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	11/27/2023

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: 11/27/23 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Emergency Preparedness survey, Cloverleaf of Knightsville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 69. Quality Review completed on 11/30/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to 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 December 27, 2023 to the Life Safety survey completed on November 27, 2023. We respectfully request a paper review and will provide any additional information requested.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexa Abbott	HFA	12/14/2023

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.

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	155542	A. BUILDING -- B. WING	11/27/2023

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients			

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	and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing			

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	participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm			

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	systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the			

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	CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on record review Administrator and Maintenance Supervisor on 11/27/23 between 9:35 a.m. and 11:50 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and or for existing staff. Based on an interview at the time of records review, the Maintenance Supervisor stated he tells staff where the Disaster Book is located and has staff sign and date a form, which was produced. The Maintenance Supervisor confirmed there is no documentation available for review that demonstrates staff knowledge of emergency preparedness policies and procedures. The finding was reviewed with the Administrator	E 0037	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Employee education have been provided to all employees on the Emergency Preparedness Book. Education will be completed during orientation and annually. ***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 on the new hires to ensure they have been	12/14/2023

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	and Maintenance Supervisor at the exit conference.		trained on the emergency preparedness book. Audits will be completed on 4 new employees weekly for 30 days, then 4 new employees monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	
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: 11/27/23 Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820 At this Life Safety Code survey, Cloverleaf of Knightsville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the	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 December 27, 2023 to the Life Safety survey completed on November 27, 2023. We respectfully request a paper review and will provide any additional information requested.	

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	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 69 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 11/30/23			
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 13 exit discharges was constructed to prevent elevation changes in accordance with LSC 7.1.7. LSC 7.1.6.2 requires abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shell be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 30 residents, staff and visitors on C Wing. Findings include:	K 0271	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be	12/27/2023

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	Based on observation with the Maintenance Supervisor on 11/27/23 at 12:25 p.m. during a tour of the facility, the south C Wing exit sidewalk surface had a six inch elevation difference to the ground right outside the exit door. Based on interview at the time of observation, the Maintenance Supervisor agreed there was an abrupt change in elevation where the ground meets the sidewalk outside the exit door, and stated the ground has settled over time at this location. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		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 railing will be installed outside of the south C wing exit door. ***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 on the installed railing. Audits will be completed on the installed rail weekly for 30 days, then monthly for 5 months to ensure the rail is installed properly and secured. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without			

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	manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 13 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors on C Wing. Findings include: Based on observations on 11/27/23 at 12:20 p.m. during a tour of the facility with the Maintenance Supervisor, the exit means of egress sidewalk from the C Wing south exit was only equipped with lighting outside the exit door. There was no lighting futher down the sidewalk to the public way and would be left in darkness. Based on interview at the time of observation, the Maintenance Supervisor agreed the only lighting outside the C Wing south exit was outside the door. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0281	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** An additional battery back up with power has been installed in the C wing south exit area to give proper lighting for egress of exit. ***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 or designee to ensure proper lighting is down the sidewalk to the public area. An	12/14/2023

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			audit will be completed weekly for 30 days, then monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure materials used as an interior finish on 1 of 6 smoke compartments had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect 30 staff, residents or visitors in C Wing smoke compartment. Findings include: Based on observations during a tour of the facility	K 0331	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified.	12/14/2023

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	with the Maintenance Supervisor on 11/27/23 at 12:30 p.m., the soiled utility room by the C Wing nurse station had approximately a 4'X4' hole in the drywall exposing the wood studs behind. The facility was unable to provide interior finish documentation for a flame spread classification of Class A or B for the aforementioned exposed wooden studs. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** The exposed wood studs in the C wing soiled utility room have been addressed. Drywall has been installed to cover the exposed studs. ***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 facility wide to locate/find any holes in the drywall. If any holes are found, they will be immediately addressed. If no holes are found, audits will be completed in 4 locations weekly for 30 days, then 4 locations monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee Monthly.	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff in one smoke compartment. Findings include: Based on observations with the Administrator and Maintenance Supervisor during a tour of the facility from 11:50 a.m. to 1:55 p.m. on 11/27/23, about 12 suspended ceiling tiles were missing in the corridor of the house portion of the facility. Additionally, there were plastic open grill tiles in	K 0353	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:***	12/14/2023

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	the ceiling tile grid where the flourescent lights are hanging above the suspended ceiling which exposed the ceiling above. Based on interview at the time of the observations, the Maintenance Supervisor stated the plastic grates are in the ceiling because the lights are above the suspended ceiling and agreed there are missing ceiling tiles in the corridor. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		The noted missing ceiling tiles and open grill tiles have been removed and replaced with the appropriate tiles. ***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 facility wide to ensure no ceiling tiles are missing. If any ceiling tiles are missing, they will be immediately addressed. If no issues are found, audits will be completed on 3 locations weekly for 30 days, then 3 locations monthly for 5 months to ensure no ceiling tiles are missing. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee Monthly.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke			

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	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 15 residents, staff and visitors in two smoke compartments.	K 0363	***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.	12/14/2023

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	Findings include: Based on observation with the Administrator and Maintenance Supervisor during a tour of the facility from 11:50 a.m. to 1:55 p.m. on 11/27/23, the corridor door serving as the entrance to the Administration office suite was propped in the fully open position with a rubber wedge. Additionally, the self-closing corridor door to a storage room over 50 square feet in the house section of the facility failed to latch into the frame when tested. Based on interview at the time of observations, the Maintenance Supervisor confirmed the Admin suite corridor door was propped in the fully open position with a rubber wedge on the floor and the storage room door failed to latch when tested. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		***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 noted doorstop has been removed from the office door. The noted self-closing door, that failed to latch, has been fixed and has a positive latch. ***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 facility wide to ensure there are no other door stops in the building. If there are any door stops found, they will be immediately removed. If no issues are found, audits will be completed on 3 office areas weekly for 30 days, then 3 offices monthly for 5 months. An audit will be completed by the	

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			maintenance director/designee facility wide to ensure all self-closing corridors have a positive latch. If any doors are found not to have a positive latch, they will be immediately addressed. If no issues are found, audits will be completed on 3 self-closing doors weekly for 30 days, then 3 self-closing doors monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee Monthly.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 5 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily	K 0511	***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***	12/14/2023

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	accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under		***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 GFCI outlet in the C Wing Shower room has been replaced with a new GFCI outlet. ***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 on the GFCI outlets. Audits will be completed on 4 outlets weekly for 30 days, then 4 outlets monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	

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	210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one resident and staff while in the C Wing Shower Room. Findings include: Based on observations on 11/27/23 at 12:17 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the electric receptacle within four feet of the sink in the C Wing Shower Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Supervisor agreed the receptacle in the C Wing Shower Room was not properly GFCI protected. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall			

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	comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 11/27/23 from 9:35 a.m. to 11:50 a.m. with the Administrator and Maintenance Supervisor, the Fire Damper	K 0521	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** The noted dampers have been repaired and/or cleaned by SafeCare. ***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 on fire dampers. Audits will be	12/14/2023

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	Inspection conducted on 10/17/22 for the facility had notations in the repairs needed column. Lobby Entrance and Admin Office noted 'paint spray'. Damper #48 O/S exit door 'needs link' and damper #49 'dirty'. Dampers numbers 40,41,43 and 50 were noted 'dirty'. Based on interview with the Maintenane Supervisor at the time of record review, he confirmed the repairs needed noted on the inspection and stated he contacted the vendor who conducted the damper inspections for paperwork documenting repairs. There was no documentation to review showing repairs of the aforementioned dampers prior to survey exit. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		completed on 4 fire dampers weekly for 30 days, then 4 fire dampers monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee Monthly.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure two mechanical room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any	K 0522	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be	12/27/2023

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	fuel-fired heating device, other than a central heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 40 residents and staff in B and C Wing. Findings include: Based on observations with the Administrator and Maintenance Supervisor during a tour of the facility from 11:50 a.m. to 1:45 p.m. on 11/27/23, the following was noted: a. the natural gas fired water heater in the Mechanical Room in the Clean Utility room behind the A Wing nurse station was not provided with combustion air taken directly from the outside. b. the intake combustion air from the outside was covered with insulation in the B Wing mechanical room that housed a fuel fired water heater. Based on interview at the time of the observations, the Maintenance Supervisor agreed the natural gas fired water heaters in A wing was not provided with combustion air taken directly from the outside and the combustion air taken from outside was covered with insulation in the B Wing mechanical room. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		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:*** Fresh air intake system will be installed in A and C wing mechanical rooms. ***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 fresh air intake system is installed and working properly. An audit will be completed weekly for 30 days, then monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	

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K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failed to follow the current space heater policy. This deficient practice could affect 4 residents and staff in the Therapy area. Findings include: Based on observation with the Administrator and Maintenance Supervisor on 11/27/23 at 12:10 p.m., a portable space heater was observed under a counter behind a chair in the Therapy area. The space heater was not in use at the time of observation. Based on records review at 10:00 a.m., the space heater policy dated March 2020 stated 'the facility prohibits the use of any portable space heating device in the facility. If any portable space heating device(s) are discovered they will be confiscated and removed from the facility.' Based on interview at the time of observation, the Administrator confirmed a space heater was in the Therapy area. The finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0781	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** The heater has been removed from the noted unit. Education has been provided to the therapy department.	12/14/2023

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			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 or designee to ensure no heaters are in the building. Audits will be completed on 3 units weekly for 30 days and 3 units monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee monthly.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (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			

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CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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	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 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect residents and staff in the Therapy area and basement. Findings include: Based on observations during a tour of the facility with the Administrator and Maintenance Supervisor on 11/27/23 between 11:50 a.m. and 1:55 p.m., in the Therapy area, a power strip used to power computer equipment was not secured and dangling under the counter. This condition could put stress on the power cord causing damage to the power cord. Additionally, a power strip used to power an air compressor for the sprinkler system in the basement was draped over piping on the ceiling and hanging freely. Based on interview at the time of each observation, the Maintenance Supervisor agreed the power strips were unsecured and dangling.	K 0920	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were found to be affected by the deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected but none were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:*** The noted power strip in the therapy room has been secured and is not dangling. The noted power strip used to power the air compressor in the basement has been secured and is not draping over the pipe. ***How the corrective action(s)***	12/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		***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 facility wide to locate/find any power strips that are not secured. If any power strips are found that are not secured, they will be immediately addressed. If no dangling power strips are found, audits will be completed in 4 locations weekly for 30 days, then 4 locations monthly for 5 months. Any negative findings will be immediately remedied. The results of the audits will be reviewed by the Quality Assurance Committee Monthly.	