09/07/2023

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2023	
	PROVIDER OR SUPPLIE			170 N	ADDRESS, CITY, STATE, ZIP COD TRACY ST		
	E HEALTH & REHA	ABILITATION		WARK	_E, IN 46770		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
E 0000							
Bldg		eparedness Survey was ndiana Department of Health in	E 0	000	Markle Health and Rehabilita is alleging compliance on 9.1		
	Survey Date: 08/1	0/23			and is requesting paper compliance for the annual life safety code recertification an state licensure survey.		
	Facility Number: 0 Provider Number: AIM Number: 100	155673					
	Health and Rehabi substantial complia Preparedness Requ Medicaid Participa CFR 483.73. The f	Preparedness survey, Markle litation was found in ance with Emergency tirements for Medicare and atting Providers and Suppliers, 42 Cacility has a capacity of 86 and at the time of this survey.					
	Quality Review co	impleted on 08/15/23					
E 0026 SS=C Bldg	(iv), 441.184(b)(8 (8), 483.73(b)(8), (7), 494.62(b)(7) Roles Under a W §403.748(b)(8), § (C)(iv), §441.184 §482.15(b)(8), §4	(6.54(b)(6), 418.113(b)(6)(C) (3), 482.15(b)(8), 483.475(b) (485.625(b)(8), 485.920(b) (aiver Declared by Secretary (3416.54(b)(6), §418.113(b)(6) (b)(8), §460.84(b)(9), (8483.73(b)(8), §483.475(b)(8), (3485.920(b)(7), §494.62(b)(7).					
	[(b) Policies and	procedures. The [facilities]					

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

must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this

> TITLE (X6) DATE

Nicole Moore Administrator 08/31/2023

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AW8L21 Facility ID: 000544 If continuation sheet Page 1 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/10/2023	
	PROVIDER OR SUPPLIEF		170 N	ADDRESS, CITY, STATE, ZIP COD TRACY ST LE, IN 46770	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	be reviewed and use years [annually for minimum, the polical address the follow. (8) [(6), (6)(C)(iv), [facility] under a was Secretary, in accordent of the Act, in the putreatment at an all by emergency material and the procedures. (8) The waiver declared by accordance with surprovision of careast identified by emergency identified by emergency include the rewaiver declared by with section 1135 or care and treatment as identified by emergency include: Based on record revaluation of the LTC facility secretary, in accordance with 42 deficient practice of the LTC facility secretary, in accordance was not available sentence that stated	cies and procedures must apdated at least every 2 or LTC facilities]. At a cies and procedures must aring:] (7), or (9)] The role of the caiver declared by the ardance with section 1135 or ovision of care and dernate care site identified anagement officials. (403.748(b):] Policies and the role of the RNHCl under a sy the Secretary, in the area and alternative care site gency management when an alternative care site gency management when an alternative care site gency management officials in the Secretary, in accordance of the LTC facility under a the Secretary, in accordance of the Act, in the provision of at an alternate care site ency management officials in CFR 483.73(b) (8). This could affect all occupants. Aview with the Maintenance constrator on 08/10/23 at 9:38 licy and procedure for the role under a waiver declared by the lance with section 1135 of the late for review. There was a procedure with emergency	E 0026	E 306 Roles under a waiver declared by the Secretary - 1 Waiver What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; · 1135 Waiver policy will be updated to include information policy and procedure and will implemented into the facility's emergency preparedness program. How other residents having the potential to be affected by the same deficient practice will be	oe nts y the e on oe

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet

Page 2 of 20

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì '		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155673	B. WIN	G		08/10/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
			170 N TRACY ST				
MARKLE	HEALTH & REHAE	BILITATION		MARKL	E, IN 46770		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	management personnel," but information on the policies or procedures were not stated. Based on interview at the time of record review the Maintenance Director acknowledged the 1135 waiver policy was incomplete.				identified and what corrective		
					action(s) will be taken;		
					· All residents have the potential		
					to be affected by the deficient		
		-			practice.		
	_	riewed with the Maintenance			· 1135 Waiver policy will be		
	•	ator, and the DON at the exit			updated to include information		
	conference.				policy and procedure and will	be	
					implemented into the facility's		
					emergency preparedness		
					program.		
					What measures will be put into	o	
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec	ur;	
					· Updated 1135 Waiver police	-	
					will be reviewed with IDT by E	D at	
					next monthly QAPI meeting		
					 All-staff will be in-serviced updated 1135 Waiver policy by 		
					9/10/23	y	
					0/10/20		
					How the corrective action(s) w	vill be	
					monitored to ensure the defici		
					practice will not recur, what qu	-	
					assurance program will be put	into	
					place;		
					· Ongoing compliance with th		
					corrective action will be monito		
					via facility QAPI program, with meetings being held monthly,		
					is overseen by the Executive	aııu	
					Director.		
					250.01.		

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2023	
	PROVIDER OR SUPPLIE		170	ET ADDRESS, CITY, STATE, ZIF N TRACY ST RKLE, IN 46770	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey of Department of Hea 483.90(a). Survey Date: 08/1 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety and Rehabilitation with Requirements Medicare/Medicaid Life Safety From F National Fire Prote Life Safety Code (6)	e Recertification and State was conducted by the Indiana Ith in accordance with 42 CFR 0/23 00544 155673	K 0000	CQI tool identified will be completed we weeks, monthly times and quarterly thereaf compliance is achieved. If Threshold of 100 an action plan will be ensure compliance. By what date the systemages will be completed to the complete complete compliance is the complete compliance is alleging compliance and is requesting part compliance for the alleging compliance for the alleging compliance state licensure surverse.	ekly x 4 s 3 months, fter until red. 0% is not met, e developed to stemic pleted; e: 9/10/23 requested. ehabilitation se on 9.10.23 per nnual life sation and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21

Facility ID: 000544

If continuation sheet

Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		(X2) MULTI A. BUILD B. WING	IPLE CONSTRUCTION ING <u>01</u>	COMI	X3) DATE SURVEY COMPLETED 08/10/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF This one-story facil Type V (000) const sprinklered. The fa with smoke detection to the corridors and detectors in the resi capacity of 86 and 1 of this survey.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open battery-operated smoke dent rooms. The facility has a had a census of 70 at the time dents have customary access		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0271 SS=E Bldg. 01	E Discharge from Exits					
	failed to ensure 1 of handrails was readil all times. LSC Sect complying with LSC ramps, LSC 7.2.5.4 with LSC 7.2.2.4 sh sides of a ramp run	on and interview, the facility 2 exit discharges with by accessible and safe to use at 2 cion 7.2.5.4.1 states guards 2 7.2.2.4 shall be provided for 2 states handrails complying hall be provided along both with a rise greater than 6 in. icient practice could affect staff vice hall.	K 0271	What corrective action accomplished for the found to have been a deficient practice; • 4ft fence system I along service hall egwere repaired. Broke repaired and fencing and is no longer loos	on(s) will be se residents affected by the handrails ress sidewalk en supports was secured	09/10/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 5 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 B. WING		COMPLETED 08/10/2023	
		155673	B. W			08/10/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MVDKI =	HEALTH & REHAE	RII ITATION	170 N TRACY ST MARKLE, IN 46770				
					_L, IN 40770		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
TAG	REGULATORT OR	CLSC IDENTIFTING INFORMATION		IAU	back and forth.		DATE
	Based on an observ	ation with the Maintenance			back and form.		
	Director and the Ad	lministrator on 08/10/23 at 1:30					
	-	ice hall exit sidewalk the			How other residents having th	е	
		ystem with handrails which			potential to be affected by the		
		om falling down the slope			same deficient practice will be		
		rom supports, and could be			identified and what corrective		
	pushed back and forth in two spots. This condition made the fence system unsteady for someone using the handrails for support or				action(s) will be taken;		
					· Maintenance director inspec	ted	
	protection. Based on an interview at the time of				all areas of egress sidewalk		
	observation, the Maintenance Director stated the				handrails and found no addition	onal	
	fence system was loose, broken and needed repaired.				areas of concern		
	The finding was not	viaryad with the Maintenance					
	-	viewed with the Maintenance rator, and the DON at the exit			What measures will be put int	•	
	conference.	ator, and the DON at the exit			place or what systemic chang		
	comerciae.				will be made to ensure that the		
	3.1-19(b)				deficient practice does not rec		
					·		
					· Maintenance director will		
					inspect all areas of egress		
					sidewalk handrails monthly ar		
					will report findings during mor	ithly	
					QAPI meetings		
					How the corrective action(s) w	vill be	
					monitored to ensure the defici		
					practice will not recur, what qu	-	
					assurance program will be pu	i into	
					place;		
					Ongoing compliance with t	his	
					corrective action will be monit		
					via facility QAPI program, with		
					meetings being held monthly,		
					is overseen by the Executive		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21

Facility ID: 000544

If continuation sheet

Page 6 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/10/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770				
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLET DATE	TION	
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatioption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 5.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.		Director. - CQI tool identified as Eq. Sidewalk Handrails will be completed weekly x 4 week monthly times 3 months, a quarterly thereafter until compliance is achieved. - If Threshold of 100% is an action plan will be develors and the ensure compliance. By what date the systemic changes will be completed. - Completion date: 9/1 Paper compliance is request.	ks, nd not met, eloped to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 7 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155673	B. WING		08/10/2023
		1	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	R		TRACY ST	
MARKLE	HEALTH & REHA	BILITATION		LE, IN 46770	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	19.3.2.1, 19.3.5.9				
	a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collectio (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32	lons) orage Rooms/Spaces eet) classified as Severe 2)			
	Based on observation and interview, the facility failed to ensure 1 of 1 COVID storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with Maintenance Director and Administrator on 08/10/23 at 11:38 a.m., the COVID storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing.		K 0321	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; - Self-closure device installed on Covid storage roodoor How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to be affected by this deficient practice - Maintenance director inspected all storage	be ents by the om
	_	riewed with the Maintenance rator, and the DON at the exit		areas/hazardous areas to ens	sure

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet

Page 8 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155673	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE S COMPLI 08/10/2	ETED		
	PROVIDER OR SUPPLIEI HEALTH & REHA		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770					
(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 CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE		
	3.1-19(b)			place. No other areas o were noted.	f concern			
				What measures will be place or what systemic or will be made to ensure the deficient practice does not be made to ensure an analysis of the made to ensure self-closure device place and will install as made will report findings of monthly QAPI meetings	changes hat the not recur; r will monthly to ces are in needed			
				How the corrective action monitored to ensure the practice will not recur, where assurance program will be place; Ongoing compliance this corrective action will monitored via facility QA program, with meetings monthly, and is overseed Executive Director. CQI tool identified Hazardous Areas Enclosed	deficient hat quality be put into ee with I be I,PI being held In by the d sure will			
				be completed weekly x 4 monthly times 3 months, quarterly thereafter until compliance is achieved. If Threshold of 10 met, an action plan will be developed to ensure cor	, and 00% is not pe			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet

Page 9 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		A. BUILDING B. WING	01	COMPLETED 08/10/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770				
(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)	(X5) COMPLETION DATE		
				By what date the systemic changes will be completed;			
				Completion date: 9/10/2			
K 0334	NEDA 404			Paper compliance is requested	d.		
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1 Cooking facilities p NFPA 96 per 9.2.3 enclosed as hazar be open to the cor	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small is microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be adous areas, but shall not ridor.					
	failed to ensure 1 of unacceptable degree could activate the su actuation device wit NFPA 96 2011 editi cases where the autl	on and interview, the facility I kitchens eliminated any I kitchens eliminated any I of risk by ensuring staff I appression system manual I thout being endangered. I on, section 1.4.2 states in those I nority having jurisdiction I existing situation presents an	K 0324	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The suppression system manual actuation device will be	nts y the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet

Page 10 of 20

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2023		
	PROVIDER OR SUPPLIED HEALTH & REHA			170 N T	ADDRESS, CITY, STATE, ZIP COD RACY ST E, IN 46770		
MARKLE (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF unacceptable degre jurisdiction shall be retroactively any pe deemed appropriate least one manual ac a minimum of 10 fe from the protected path of egress. This staff in the kitchen room. Findings include: Based on observati Director and Admir the kitchen was pro system and a K-cla instructions. The s actuation device we cooking equipment nozzle. This condit statt because staff of trying to activate the	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e of risk, the authority having	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) relocated to a distance of at le 10feet and no more than 20fer from cooking equipment and a suppression spray nozzle. How other residents having th potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents in dining roc have the potential to be affecte by the deficient practice. Suppression system will inspected by vendor for compliance with regulations an immediately correct any areas concern if noted What measures will be put into place or what systemic change will be made to ensure that the	east et a e med be and a of	(X5) COMPLETION DATE
	of observation, the the suppression sys was next to cooking The finding was re	Maintenance Director agreed tem manual actuation device			deficient practice does not recommend to the deficient practice does not recommend to the deficient practice will inspect system monthly, correct areas of condification of the deficiency of th	ur; etor m eern, vill be ent uality	

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/10/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770			
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0351 SS=F Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II comprotection measure substituted for sprinklers where state sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and	Installation nd hospitals where required		monitored via facility QAPI program, with meetings being monthly, and is overseen by the Executive Director. CQI tool identified as Cooking Facilities will be completed weekly x 4 weeks, monthly times 3 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% not met, an action plan will be developed to ensure compliant by what date the systemic changes will be completed; Completion date: 9/10/2	is ence.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 12 of 20

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED			
155673		B. W	B. WING			2023		
				CTREET	ADDRESS CITY STATE ZIR COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
MADIZIE	MADIZI E LIFALTILI 9 DELIADII ITATIONI			170 N TRACY ST MARKLE, IN 46770				
MARKLE HEALTH & REHABILITATION				WARKI	_E, IN 46/70			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Standard for Insta	llation of Sprinkler						
	Systems.							
	•	, 19.3.5.3, 19.3.5.4,						
		9.3.5.10, 9.7, 9.7.1.1(1)						
		on and interview, the facility	K 0	351	K 351 Sprinkler System		09/10/2023	
		quate signage for 1 of 1 fire			Installation			
	-	ion (FDC). NFPA 25, Standard						
	_	Testing, and Maintenance of			What corrective action(s) will be	ре		
	-	rotection Systems, 2011			accomplished for those reside			
		Department Connections. 13.7.1			found to have been affected b			
		nnections shall be inspected			deficient practice;	,		
	quarterly to verify the	•			The Fire Department			
	(1) The fire department connections are visible and accessible.				Connection (FDC) sign has be	en		
					replaced with a new, non-faded			
	(2) Couplings or sw	vivels are not damaged and			and easily readable sign			
	rotate smoothly.				, , ,			
		e in place and undamaged.			How other residents having th	е		
		lace and in good condition.			potential to be affected by the			
	(5) Identification sig	——————————————————————————————————————			same deficient practice will be			
	(6) The check valve	-			identified and what corrective			
	* *	rain valve is in place and			action(s) will be taken;			
	operating properly.	•			All residents have the			
		nent connection clapper(s) is in			potential to be affected by the			
	place and operating	properly.			deficient practice.			
	This deficient practi	ice could affect all residents.			· The Fire Department			
	_				Connection (FDC) sign has be	en		
	Findings include:				replaced with a new, non-fade			
					and easily readable sign. No			
	Based on observation	on with the Maintenance			other concerns noted.			
	Director and Admir	nistrator on 08/10/23 at 9:38						
	a.m., the FDC locat	ed by the front parking lot was						
	faded and unreadab	le. Based on interview at the			What measures will be put into	0		
	time of observation,	, the Maintenance Director			place or what systemic change			
		needed to be replaced.			will be made to ensure that the			
					deficient practice does not rec	ur;		
	The finding was rev	viewed with the Maintenance			· The Maintenance Dire			
	Director, Administr	ator, and the DON at the exit			or designee will inspect FDC			
	conference.				signage monthly and will repo	rt		
					findings during monthly QAPI.			
	3.1-19(b)				noted to be faded or unreadab			
					<u> </u>			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 13 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

CENTERSTOR	WIEDICARE & WEDIC	_			ONID NO. 0936-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155673	B. WING		08/10/2023	
		.55575			00,10,2020	
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF F	NO VIDER OR BUITEIEN		170 N	TRACY ST		
MARKLE	HEALTH & REHAE	BILITATION	MARK	LE, IN 46770		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	<u> </u>	DATE	
				sign will be replaced immedia	ately.	
				l., ., ., ., ., ., ., ., ., ., ., ., ., .		
				How the corrective action(s)		
				monitored to ensure the defic		
				practice will not recur, what q	•	
				assurance program will be pu	ıt into	
				place;		
				· Ongoing compliance v	vith	
				this corrective action will be		
				monitored via facility QAPI		
				program, with meetings being	g held	
				monthly, and is overseen by	the	
				Executive Director.		
				· CQI tool identified as F	DC	
				Sign will be completed weekl		
				weeks, monthly times 3 mont	- I	
				and quarterly thereafter until	,	
				compliance is achieved.		
				· If Threshold of 100% is	s not	
				met, an action plan will be	, not	
				developed to ensure complia	nco	
				1	nice.	
				By what date the systemic		
				changes will be completed;		
				Completion date: 9/10/2	۷۵	
K 0372	NFPA 101					
SS=E		Iding Spaces Smake				
Bldg. 01	Barrie	lding Spaces - Smoke				
Diag. 01		Iding Spaces Smales				
		Iding Spaces - Smoke				
	Barrier Construction	UII				
	2012 EXISTING	all barranetments 11				
		nall be constructed to a				
		tance rating per 8.5. Smoke				
		ermitted to terminate at an				
		e dampers are not required				
		ns in fully ducted HVAC				
	systems where an	approved sprinkler system				
	is installed for smo	oke compartments adjacent				

FORM CMS-2567(02-99) Previous Versions Obsolete

to the smoke barrier. 19.3.7.3, 8.6.7.1(1)

Event ID:

AW8L21

Facility ID: 000544

4 If continuation sheet

Page 14 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED			
		155673	B. WING 08				8/10/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			TRACY ST			
MARKI F	HEALTH & REHA	BII ITATION	MARKLE, IN 46770					
	1				1		T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION Describe any mechanical smoke control		+	TAG	DEFICIENCE		DATE	
	system in REMARKS. #1.) Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3		L V	272	V 272 Subdivision of Buildin	~	00/10/2022	
			I K U	372	K 372 Subdivision of Buildin Spaces – Smoke Barriers	g	09/10/2023	
					Spaces - Silloke Barriers			
		walls were protected to maintain			What corrective action(s) will	20		
		te of each smoke barrier. LSC			accomplished for those reside			
		aires penetrations for cables,			found to have been affected b			
	cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or				deficient practice;	<i>y</i> o		
					#1 - Three smoke barrier wa	lls		
					above drop ceiling in service l			
					100 hall and 200 hall were rep			
	floor/ceiling assembly constructed as a smoke				using fire caulk to meet			
	barrier, or through the ceiling membrane of the				requirements for smoke			
	roof/ceiling of a smoke barrier assembly, shall be				penetrations.			
		em or material capable of			#2 - Smoke barrier wall at	ove		
	_	ement of smoke. This deficient			drop ceiling in service hall wa	5		
	_	et staff and at least 40 residents			repaired by removing joint			
	in four smoke comp	partments.			compound and sealing with fir			
					caulk to meet requirements for	r		
	Findings include:				smoke penetrations			
	Based on observation	ons with the Maintenance			How other residents having th	е		
	Director and Admir	nistrator on 08/10/23 between			potential to be affected by the			
	1:45 p.m. and 2:15	p.m., the following unsealed			same deficient practice will be			
	penetrations were d				identified and what corrective			
		ceiling of the service hall			action(s) will be taken;			
	smoke wall had a 3	/4-inch unsealed gap around			· All residents have the			
	pipes.				potential to be affected by the			
		ceiling of the 200-hall smoke			deficient practices.			
		unsealed gap around wires and			· All smoke barrier walls,			
	a one-inch hole thro				ceiling areas and attic were			
		ceiling of the 100- hall smoke			inspected for (#1) penetration			
		unsealed gap around wires.			and/or (#2) use of joint compo			
		at the time of observation, the			no additional areas were iden	utied.		
		tor agreed the aforementioned			What massings will be said to	•		
	smoke walls contain	ned unsealed penetrations.			What measures will be put int			
					place or what systemic chang			
	#2) Paged on all	myations, records review, and			will be made to ensure that the			
	#2.) Based on observations, records review, and		- 1		deficient practice does not rec	ur,		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155673	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 08/10	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE		
	barrier walls were caccording to the aut (AHJ). LSC 8.2.3.1 structural elements be determined in ac set forth in ASTM I for Fire Tests of Bu Materials, or ANSIATESTS of Building Cother approved test methods approved by penetrations in smo firestop system or dwith ASTM E 814. affect 30 residents in Findings include: Based on observation Director and Admir p.m., above the drop smoke wall five per joint compound. Ba observation, the Masmoke wall penetra compound. The findings were residents in the findings were residents.	ty failed to ensure 1 of 5 smoke onstructed to requirements hority having jurisdiction attates the fire resistance of and building assemblies shall cordance with test procedure E 119, Standard Test Methods ilding Construction and TUL 263, Standard for Fire onstruction and Materials; methods; or analytical by the AHJ. The AHJ requires ke barriers to be sealed with a evice tested in accordance This deficient practice could in two smoke compartments. Ons with the Maintenance distrator on 08/10/23 at 1:45 to ceiling of the service hall distrations were sealed with seed on interview at the time of intenance Director and agree the time of the service with the Maintenance attended with the Mai		The Maintenance designee will conduct a identify (#1) penetratio (#2) use of joint compositive walls, ceilings and for 4 weeks, then more months and quarterly the until compliance is active. How the corrective active monitored to ensure the practice will not recur, assurance program with place; Ongoing compliant this corrective action with monitored via facility of program, with meeting monthly, and is overse executive Director. CQI tool identified Barrier will be completed weeks, monthly time and quarterly thereafted compliance is achieved. If Threshold of 10 met, an action plan will developed to ensure of By what date the system changes will be completed. Completion date: Paper compliance is respective.	an audit to ons and/or ound in the attic weekly thly for 3 chereafter nieved. ion(s) will be ne deficient what quality II be put into once with will be put into once with will be now the deficient what quality II be put into once with will be now the deficient what quality II be put into once with will be now the deficient what quality II be now the now t		
K 0374 SS=E Bldg. 01	Barrie	lding Spaces - Smoke lding Spaces - Smoke					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED	
		155673	B. W	B. WING 08		08/10	08/10/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R						
MARKI F	HEALTH & REHAL	BII ITATION		170 N TRACY ST MARKLE, IN 46770				
		BILITATION		IVII/ U CI CL	1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY 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	
		arriers are 1-3/4-inch thick						
		d-core doors or of						
		resists fire for 20 minutes.						
	1	ve plates of unlimited height						
	-	ors are permitted to have						
		assemblies per 8.5. Doors						
	_	automatic-closing, do not						
		and are not required to swing						
		egress travel. Door opening						
	1 '	um clear width of 32 inches						
	for swinging or ho							
	19.3.7.6, 19.3.7.8		17.0	27.4			00/10/2022	
		on and interview, the facility	K 0	3/4	K 374 Subdivision of Buildin	_	09/10/2023	
		f 5 sets of smoke barrier doors			Spaces – Smoke Barrier Doo	ors		
		novement of smoke for at least						
		101 2012 19.3.7.8 requires			What corrective action(s) will be			
		riers shall comply with LSC			accomplished for those reside			
		2 8.5.4.1 requires doors in smoke			found to have been affected b	y tne		
		he opening leaving only the			deficient practice;	_		
		e necessary for proper operation 1/8 inch. This deficient			· · · 100 hall smoke barrie	er.		
		et 30 residents in two smoke			door has been adjusted to			
		et 30 fesidents in two smoke			eliminate 1/4 inch gap			
	compartments.				How other residents having th	0		
	Finding include:				How other residents having the			
	Finding menue:				potential to be affected by the same deficient practice will be			
	Rased on observation	ons with the Maintenance			identified and what corrective	;		
		nistrator on 08/10/23 at 12:50						
		rier doors entering the 100-hall			action(s) will be taken; All residents have the			
		between the doors when			potential to be affected by the			
		interview at the time of			deficient practice.			
		aintenance Director agreed			All smoke barrier doors v	vere		
		_			inspected for gaps by	vci c		
	there was a gap larger than 1/8 inch between the smoke doors when closed.				Maintenance Director. No			
	Smoke doors when	Cicaca.			additional concerns were			
	The finding was rev	viewed with the Maintenance			identified.			
	_	rator, and the DON at the exit			identified.			
	conference.	and, and the DOIN at the Call			What measures will be put into	n		
	Comprehense.				place or what systemic change			
	3.1-19(b)				will be made to ensure that the			
i e	(-)				, so made to ensure that the	_	·	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 17 of 20

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155673	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/10/2023
	NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION		STREET 170 N MARK		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	N (X5) BE COMPLETION DATE	
				deficient practice does not r The Maintenance E or designee will inspect all s barrier doors weekly and wi immediately make adjustments/repairs as need	Director smoke ill
				How the corrective action(s monitored to ensure the det practice will not recur, what assurance program will be place; · Ongoing compliance	ficient quality put into
				this corrective action will be monitored via facility QAPI program, with meetings being monthly, and is overseen by Executive Director.	ng held y the
				Barrier Doors will be completed weekly x 4 weeks, monthly 3 months, and quarterly the until compliance is achieved by the interpretation of 100 not met, an action plan will developed to ensure compliance.	eted times reafter d. % is be
K 0761				By what date the systemic changes will be completed; Completion date: 9/10	
SS=F Bldg. 01	failed to ensure and of 6 fire door asser accordance of LSC	eview and interview the facility mual inspection and testing of 6 mblies were completed in 2.19.1.1.4.1.1 communicating and fire barriers required by	K 0761	K 761 Maintenance, Inspectand Testing - Doors What corrective action(s) was accomplished for those resi	ill be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AW8L21 Facility ID: 000544

If continuation sheet Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155673		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2023		
NAME OF	PROVIDER OR SUPPLIEI	R	•		ADDRESS, CITY, STATE, ZIP COD	•	
MARKLE	E HEALTH & REHA	BILITATION			TRACY ST LE, IN 46770		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG			_	TAG	DEFICIENCY)		DATE
		permitted only in corridors and			found to have been affected b	y the	
	*	by approved self-closing fire See also Section 8.3.) LSC			deficient practice; · All six fire door		
		equired to have a fire protection			assemblies were re-inspected		
		.4.2 shall be protected by			using an itemized checklist to		
		beled fire door assemblies and			document verification of the 1	1	
		blies and their accompanying			required items for each door.	•	
	hardware, including all frames, closing devices, anchorage, and sills in accordance with the						
	requirements of NFPA 80, Standard for Fire Doors				How other residents having th	е	
	and Other Opening Protectives, except as				potential to be affected by the		
	otherwise specified in this Code. NFPA 80 5.2.1				same deficient practice will be	!	
	states fire door assemblies shall be inspected and				identified and what corrective		
	tested not less than annually, and a written record				action(s) will be taken;		
	_	nall be signed and kept for			· All residents have the		
		HJ. NFPA 80, 5.2.4.1 states fire			potential to be affected by the		
		all be visually inspected from			deficient practice.		
		the overall condition of door			· All six fire door assembli	es	
	-	0, 5.2.4.2 states as a minimum,			were re-inspected using an		
	the following items				itemized checklist to documer		
		or breaks exist in surfaces of			verification of the 11 required	items	
	either the door or fi				for each door.		
		light frames, and glazing beads rely fastened in place, if so					
	equipped.	ery rastened in prace, it so			What measures will be put int	^	
		e, hinges, hardware, and			place or what systemic chang		
		reshold are secured, aligned,			will be made to ensure that th		
		er with no visible signs of			deficient practice does not red		
	damage.				· The Maintenance Dire		
	(4) No parts are mi	ssing or broken.			or designee will inspect all fire		
		s do not exceed clearances			door assemblies annually using		
	listed in 4.8.4 and 6				itemized checklist to documer	_	
	(6) The self-closing	g device is operational; that is,			verification of all 11 required in	tems	
		apletely closes when operated			for each door.		
	from the full open	position.			· · · Itemized checklists w	ill	
	(7) If a coordinator	is installed, the inactive leaf			be signed by Maintenance		
	closes before the ac	ctive leaf.			Director or designee and retai	ned	
		are operates and secures the			for inspection		
	door when it is in the	he closed position.					
	(9) Auxiliary hardy	vare items that interfere or	1		How the corrective action(s)	ıill ba	1

PRINTED: 09/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155673	B. WING 08/10/2023			/2023	
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 170 N TRACY ST MARKLE, IN 46770				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		I	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	prohibit operation a	are not installed on the door or			monitored to ensure the defici	ent	
	frame.				practice will not recur, what qu		
	(10) No field modif	ications to the door assembly			assurance program will be pu	•	
		ed that void the label.			place;		
	(11) Gasketing and	edge seals, where required, are			· Ongoing compliance	with	
	inspected to verify their presence and integrity.				this corrective action will be		
	This deficient practice could affect all residents.				monitored via facility QAPI		
					program, with meetings being	held	
	Findings include:				monthly, and is overseen by tl	ne	
					Executive Director.		
		view with the Maintenance			· · · CQI tool identified as I	Fire	
		nistrator on 08/10/23 at 10:19			Door Inspections will be		
		ation of an annual inspection			completed weekly x 4 weeks,		
		assemblies were not itemized.			monthly times 3 months, and		
	•	iter system the fire door			quarterly thereafter until		
	-	ked as complete, but it did not			compliance is achieved.		
		quired items were verified for			· If Threshold of 100%		
		n interview at the time of			not met, an action plan will be		
		observation, the Maintenance			developed to ensure compliar	ice.	
		sed a checklist with the			By what date the systemic		
	required items, but the checked items were not				changes will be completed;		
	documented.				· Completion date: 9/10/2	3	
	The finding was rev	viewed with the Maintenance					
	_	rator, and the DON at the exit					
	conference.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AW8L21 Facility ID: 000544 If continuation sheet Page 20 of 20