STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. BUILDING -- B. WING	01/13/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/13/25 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Emergency Preparedness survey, Cloverleaf of Knightsville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 64. Quality Review completed on 01/15/25	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective February 12, 2025, to the Life Safety survey completed on January 13, 2025. We respectfully request a paper review and will provide any additional information requested.<br="" p="">	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/13/25 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Life Safety Code survey, Cloverleaf of	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexa	Abbott	01/22/2025

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.

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	Knightsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in resident rooms on the A wing. Resident rooms in the B and C wings were equipped with battery operated smoke alarms. The facility has a capacity of 102 and had a census of 64 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the detached laundry building. Quality Review completed on 01/15/25		February 12, 2025, to the Life Safety survey completed on January 13, 2025. We respectfully request a paper review and will provide any additional information requested. ="" p="">	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation the facility failed to ensure documentation for the preventative maintenance of 51 of 51 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements	K 0300	The corrective action taken for those residents found to be affected by the deficient practice include: No other 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	02/12/2025

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	155542	A. BUILDING 01 B. WING	01/13/2025

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	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 01/13/25 between 9:13 a.m. and 11:50 a.m. with the Maintenance Director present, there was no itemized list of resident room battery operated smoke alarms testing for functionality for the month of December in 2024. Based on interview at the time of record review, the Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for monthly testing adding that he must have forgotten to document his inspections for the month of December of 2024. Based on observations made during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all 51 resident sleeping rooms. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 01/13/25. 3.1-19(b)		action(s) will be taken: Potentially all residents could be affected but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Education has been provided to the Maintenance Director on monthly testing for battery operated smoke alarms. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be completed by the administrator/ designee to ensure the monthly testing on battery operated smoke alarms is completed. Audits will be completed monthly x6 months. Any negative findings will be immediately remedied. The results of the audit will be reviewed by the Quality Assurance Committee monthly. **="" i="">** ="" p="">**="" i="">** ="" p="">**="" i="">** ="" p="">***i="">*** **="" i="">** ="" p="">	

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K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 32 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 01/13/25 at 12:06 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an	K 0324	**="" ithe="">** ="" p="">**="" ihow="">** ="" p="">**="" iwhat="">** ="" p="">**="" span="">** The corrective action taken for those residents found to be affected by the deficient practice include: No other residents were found to be affected by the deficient practice. How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken: Potentially all residents could be affected but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The stove has been outlined in red tape to indicate its position under the hood. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be completed by the maintenance director/designee to ensure the tape remains in place. The audit will be completed	02/12/2025

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	approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview at the time of the observation, the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was discussed with the Administrator and the Maintenance Director at the exit conference on 01/13/25. 3.1-19(b)		weekly for 30 days, then monthly for 5 months. Any negative findings will be immediately remedied. The results of the audit will be reviewed by the Quality Assurance Committee monthly.	