STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155673	A. BUILDING -- B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARKLE HEALTH & REHABILITATION	170 N TRACY ST MARKLE, IN 46770

(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: 10/25/22 Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340 At this Emergency Preparedness survey, Markle Health and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 86 and had a census of 66 at the time of this survey. Quality Review completed on 10/25/22	E 0000		
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: 10/25/22 Facility Number: 000544 Provider Number: 155673 AIM Number: 100267340 At this Life Safety Code survey, Markle Health and Rehabilitation was found not in compliance with Requirements for Participation in	K 0000	K-000 Credible Allegation of Compliance The creation & submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulation. This provider respectfully requests the Plan of Correction be considered the letter of credible compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki L Walburn	Executive Director	11/25/2022

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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	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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 86 and had a census of 66 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached barn providing facility services including storage of beds and other maintenance equipment that was not sprinklered. Quality Review completed on 10/25/22		PROVIDER REQUESTS A DESK REVIEW in lieu of a Post Survey Revisit.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 2 exit discharge with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 Guards complying with 7.2.2.4 shall be provided for ramps, 7.2.5.4.2 Handrails complying with 7.2.2.4 shall be provided	K 0271	K271 I. Correction Action Taken: The 4 foot high fence system has been repaired & is secure.	11/25/2022

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	along both sides of a ramp run with a rise greater than 6 in. (150 mm). This deficient practice could affect staff exiting from the service hall. Findings include: Based on an observation with the Maintenance Director on 10/25/22 at 11:35 p.m., along the service hall exit sidewalk the 4-foot high fence system with handrails which protected persons from falling down the slope was loose, broken from supports, and could be pushed back and forth. This condition made the fence system unsteady for someone using the handrails for support or protection. Based on an interview at the time of observation, the Maintenance Director stated the fence system was loose and needed repaired. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		New wood post spikes were purchased & have been installed on the fence system. The area of fencing that was loose is now secure & is no longer unsteady. The handrails can now be used for support or protection. II. Identification of Other Residents: The entire fence area was assessed for repairs needed. No other areas of concern were identified. III. Measures Put in Place: Maintenance will inspect the fencing system for any safety concerns & will document findings to the safety committee each month. Any areas of concern will be promptly addressed. IV. Monitoring of Corrective Action Taken: Results of the monthly inspection, which will be documented on the Safety Committee Minutes & will be reported at each monthly QAPI meeting by the maintenance supervisor/designee until the IDT team determines there is no longer a need.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and	K 0761		11/25/2022

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	interview, the facility failed to ensure 1 of 4 smoke barrier door assemblies are routinely inspected and repaired as part of the facility maintenance program. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 10/25/22 at 11:30 p.m., the smoke barrier door frame in memory care contained ten holes up to a half inch in diameter. Based on records review at 10:30 a.m., the inspection form for the Memory Care smoke door dated 07/27/22 indicated the door passed inspection. Based on interview at the time of observation, the Maintenance Director agreed there were holes in the frame of the smoke door and that it was missed during the last annual inspection. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		K761 I. Corrective Action Taken: The holes on the smoke barrier door frame in the memory care have been filled in. II. Identification of Other Residents: Maintenance visually checked the door frames of all other smoke barrier doors to identify if there were any other door frames affected. There were no other door frames identified as being affected. III. Measures Put In Place: Maintenance/designee will check all smoke barrier doors on monthly rounds and document findings on a form called "Smoke Barrier Door Inspection". IV. Monitoring of Corrective Action Taken: Results of the monthly rounds will be reported to the QAPI committee each month x 3 months. After 3 months, QAPI committee will re-evaluate the continued need for the monthly monitoring.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens			

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	Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents outside of the Medical Records office. Findings include: Based on observations with the Maintenance Director on 10/25/22 at 11:05 p.m., a refrigerator (high power draw equipment) was plugged into	K 0920	K920 I. Corrective Action Taken: Power strip was removed and the refrigerator was plugged into the wall outlet. II. Identification of Other Residents: Staff were inserviced regarding the use of power strips and appliances being plugged into the wall instead of a power strip. Inservice was	11/25/2022

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	and supplied power by a power strip in the Medical Records office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		completed by 11.25.22. III. Measures Put In Place: Maintenance director/designee will visually audit, during monthly rounds, for the presence of any appliances being improperly plugged into a power strip. Any non-compliance will be immediately corrected & staff re-educated. Results of these monthly rounds will be documented on a tracking log. IV. Monitoring of Corrective Action Taken: The completed monthly tracking log will be reviewed at the QAPI meetings each month x 6 months, at which time the QAPI committee will determine the need for continued monitoring.	