| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 03/31/2014 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PLAINFIELD HEALTH CARE CENTER | 3700 CLARKS CREEK RD<br>PLAINFIELD, IN 46168 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| K010000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 03/31/14<br><br>Facility Number: 000121<br>Provider Number: 155215<br>AIM Number: 100290940<br><br>Surveyor: Mark Caraher, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Plainfield Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This two story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping | K010000 | Preparation and/or execution of the plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| | rooms. The facility has a capacity of 189 and had a census of 92 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/03/14.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K010025 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br>Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect twenty residents, staff and visitors if smoke from a fire were to infiltrate the protective barriers.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on | K010025 | 1. What corrective actions will be accomplishedfor those residents found to have been affectedby the deficient practice: The twelve inch holeabove the electric water heater and the threeby one inch hole was repaired using 5/8"sheetrock which will maintain the smoke resistance of the smoke barrier.2. How other residents having the potential tobe affected by the same deficient practice willbe identified and what corrective action will betaken: All residents have the potential to be affected by this deficient practice. The maintenance director/assistant checked smokebarriers to ensure all penetrations are protectedto maintain the fire resistance of the smokebarrier.3. What measures will be put into place or whatsystemic changes will be made to ensure thatthe deficient practice does not recur: The Maintenance Director/designee will check thesmoke barriers on | 04/07/2014 |

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| | 03/31/14, the following openings were noted in the ceiling smoke barrier of the downstairs Mechanical Room:<br>a. a twelve inch long by ten inch wide hole above an electric water heater for the passage of two, three inch in diameter water pipes.<br>b. a three inch long by one inch wide hole from which a support bracket protruded.<br>Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.<br><br>3.1-19(b) | | monthly rounds and afterany smoke barrier penetrations to ensure facilityremains compliant.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Maintenance Director will reportresults to the Quality Assurance Team on a quarterly basis. | |

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| K010038<br>SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 22 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, six of six exit doors in resident sleeping areas were magnetically locked and could be opened by entering a code. The facility exit by Room 25 is marked | K010038 | 1. What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The code was immediately posted above the keypad at the exit door by room 25.2. 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. MaintenanceDirector checked all exit doors to ensure thecode was placed above keypad.3. What measures will be put into place orwhat systemic changes will be made to ensurethat the deficient practice does not recur:Maintenance Director/designee will checkexit door keypads for codes on weekly roundsto ensure facility remains compliant.4. How the corrective action(s) will bemonitored to ensure the deficient practice willnot recur: Maintenance Director will report findings to the Quality Assurance Team on a quarterly basis. | 04/01/2014 |

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| | with an exit sign but did not have the code posted. Based on interview at the time of observation, the Maintenance Director stated residents which have a clinical diagnosis to be in a secure building reside in the Alzheimer's wing (Room 99 through 113) and acknowledged the exit access code was not posted at the facility exit by Room 25. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.<br><br>3.1-19(b) | | | |

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| K010062 SS=C | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of P.I.P.E. "Report of Inspection" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:00 a.m. on 03/31/14, facility sprinkler system gauges were not stated as being recalibrated or replaced within the most recent five year period. Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, all four gauges at the downstairs sprinkler system riser had a | K010062 | 1. What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: Plainfield Health Care Center contracted witha licensed vendor (P.I.P.E. INC.) to changeout the 4 sprinkler gauges.2. How other residents having the potential tobe affected by the same deficient practice willbe identified and what corrective action(s) willbe taken: All residents have the potential to beaffected by this deficient practice. Maintenance Director checked all gauges to ensure they were recalibrated or replacedwithin the time period allowed.3. What measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Maintenance Director/designee will checkgauges on monthly rounds to ensure facilityremains compliant. 4. How the corrective action(s) will be monitored to ensure the deficient practice willnot recur: Maintenance Director will report findings to the Quality Assurance Team on a quarterly basis. | 04/07/2014 |

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| | manufacture date of 2008. Based on interview at the time of the observation, the Maintenance Director acknowledged each of the four sprinkler system gauges at the downstairs sprinkler system riser had exceeded the five year requirement for recalibration or replacement.<br><br>3.1-19(b) | | | |

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| K010066<br>SS=D | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4<br>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 2 outside areas where smoking was permitted. This deficient practice could affect two staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, the outdoor smoking area | K010066 | 1. What corrective actions will be accomplished for those residents found to havebeen affected by this deficient practice: Maintenance Director removed all cigarette butts from the exit area by Physical Therapy.2. How other residents having the potential tobe affected by the same deficient practice willbe identified and what corrective action(s) willbe taken: All residents have the potential to beaffected by this deficient practice. The Maintenance Director checked all exits forcigarette butts and removed if | 04/02/2014 |

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| | located within three feet of the facility exit by Physical Therapy had in excess of 100 extinguished cigarette butts deposited on the ground. A noncombustible ash tray and a metal container with a self closing cover device into which ashtrays can be emptied were not provided in this area where staff and visitor smoking was taking place. Based on interview at the time of the observations, the Maintenance Director stated this smoking location is not the designated outdoor smoking area and acknowledged cigarette butts were disposed on the ground by staff and visitors and a noncombustible ash tray and metal container with a self closing cover device into which ashtrays can be emptied were not provided at this outside smoking area.<br><br>3.1-19(b) | | found.3. What measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Maintenance Director/designee will checkexterior of building for cigarette butts on weekly rounds. Staff was in-serviced onfacility smoking areas.4. How the corrective action(s) will be monitored to ensure the deficient practice willnot recur: Maintenance Director will report findings to the Quality Assurance Team on a quarterly basis. | |

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| K010067<br>SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br>Based on observation and interview, the facility failed to ensure 5 of 5 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, all resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director | K010067 | It is the policy of this facility to ensure the firedampers in the ductwork at smoke barriers are inspected and maintained at least every four years.All residents have the potential to be affected bythis finding. The Maintenance Director inspected all80 fire dampers in the facility and all are in workingorder. All repairs needed were completed at the timeof inspection. The facility has developed a trackingform for the inspection of the fire dampers whichwill kept in the facility preventative maintenance log.The inspections and maintenance will be completedannually. The Maintenance Director is responsiblefor maintaining these records. Please accept this as an application for waiver for the K067 deficiency.This waiver request has been requested and approved on previous Life Safety Code recertification. This waiver is supported by the following facts: 1. When the fire alarm system istriggered, there is an automatic shut down on the airhandlers.2. None of the existing cold air returns go througha firewall. Based upon the inspector'srecommendation for a waiver and the facts, | 04/02/2014 |

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| | acknowledged all resident rooms were using the egress corridor as a return air system.<br><br>3.1-19(b) | | werequest a waiver to K067. | |

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| K010147 SS=D | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br>Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 main electrical rooms. NFPA 70, Article 100-26(a) states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 100-26(a) (1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 100-26(b) states the working space required by this section shall not be used for storage. This deficient practice could affect two staff and visitors in the Mechanical Room by Room 42.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, a six foot long by three feet wide by four foot high mobile plastic cart containing two bags filled with combustible trash was stored within one | K010147 | 1. What corrective actions will be accomplished for those residents found to havebeen affected by this deficient practice: Maintenance Director removed the mobile plastic cart from the facility's mechanical room by room 42.2. How other residents having the potential tobe affected by the same deficient practice willbe identified and what corrective action(s) willbe taken: All residents have the potential to be affected by this deficient practice: MaintenanceDirector checked all mechanical rooms for combustible items.3. What measures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Maintenance Director/designee will check mechanical rooms for combustible items during daily rounds.4. How the corrective action(s) will be monitored to ensure the deficient practice willnot recur: Maintenance Director will report findings to the Quality Assurance Team on a quarterly basis. | 04/02/2014 |

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| | foot of the front panel of the facility's main electrical panel in the Mechanical Room by Room 42. Based on interview at the time of observation, the Maintenance Director acknowledged a mobile cart containing combustible trash was stored within one foot of the working space in front of the enclosed main electrical panel in the Mechanical Room by Room 42.<br><br>3.1-19(b) | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| K010211 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:<br>o The corridor is at least 6 feet wide<br>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>o The dispensers have a minimum spacing of 4 ft from each other<br>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>o Dispensers are not installed over or adjacent to an ignition source.<br>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 | | | |
| | Based on observation and interview, the facility failed to ensure 1 of over 100 alcohol based hand sanitizers was not installed over an ignition source. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 30 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 03/31/14, an alcohol based hand sanitizer was installed four inches above a light switch in the Alzheimer's area | K010211 | 1. What corrective actions will be accomplishedfor those residents found to have been affectedby the deficient practice: The Maintenance Directorimmediately removed the hand sanitizer.2. How other residents having the potential tobe affected by the same deficient practice willbe identified and what corrective action will betaken: All residents have the potential to be affected by this deficient practice. The MaintenanceDirector checked all light switches to ensure therewere no alcohol based sanitizer near this possibleignition source.3. What measures will be put into place or whatsystemic changes will be made to ensure thatthe deficient practice does not recur: MaintenanceDirector/designee | 04/07/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 03/31/2014 |
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| | nourishment room which was open to the Lincoln Dining Room. The aforementioned hand sanitizer had ethyl alcohol stated as an ingredient on its packaging. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hand sanitizer location was alcohol based and was installed over an ignition source.<br><br>3.1-19(b) | | will check light switches duringweekly rounds to ensure there is no alcohol basedsanitizer near this possible ignition source. Staff were inserviced on the importance of not placing analcohol based sanitizer over or adjacent to an ignition source.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Maintenance Director will reportresults to the Quality Assurance Team on a quarterly basis. | |