and 2022 gen	form for percentage of load months. It review and interview, the sure the transfer time to the truce on the monthly load test thin 10 seconds to the toply for 1 of 1 emergency e past 12 month period. (a) of 2012 NFPA 99 requires the generator serving the all system to be in accordance e Standard for Emergency and steems, Chapter 8. This ould affect all residents, as well			(EACH CORRECTIVE ACTION SHOULD BE	ce ce: cad y sults ed by og. ges
	time, however, the to emergency power seconds for the pass asked, the Mainten always put 30 secon because that's the very documented. He fit what the actual transport of the second sec					
	_	eviewed with the Administrator upervisor during the exit				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 0/2022	
	PROVIDER OR SUPPLIEF		9325 N	ADDRESS, CITY, STATE, ZIP I CRAWFORD ST ITSVILLE, IN 47857	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
K 0000						
Bldg. 01	Licensure Survey w Department of Head 483.90(a). Survey Date: 08/30 Facility Number: 0 Provider Number: 100 At this Life Safety of Knightsville was for Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupation of the Band C wings of the Band C wings of this survey. All areas where reswere sprinklered an services were sprinklered and se	000296 155542 467820 Code survey, Cloverleaf of and not in compliance with	K 0000	By submitting the encematerials, we are not truth or accuracy of an findings or allegations the right to contests the or allegations as part proceedings and submitted submitted in the proceedings and submitted in the proceedings an	admitting the ny specific s. We reserve ne findings of any mit these o our . The facility of red our nee effective to the Life sted on respectfully w and will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		A. BU	A. BUILDING 01 COMI B. WING 08/3			survey eted 2022	
	PROVIDER OR SUPPLIER			9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST TSVILLE, IN 47857		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0300 SS=E Bldg. 01	Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included Based on record revinterview, the facility documentation for the of battery operated resident rooms was states to ensure opershall have an inspect program. NFPA 72 equipment shall be accordance with mainstructions and per 14. This deficient presidents, staff and Findings include: Based on record reviewith the Maintenant was documentation operated smoke alar monthly, however, and in other composition of the C Wingon battery operated room 54 during a total alarm battery did had 06/20/22. The Main battery operated smoket smo	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, don Form CMS-2567. Friew, observation, and try failed to ensure the preventative maintenance smoke alarms in 15 of 50 complete. NFPA 72 14.2.1.1.1 rations integrity, the system strion, testing, and maintenance 29.10 states fire-warning maintained and tested in mufacturer's published the requirements of Chapter practice could affect at least 20	K 03	300	It is the practice of this facilit to assure that all Battery-Operated Smoke detectors are inspected and maintained in accordance wi federal life safety code. The corrective action taken f those residents found to be affected by the deficient practice include: No residents were found to be affected by the deficient practit 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 affected but none were identified that measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: All 15 Battery Operated smoked detectors have been inspected the month of September with resisues noted.	th or ce. re y be ed. ito	09/30/2022

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155542	l í	JILDING	onstruction 01	(X3) DATE COMPL 08/30/	ETED
			<i>5.</i> W1		ADDRESS, CITY, STATE, ZIP COD	30/30/	
	PROVIDER OR SUPPLIER		9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
K 0331 SS=E Bldg. 01	time of record revice confirmed there was to show resident ro Wing were tested in month period. This finding was reand Maintenance Sconference. 3.1-19(b) NFPA 101 Interior Wall and Conference Wall and Conference wall and Conference wall and Conference was fixed or movable columns, and have Class A or Class interior finish for a prescribed in 10.2, 19.3.3.1, 19 Indicate flame spin	Ceiling Finish eiling finishes, including surfaces of buildings such sele walls, partitions, e a flame spread rating of B. The reduction in class of a sprinkler system as 2.8.1 is permitted. 3.3.2 ead rating(s).		TAG	How the corrective action(s) will be monitored to ensure 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 change will be completed: September 30, 2022	the se se: ges er	DATE
	failed to ensure 1 o provided with a con flame spread rating sprinklered facility wall finish as the in	on and interview, the facility f 5 smoke compartments was mplete interior finish with a of Class A or Class B for a LSC 3.3.90.4 defines interior iterior finish of columns, fixed and fixed or movable partitions.	K 0:	331	It is the practice of the facilit to assure that all Interior wa and ceiling finishes, and or smoke compartments have a flame spread rating that meet the requirements of federal I safety code.	II a ets	09/30/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	ΓED
		155542	B. W	'ING		08/30/2	022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			CRAWFORD ST		
CLOVER	LEAF OF KNIGHTS	SVILLE			TSVILLE, IN 47857		
			ı		,	Т	(77.5°)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		,	DATE
		terior finish is not intended to			The corrective action taken f	or	
	apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient				those residents found to be		
					affected by the deficient		
	-	t up to 34 residents, staff, and			practice include:		
	visitors while in the	same smoke compartment.			No residents were found to be		
	Findings :11				affected by the deficient practi	I .	
	Findings include:				How other residents that have	I .	
	Deced on cheamistics on 08/20/22 at 12:21 mm				the potential to be affected b	У	
	Based on observation on 08/30/22 at 12:21 p.m.				the same defective practice		
	during a tour of the facility with the Maintenance				will be identified and what		
Supervisor, there was a one foot by one and a half					corrective action(s) will be		
	foot plywood attic access panel in the Beauty				taken:		
	Shop. This was acknowledged by the				Potentially all residents could		
	Maintenance Supervisor at the time of				affected but none were identif		
		more, the Maintenance			What measures will be put in	ito	
	-	plywood attic access panel			place and what systemic		
		e spread rating as far as he			changes will be made to		
	knew.				ensure that the deficient		
					practice does not recur:		
	_	viewed with the Administrator			An appropriate flame spread r		
		upervisor during the exit			sheet of Drywall was installed		
	conference.				the pre-existing attic access p		
	21104)				in the Beauty Shop. An audit of		
	3.1-19(b)				the entire building was conduction		
					and all attic access panels me	t	
					requirements.		
					How the corrective action(s)		
					will be monitored to ensure t	ne	
					deficient practice will not		
					recur, what quality assuranc		
					program will be put into place	e:	
					An audit will be completed by		
					maintenance or designee to	.	
					inspect ALL attic access pane		
					monthly for three months. Any	'	
					negative findings will be		
					immediately remedied, and		
					administrator notified. The res		
					of these audits will be reviewe		
					the Quality Assurance Meeting	g.	

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instrument.

listed and marked sensitivity range, it shall be

(2) Manufacturer's calibrated sensitivity test

tested using any of the methods:

(1) Calibrated test method.

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taken:

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will be identified and what

corrective action(s) will be

Potentially all residents could be

affected but none were identified.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		A. BUILDING <u>01</u> CON		(X3) DATE SURVEY COMPLETED 08/30/2022	
	PROVIDER OR SUPPLIER		9325 N	ADDRESS, CITY, STATE, ZIP COD N CRAWFORD ST HTSVILLE, IN 47857	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	(X5) E COMPLETION
TAG	(3) Listed control ed purpose. (4) Smoke detector arrangement wherel at the control unit wits listed sensitivity (5) Other calibrated to the authority hav Detectors found to listed and marked scleaned and recalibrated to the detector sensiti measured using any an unmeasured control of the purpose.	sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be rated, or replaced. vity cannot be tested or spray device that administers centration of aerosol into the sient practice could affect all	TAG	What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur: Safe Care, Cloverleafs fire s contractor, replace all four side detectors that had failed the previous inspection. How the corrective action(s will be monitored to ensure deficient practice will not recur, what quality assurant program will be put into plate An audit will be completed b maintenance or designee to	afety moke s) e the ace
	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.			inspect All smoke detectors three months to assure all the shifts match up with the corretime of day. Any negative fin will be immediately remedied administrator notified. The resof these audits will be review the Quality Assurance Meeti. The date the systemic charwill be completed: Septemb 30, 2022	ne ect dings d, and esults ved by ng. nges
K 0353 SS=E	NFPA 101 Sprinkler System	- Maintenance and Testing			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 08/30/2022			ETED		
	PROVIDER OR SUPPLIER			9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST TSVILLE, IN 47857		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 01	Automatic sprinkles are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure sprincorrosion in 2 of 6 streplaced. NFPA 25 sprinklers shall not be free of corrosion physical damage; arcorrect orientation (sidewall). Furtherm that shows signs of replaced: (1) Leakan Damage (4) Loss of responsive element unless painted by the This deficient practices in the provided in the same secondary in the s	supply source RKS information on non-required or partial r system. and NFPA 25 on and interview, the facility inkler heads covered with smoke compartments were, 2011 edition, at 5.2.1.1.1 show signs of leakage; shall foreign materials, paint, and indishall be installed in the e.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be ige (2) Corrosion (3) Physical fluid in the glass bulb heat (5) Loading (6) Painting e sprinkler manufacturer. Increase could affect at least 30 staff and visitors within the	K 0	353	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 affected but none were identification what measures will be put in place and what systemic.	or ce. e y	09/30/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/30/2022	
	PROVIDER OR SUPPLIER		9325 N	ADDRESS, CITY, STATE, ZIP COD N CRAWFORD ST HTSVILLE, IN 47857	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	with the Maintenand sprinkler head in the covered with corross one sprinkler head is also covered with coat the time of each of Supervisor agreed the Soiled Utility room covered with corross replaced.	o.m. during a tour of the facility the Supervisor, there was one to A Wing Soiled Utility room tion, furthermore, there was to the B Wing Janitor's Closet torrosion. Based on interview tobservation, the Maintenance the sprinkler heads in the and Janitor's Closet were tion and needed to be wiewed with the Administrator topervisor during the exit		changes will be made to ensure that the deficient practice does not recur: Safe Care, Cloverleaf's fire s contractor, provided an estim repair and fix the corrosive sprinkler heads. The quote w accepted and they plan to be onsite as soon as the ordered parts arrive. An audit of the e building was conducted, and additional sprinkler heads me requirements. How the corrective action(s will be monitored to ensure deficient practice will not recur, what quality assuran program will be put into pla An audit will be completed by maintenance or designee to inspect All sprinkler heads monthly for three months to assure all the sprinklers mee safety code standards. Any negative findings will be immediately remedied, and administrator notified. The re of these audits will be review the Quality Assurance Meetin The date the systemic chan will be completed: Septemb 30, 2022	ate to as d chirce all et) the ce ce; / t life sults ed by ng. ges
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING	lding Spaces - Smoke Iding Spaces - Smoke arriers are 1-3/4-inch thick			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/30/2022 155542 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9325 N CRAWFORD ST CLOVERLEAF OF KNIGHTSVILLE KNIGHTSVILLE, IN 47857 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0374 09/30/2022 It is the practice of the facility failed to ensure 1 of 5 sets of smoke barrier doors to assure that all smoke barrier would close to form a smoke resistant barrier. doors will close to form a LSC, Section 19.3.7.8 requires that doors in smoke smoke resistant barrier. barriers shall comply with LSC, Section 8.5.4. LSC, The corrective action taken for Section 8.5.4.1 requires doors in smoke barriers to those residents found to be close the opening leaving only the minimum affected by the deficient clearance necessary for proper operation which is practice include: defined as 1/8 inch to restrict the movement of No residents were found to be smoke. This deficient practice could affect up to affected by the deficient practice. 34 residents, as well as staff and visitors in the B How other residents that have Wing. the potential to be affected by the same defective practice Findings include: will be identified and what corrective action(s) will be Based on observation on 08/30/22 at 12:12 p.m. taken: during a tour of the facility with the Maintenance Potentially all residents could be Supervisor, the set of smoke barrier doors in the B affected but none were identified. Wing did not close completely when tested. What measures will be put into There was a two inch gap between the set of place and what systemic doors when closed fully. Based on interview at changes will be made to the time of observation, the Maintenance ensure that the deficient Supervisor agreed the set of smoke barrier doors practice does not recur: in the B Wing did not close completely when Safe Care, cloverleafs fire safety tested. contractor, installed a device on the door closure system that This finding was reviewed with the Administrator allowed the door to properly close and Maintenance Supervisor during the exit in accordance with federal life conference. safety code.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		î ´	JILDING	ONSTRUCTION 01	(X3) DATE COMPI 08/30	LETED	
	PROVIDER OR SUPPLIE			9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST TSVILLE, IN 47857		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION
K 0712 SS=C Bldg. 01	3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and conditions. Fire d and unexpected t conditions, at lease	the transmission of a fire simulation of emergency fire rills are held at expected imes under varying st quarterly on each shift.		TAG	How the corrective action(s) will be monitored to ensure 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 door monthly for three months to assure all doors close and late properly. Any negative finding be immediately remedied, and administrator notified. The rest of these audits will be reviewed the Quality Assurance Meetin The date the systemic change will be completed: September 30, 2022	the ce ch gs will d sults ed by g. ges	DATE
	aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record re failed to ensure 6 of the past 12 month p designated shift times.	ay be used instead of	K 0'	712	It is the practice of the facilit to assure Fire Drills are conducted in accordance wi federal life safety code. The corrective action taken those residents found to be	th	09/30/2022

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155542	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE S COMPL 08/30/	ETED
	ROVIDER OR SUPPLIER LEAF OF KNIGHTS			9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST TSVILLE, IN 47857		
(X4) ID PREFIX TAG	REGULATORY OR Findings include: Based on review of 10:00 a.m. with the present, there were during the past 12 minterview at the time the Maintenance Sudrills are performed p.m., second shift bp.m., and third shift a.m. The following a. Fire drills perform 11/09/21 at 11:40 a. 05/09/22 at 2:00 p.m. fire drills, when the time frame. b. Fire drills perform and 12/05/21 at 6:00 shift fire drills, when second shift time frames are drills, when the second shift time frames are ports were confirmated on interview the dates and times reports were confirmated on the second shift fire drills, when the second shift time frames are ports were confirmated on interview the dates and times reports were confirmated during the documented during the documented incorrect.	med on 08/10/21 at 12:00 p.m., m., 02/03/22 at 10:00 a.m., and n. were all listed as second shift y all fell under the first shift med on 09/13/21 at 8:00 p.m., 0 p.m. were all listed as third in they both fell under the ame. at the time of record review, of the previous fire drill med by the Maintenance ther said all the fire drills are past 12 month period were the correct shifts, but were ctly on the fire drill forms.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) affected by the deficient practice include: No residents were found to be affected by the deficient practic How other residents that hav the potential to be affected be the same defective practice will be identified and what corrective action(s) will be taken: Potentially all residents could affected but none were identified What measures will be put in 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 fire shift at the correct time. How the corrective action(s) will be monitored to ensure to 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 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 change will be completed: September	ce. re y be ed. ato st he e: s a t	(X5) COMPLETION DATE
					_		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155542	B. WING		-	08/30/2022	
		111			_		-
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD		
01 0) /ED		N/II.1.5			N CRAWFORD ST		
CLOVER	LEAF OF KNIGHTS	SVILLE		KNIG	HTSVILLE, IN 47857		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTION CORRECTIO		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0761							
SS=C							
Bldg. 01							
	1. Based on observa	ation, record review, and	K 0'	761	It is the practice of the facilit	у	09/30/2022
	interview; the facilit	ty failed to ensure an annual			to assure all Fire Doors be	-	
	inspection and testir	ng of 1 of 1 oxygen room fire			inspected and tested in		
	door assembly was	completed in accordance with			accordance with NFPA 80.		
	LSC 19.1.1.4.1.1. C	Communicating openings in			The corrective action taken f	or	
	dividing fire barrier	s required by 19.1.1.4.1 shall be			those residents found to be		
	permitted only in co	orridors and shall be protected			affected by the deficient		
	by approved self-clo	osing fire door assemblies.			practice include:		
	(See also Section 8.	3.) LSC 8.3.3.1 Openings			No residents were found to be	:	
	required to have a fi	re protection rating by Table			affected by the deficient practice.		
	8.3.4.2 shall be prot	ected by approved, listed,			How other residents that have	re	
	labeled fire door ass	semblies and fire window			the potential to be affected b	у	
	assemblies and their	accompanying hardware,			the same defective practice		
	including all frames	, closing devices, anchorage,			will be identified and what		
	and sills in accordar	nce with the requirements of			corrective action(s) will be		
	NFPA 80, Standard	for Fire Doors and Other			taken:		
	Opening Protectives	s, except as otherwise			Potentially all residents could	be	
	specified in this Coo	de. NFPA 80 5.2.1 states fire			affected but none were identif	ied.	
	door assemblies sha	ll be inspected and tested not			What measures will be put ir	ito	
	-	and a written record of the			place and what systemic		
	-	signed and kept for inspection			changes will be made to		
	•	80, 5.2.4.1 states fire door			ensure that the deficient		
		visually inspected from both			practice does not recur:		
	sides to assess the o	verall condition of door			All fire doors have been inspe	cted,	
	assembly.				tested, and documented in		
					accordance with NFPA 80.		
		ates as a minimum, the			How the corrective action(s)		
	following items sha				will be monitored to ensure t	:he	
		r breaks exist in surfaces of			deficient practice will not		
	either the door or fra				recur, what quality assuranc		
		light frames, and glazing beads			program will be put into place	e:	
		ely fastened in place, if so			An audit will be completed by		
	equipped.				maintenance or designee to	_	
		, hinges, hardware, and			inspect All fire doors monthly	for	
		eshold are secured, aligned,			three months. Any negative		
	-	er with no visible signs of			findings will be immediately		
damage.				remedied, and administrator			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/30/2022	
	PROVIDER OR SUPPLIEF		9325 N	ADDRESS, CITY, STATE, ZIP COD I CRAWFORD ST ITSVILLE, IN 47857	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF (4) No parts are mis	_	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) notified. The results of these	(X5) COMPLETION DATE
	listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open p (7) If a coordinator closes before the ac (8) Latching hardward door when it is in th (9) Auxiliary hardward prohibit operation a frame. (10) No field modification have been performed for the coordinate of the coordin	device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the ne closed position. For are items that interfere or are not installed on the door or acceptance to the door assembly and that void the label. Hedge seals, where required, are their presence and integrity. In the door affect at least least 20		audits will be reviewed by the Quality Assurance Meeting. The date the systemic chan will be completed: Septemb 30, 2022	ges
	Findings include: Based on record review the Maintenant facility was unable an annual inspection include, one oxygen assembly. Based or record review, the Me inspects all fire/s regular basis but had during the past 12 mon observations during the Maintenance Su was one oxygen transsembly noted in the This finding was re	visitors on the C Wing. view on 08/30/22 at 11:15 a.m. ce Supervisor present, the to provide documentation for in of fire door assemblies, in transfilling room fire door in interview at the time of Maintenance Supervisor said smoke door assemblies on a is no documentation available month period or prior. Based ing a tour of the facility with inpervisor at 1:30 p.m., there insfilling room fire door the facility. viewed with the Administrator inpervisor during the exit			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542 NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	STATEMENT OF DE	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP COD 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857 (X5) PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	AND PLAN OF CORR	RRECTION				<u>01</u>	l	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION)			155542	B. WI	NG		08/30/	2022
CLOVERLEAF OF KNIGHTSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PROVIDE	ER OR SUPPLIER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	CLOVERLEAF (OF KNIGHTS	SVILLE					
TREFTA (EACH DEFICIENCE MIGST BETREEEDED BY TOLE TREFTA CROSS-REFERENCED TO THE APPROPRIATE	(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	`					CROSS-REFERENCED TO THE APPROPRIA	TE	
	TAG RE	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
3.1-19(b)	3.1-19	19(b)						
2. Based on record review, observation and	2. Ba	Based on record	review, observation and					
interview, the facility failed to maintain 1 of 1								
rolling fire door in accordance with NFPA 80,	rolling	ng fire door in a	accordance with NFPA 80,					
Standard for Fire Doors and Other Opening	Standa	dard for Fire Do	oors 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	1 -							
maintenance. NFPA 80 5.2.1 requires fire door	mainto	ntenance. NFPA	A 80 5.2.1 requires fire door					
assemblies shall be inspected and tested not less	assem	mblies shall be i	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.	occupa	ipants while in the	the dining room.					
Findings include:	Findin	lings include:						
Based on record review on 08/30/22 at 10:35 a.m.	Based	ed on record rev	riew on 08/30/22 at 10:35 a.m.					
with the Maintenance Supervisor present, there								
was no annual rolling fire door inspection to	was no	no annual rollin	ng 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	This f	finding was rev	viewed with the Administrator					
and Maintenance Supervisor during the exit								
conference.								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 0/2022	
	PROVIDER OR SUPPLIER		9325 N	ADDRESS, CITY, STATE, ZIP CO I CRAWFORD ST TSVILLE, IN 47857	OD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	3.1-19(b)					
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and assoc of supplying service 10-second criterion monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test und a complete simula automatic or manuloads, and are con- personnel. Mainte energy power sour accordance with Noircuit breakers are program for period components is est manufacturer required for maintenance are and readily availal and circuits are mo and separate from Minimizing the pos- emergency power consideration for re-	other alternate power inted equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to this capability for the life branches. Maintenance generator and transfer primed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised anths for 4 continuous hours. Indeed to cold start and the inspected by competent the inspected and testing of stored arces (Type 3 EES) are in the inspected annually, and a dically exercising the tablished according to the inspected annually and inspected in the inspected annually, and a dically exercising the tablished according to the inspected annually identifiable, in normal power circuits. In sibility of damage of the inspected is a design				

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f ´		lì í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED			
		155542	B. W	ING		08/30/	2022
NAME OF D	PROVIDER OR SUPPLIER	·	_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					CRAWFORD ST		
CLOVER	LEAF OF KNIGHTS	SVILLE		KNIGH	TSVILLE, IN 47857		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	NFPA 111, 700.10		17.0	010			00/20/2022
		review and interview, the	K 0	918	It is the practice of the facilit	-	09/30/2022
		intain a complete written record			to assure that our Generator		
		or load testing for 1 of 1 e past 12 months. Chapter			exercised in accordance with NFPA 101.	n	
	-	12 NFPA 99 requires monthly			The corrective action taken f		
		ator serving the emergency			those residents found to be	OI	
		be in accordance with NFPA			affected by the deficient		
		or Emergency and Standby			practice include:		
		hapter 8. Chapter 6.4.4.2 of			No residents were found to be	<u> </u>	
	-	a written record of inspection,			affected by the deficient practi		
	-	ising period, and repairs for the			How other residents that have		
	-	ularly maintained and available			the potential to be affected b		
	for inspection by th				the same defective practice	,	
		eficient practice could affect all			will be identified and what		
	residents, staff and	-			corrective action(s) will be		
					taken:		
	Findings include:				Potentially all residents could	be	
					affected but none were identif		
	Based on record rev	view on 08/30/22 at 1:05 p.m.			What measures will be put in	nto	
	with the Maintenan	ce Supervisor present, there			place and what systemic		
	was no documentati	ion on the emergency			changes will be made to		
		test form for percentage of load			ensure that the deficient		
		load tests during the past 12			practice does not recur:		
		interview at the time of record			The generator has been exerc		
		nance Supervisor agreed there			under load during the month of		
		ion provided on the monthly			September and transferred the		
	-	form for percentage of load			load within the 10-sec time fra		
	during the past 12 n	nonths.			How the corrective action(s)		
					will be monitored to ensure t	the	
		viewed with the Administrator			deficient practice will not		
		upervisor during the exit			recur, what quality assurance		
	conference.				program will be put into place	e:	
	2 1 10/4)				An audit will be completed by		
	3.1-19(b)				maintenance or designee to	laad	
	2 Dagad am maa 1	ravious and interviews the			exercise the generator under		
		review and interview, the sure the transfer time to the			monthly for three months. Any	′	
		rce on the monthly load test			negative findings will be		
	-	thin 10 seconds to the			immediately remedied, and administrator notified. The res	ulte	
	I BUDDITOU SCIVICE WII	ann io seconas to the			T CONTINUED TO PER LES		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155542		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/30/2022	
	PROVIDER OR SUPPLIER		9325	ET ADDRESS, CITY, STATE, ZIP COD S N CRAWFORD ST BHTSVILLE, IN 47857	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	generator during the Chapter 6.4.4.1.1.4(monthly testing of t emergency electrica with NFPA 110, the Standby Powers Sys	ply for 1 of 1 emergency e past 12 month period. (a) of 2012 NFPA 99 requires the generator serving the al system to be in accordance e Standard for Emergency and stems, Chapter 8. This build affect all residents, as well		of these audits will be revie the Quality Assurance Mee The date the systemic cha will be completed: Septem 30, 2022	ting. Inges
	with the Maintenand 2021 and 2022 generator was tested minutes under load time, however, the to emergency power seconds for the past asked, the Maintenar always put 30 second because that's the widocumented. He fur what the actual transition of the past asked is the maintenary of the past asked in t	view on 08/30/22 at 1:05 p.m. ce Supervisor present, the erator log form documented the d monthly for at least 30 with a five minute cool down transfer time from normal power r was always listed as 30 to 12 month period. When the supervisor said he hads as the transfer time ray it had always been refer said he was not sure sfer time was.			
K 0920 SS=B Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(Y2) DATE SLIDVEY		
i '		i '	<u> </u>			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 B. WING				COMPLETED 08/30/2022	
		155542	B. W	ING		08/30	/2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					CRAWFORD ST			
CLOVER	LEAF OF KNIGHTS	SVILLE		KNIGH	TSVILLE, IN 47857			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	` ,	les that have been						
	• •	alified personnel and meet						
		10.2.3.6. Power strips in						
		cinity may not be used for						
		, personal electronics),						
		m care resident rooms that						
	do not use PCREI	E. Power strips for PCREE						
	meet UL 1363A o	r UL 60601-1. Power strips						
		the patient care rooms						
) meet UL 1363. In						
		ooms, power strips meet						
		ls. All power strips are						
	used with general	precautions. Extension						
	cords are not used	d as a substitute for fixed						
	wiring of a structu	re. Extension cords used						
	temporarily are re	moved immediately upon						
	completion of the	purpose for which it was						
	installed and mee	ts the conditions of 10.2.4.						
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5						
		on and interview, the facility	K 0	920	It is the practice of the facilit	.y	09/30/2022	
	_	ower strip was not used as a			to assure there are no power	r		
		wiring in 1 of 1 staff			strips in the patient care			
		LSC 19.5.1 requires utilities to			vicinity.			
		n 9.1. LSC 9.1.2 requires			The corrective action taken t	for		
	_	d equipment to comply with			those residents found to be			
	,	Electrical Code, 2011 Edition.			affected by the deficient			
		00.8 requires that, unless			practice include:			
		ed, flexible cords and cables			No residents were found to be	;		
		a substitute for fixed wiring of			affected by the deficient pract			
		eficient practice could affect			How other residents that have			
	staff only.				the potential to be affected b	у		
					the same defective practice			
	Findings include:				will be identified and what			
					corrective action(s) will be			
		on on 08/30/22 at 11:02 a.m.			taken:			
		facility with the Maintenance			Potentially all residents could			
	_	as a microwave and toaster			affected but none were identif			
		er strip in the staff Conference			What measures will be put in	nto		
	Room. Based on in	nterview at the time of			place and what systemic			

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Event ID:

201921

Facility ID: 000296

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLE						
		155542	B. WING 08/30/2022					
NAME OF P	PROVIDER OR SUPPLIEF			9325 N	ADDRESS, CITY, STATE, ZIP COD CRAWFORD ST			
CLOVER	LEAF OF KNIGHTS	SVILLE		KNIGHTSVILLE, IN 47857				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE	
		intenance Supervisor			changes will be made to			
	staff Conference Ro	ise of the power strip in the			ensure that the deficient			
	stall Conference Ro	oom.			practice does not recur:	- alv		
	This finding was re	viewed with the Administrator			The power strip was immediate removed from the patient care	•		
	_	upervisor during the exit			vicinity. All rooms in the facility			
	conference.	apervisor during the exit	have been audited for additional					
			power strips with no findings.					
	3.1-19(b)				How the corrective action(s)			
					will be monitored to ensure t			
					deficient practice will not			
					recur, what quality assuranc	е		
					program will be put into place	e:		
					An audit will be completed by			
					maintenance or designee to a	udit		
					patient care vicinity of power s	strips		
					for three months. Any negative	е		
					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 chang	•		
					will be completed: September	er		
					30, 2022			

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