

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155587	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/27/2012
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NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 34 S MAIN ST CLOVERDALE, IN 46120
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K0000	<p>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).</p> <p>Survey Date: 02/27/12</p> <p>Facility Number: 000415 Provider Number: 155587 AIM Number: 100291250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Summerfield Health Care 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.</p> <p>This one story fully sprinklered facility with a laundry, maintenance shop, storage room</p>	K0000	<p>This plan of correction represents the Center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to the alleged deficiency and is submitted at the request of the Indiana State Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider as 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 the provision of federal and state law requires it. Summerfield Health Care Center submits that it was in substantial compliance with certification requirements at the time of the survey.</p>	

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	<p>and employee lounge in two separate partial basements was determined to be of Type V (000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity for 43 and had a census of 37 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure a door protecting a corridor opening in 1 of 5 smoke compartments would latch. This deficient practice affects staff, visitors and 6 residents in the east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 2:45 p.m., the corridor door to the resident room 2 on the east hall failed to latch when tested twice. The maintenance supervisor said at the time of observation, the door latch was affected by changes in</p>	K0018	<p>I. Resident Rm. #2 door has been fixed and now latches appropriately. The door to the isolation supply closet has been repaired and closes without impediment. II. the alleged deficient practice could affect all doors and residents of the facility. III. All doors have been inspected for proper closure and impediments. The Maintenance Supervisor will PM(preventative maintenance) all doors monthly to ensure proper closure of all doors. The staff will be inserviced on Work Order placement to ensure that any door that maybe malfunctioning will be addressed between monthly PM's. That inservice will occur 3/23/12. IV. The Maintenance Supervisor/Designee will PM review all doors in facility monthly. The Administrator will review PM monthly times 3</p>	04/24/2012			

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	<p>the weather.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings in 1 of 5 smoke compartments. This deficient practice affects staff, visitors and 11 residents in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 2:10 p.m., the corridor door to the isolation supply closet on the south hall was prevented from closing when it hit the door frame. Upon closer inspection it was found a door hinge was damaged. The maintenance supervisor said at the time of observation you had to lift the door to get it closed into the frame.</p> <p>3.1-19(b)</p>		<p>months. The QA committee will review the PM of all doors for at least 6 months to ensure substantial compliance.</p>				

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K0021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure smoke barrier/fire doors in 5 of 5 smoke compartments were held open only by a device which caused the door to close automatically upon activation of the fire alarm system. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 2:30 p.m., magnets holding all smoke barrier/fire doors failed to release and the doors did not close when the fire alarm was activated by the</p>	K0021	<p>I. The system which activates the magnetic closures has been repaired and all magnetized doors release when system is activated. II. All residents have the potential to be affected by the alleged deficient practice. III. The fire system was maintained on 3/1/12 by Superior Systems and Supply. The fire panel was repaired and now releases all doors when system is activated. IV. The Maintenance Supervisor will monitor the magnetized doors during all scheduled and non-scheduled fire drills at least monthly and document any failures in the system, and repair accordingly. The QA committee will monitor all fire drills and documentation to ensure all systems are working according to code for at least 6 months, longer if necessary.</p>	04/24/2012			

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	<p>maintenance supervisor. The test was repeated with the same result. The maintenance director acknowledged at the time of the observations, there was something wrong with the system.</p> <p>3.1-19(b)</p>				

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the exit discharge for 1 of 6 exits was readily accessible. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 20 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 1:20 p.m., the gate in the six foot tall wooden fence providing access to the public way from the main dining room exit could not be opened more than six inches before it became stuck. It could not be opened and the bottom appeared to be wedged against the ground outside the fence. The maintenance supervisor said at the time of</p>	K0038	<p>I. The gate on the wooden fence now swings freely when opened. II. All residents have the potential to be affected by the alleged defiecient practice. III. The gate has been repaired and now swings freely when opened. The gate has also been shortened to prevent any swelling from impeding the swing of the gate. IV. The Maintenance Supervisor will monitor the opening of the gate, 2 times wkly for 2 weeks and weekly thereafter. The QA committee will monitor the PM of the gate for the next 6 months to ensure that it swings freely.</p>	04/24/2012			

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	<p>observation, the wooden gate had "swollen" preventing the gate from opening fully.</p> <p>3.1-19(b)</p>				

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K0046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 battery powered exit discharge emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 18 residents on the south and west wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 between 12:10 p.m. and 3:00 p.m., the battery powered exit discharge emergency lighting fixture above the west exits from the south and west wings failed to illuminate when each was tested twice. The maintenance supervisor commented at the times of observation, the south wing fixture needed the battery replaced, and he was unaware the west exit light was not working.</p>	K0046	<p>I. The emergency lighting on the west exit from the south and west wings have been repaired. II. All other outside emergency lighting has been tested to ensure they are in proper working order. III. The Maintenance Supervisor will test all the outside emergency lighting for 30 seconds weekly and then a 90 minute test annually. All testing will be recorded on PM documentation for proof of testing. IV. The QA committee will monitor the PM documentation of all the outside emergency lighting for the next 6 months to ensure that all lighting is in proper working order.</p>	04/24/2012	

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the evacuation of smoke compartments and the use of the special kitchen fire extinguisher in the written fire plan for the protection of 37 of 37 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Procedure</p>	K0048	<p>I. The policy for "Responding to a Fire" has been re-written to include the procedure for internal evacuation from one smoke compartment to another. As well as, the use of the K class extinguisher located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. II. All residents have the potential to be affected by the alleged deficient practice. III. The staff has been inserviced on the changes to the "Responding to a Fire" policy on 3/23/12. IV. The Maintenance Supervisor will monitor staff understand of the policy changes during regularly scheduled fire drills(monthly). The QA committee will monitor for the next 6 months via the fire drill documentation to ensure staff understand the policy changes.</p>	04/24/2012			

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	<p>Guidelines for Responding to a Fire in the facility Policy and Procedure manual with the maintenance supervisor and administrator on 02/27/12 at 12:40 p.m., the procedure did not address internal evacuation from one smoke compartment to another and use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The administrator and maintenance supervisor acknowledged the omission of these elements in the fire procedure.</p> <p>3.1-19(b)</p>			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in a monitored area accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0051	<p>I. An annunciator panel has been installed at the nurses station. II. All residents have the potential to be affected by the alleged deficient practice. III. The staff has been inserviced on the annunciator panel and its use on 3/23/12. IV. The Maintenance Supervisor will monitor the procedure and use of the annunciator panel during the monthly scheduled fire drills. any problems will be documented at that time and corrected. The QA committee will monitor the proper use of the annunciator panel via the fire drill documentation for the next 6 months.</p>	04/24/2012			

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	Based on observation with the maintenance supervisor on 02/27/12 at 2:20 p.m., the fire alarm control panel was located in a closet on the south hall. The maintenance supervisor acknowledged at the time of observation, any audible trouble alarm could not be heard by staff who were not in the corridor outside the closet. He said the facility relied on staff in the hall to hear the alarm and notify him of any trouble alarm. He agreed staff were not available at all times on the south hall to monitor the panel for trouble.				

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 3 common areas were free of foreign materials such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects visitors, staff and 20 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 1:30 p.m., six sprinkler heads providing protection in the dining room were covered with a fuzzy gray grime. The maintenance supervisor agreed at the time of observation, the sprinkler heads were not clean.</p> <p>3.1-19(b)</p> <p>2. Based on observation and</p>	K0062	<p>I. The sprinkler heads in the dining room have been cleaned. The sprinkler head in the laundry chute has been unobstructed. II. All residents have the potential to be affected by the alleged deficient practice. III. The housekeeping staff will be responsible for keeping the sprinkler heads cleaned. This job duty will be added to their "Job Duties" list for daily check off. The Housekeeping staff will be inserviced on proper cleaning of the sprinkler heads on 3/23/12. IV. The Maintenance Supervisor and the Housekeeping/Laundry Supervisor will make weekly rounds to ensure all sprinkler heads are clean and free of obstruction. The QA committee will monitor the weekly PM rounds of the sprinkler heads for the next 6 months to ensure compliance.</p>	04/24/2012			

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NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 34 S MAIN ST CLOVERDALE, IN 46120
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	<p>interview, the facility failed to ensure 1 of 1 laundry chute sprinkler heads was free of obstructions to the spray pattern. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. This deficient practice affects visitors, staff and 11 residents on the south wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 2:45 p.m., the sprinkler head providing protection within the laundry chute was blocked by a drawer which had fallen from above it. The maintenance supervisor acknowledged at the time of observation, the drawer created an obstruction to the sprinkler spray pattern.</p> <p>3.1-19(b)</p>			

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K0071 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was sealed by fire resistive construction and provided with a self closing fire rated door assembly. LSC 9.5 requires compliance with LSC 8.2. LSC 8.2.3.2.1(b) requires fire doors shall be self closing. This deficient practice could affect visitors, staff, and 11 residents on the south wing.</p>	K0071	<p>I. A new chute has been measured and ordered as of 3/13/12. II. All residents have the potential to be affected by the alleged deficient practice. III. Due to specific manufacturing, the chute must be custom made and is projected to be complete and in the facility by April 15, 2012. The chute is projected to be installed by 4/24/2012. The chute will be sealed by fire resistive construction, as well as a self-closing door. It will have an automatic extinguishing system with a self-closing type "H"</p>	04/24/2012			

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	<p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/27/12 at 2:50 p.m., a laundry chute was located in the south wing soiled utility room and emptied into the laundry in the basement below. The laundry chute was a part of a painted wood cabinet with a wood door. The door did not self close, did not have a fire rating and was secured with a hook latch. The chute ceiling consisted of a wood drawer located at the top of the chute and had fallen at the back of the cabinet where the slide rails failed to hold it in place. The result was a gap between the cabinet face and drawer assembly. Part of the chute was lined with a metal material. On the basement level where the chute emptied into the laundry, the wood frame was not completely lined with a one hour fire rated material. A section of the vertical chute assembly was missing. The condition of the chute was acknowledged by the maintenance supervisor who reported he planned to replace the</p>		<p>hopper door that closes with heat rising above 165 degree F. IV. The Maintenance Supervisor will monitor the Self closing doors and hopper doors through the PM weekly. The QA committee will monitor compliance by reviewing the PM documentation for the next 6 months. V. 4/24/12 Due to Custom Manufacturing.</p>	

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	chute and provided details of the assembly but no installation date had been set.  3-19(b)			

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside. This deficient practice affects visitors, staff and 11 residents on the south hall.</p> <p>Findings include:</p> <p>Based on observation on 02/27/12 at 2:25 p.m. with the maintenace supervisor, the oxygen storage room located on the south hall was identified as the oxygen transfer area also. The mechanical vent for the room</p>	K0143	<p>I. Continuous mechanical ventilation to the outside has been installed in the Oxygen Transfill Room. II. All Residents have the potential to be affected by the alleged deficient practice.III. The Maintenance Supervisor/Designee will monitor that the continuous mechanical ventilation is properly working weekly through the PM program.IV. The QA committee will monitor the documentation of the PM program for the outside mechanical ventilation for the Oxygen Transfill Room for the next 6 months.</p>	04/24/2012

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	<p>did not appear to be running. The maintenance supervisor then flipped a switch outside the entry door and the vent could be heard running. He acknowledged at the time of observation, turning the vent off did not provide the continuous mechanical ventilation required for the oxygen transfilling room.</p> <p>3.1-19(b)</p>			