

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 12/19/2012
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NAME OF PROVIDER OR SUPPLIER PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN 46168
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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: 12/19/12</p> <p>Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>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.</p> <p>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</p>	K0000		

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>rooms. The facility has a capacity of 189 and had a census of 137 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 2 Caring Hands Hall paths of egress was marked with an approved sign to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice could affect 24 residents, staff and visitors in the Caring Hands dining room needing to exit the Caring Hands Hall from the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 12/19/12, the Caring Hands Hall and dining room is an Alzheimer and dementia care area and there are two exits from this secured wing. One of these exits is from the Caring Hands dining room into the Center Hall. The Caring Hands dining room exit into the Center Hall was not provided with an exit sign</p>	K0022	<p>-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; An additional Exit sign was installed above the door entrance to center hall. Exit sign contains LED lighting inside. -How other residents have the potential to be affected by the dame deficient practice will be identified and what corrective actions will be taken; An additional Exit sign was installed above the door entrance to center hall. Exit sign contains LED lighting inside. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reocur; All Exit signs will be veirfied on a daily walk through and results reported to the QAA committee monthly. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All Exit signs will be veirfied on a daily walk through and results reported to the QAA committee monthly. -By what date the systemic changes will be completed.1/16/2013</p>	01/16/2013			

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	<p>above the door in the dining room to indicate the direction of exit travel from the dining room. Based on interview at the time of observation, the Maintenance Director acknowledged exit signage was not provided at the Caring Hands Hall dining room exit to the Center Hall.</p> <p>3.1-19(b)</p>				

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K0067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>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.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 12/19/12, 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</p>	K0067	<p>Plan of correction:Corrective Action (K067): It is the policy of to ensure the fire dampers in the ductwork at smoke barriers are inspected and maintained at least every four years. All residents have the potential to be affected by this finding. The maintenance supervisor inspected all 80 fire dampers in the facility and all are in working order. All repairs needed were completed at the time of inspection. The facility has developed a tracking form for the inspection of the fire dampers which will be kept in the Facility Preventative Maintenance Log. The inspections and maintenance will be completed annually. The Maintenance Director is responsible for maintaining these records. Please accept this letter as an application for a 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 followinf facts: A. When the fire alarm system is triggered, there is an automatic shut down on the air handlers. B. None of the existing cold air returns go through a firewall. Based upon the inspector's recommendation for a waiver,</p>	01/16/2013			

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	acknowledged all resident rooms were using the egress corridors as a return air system. 3.1-19(b)		and the facts outlined above, we request a waiver fo K067.		

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K0147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two residents, staff and visitors in Room 14.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 12/19/12, an oxygen concentrator was plugged into a power strip near a bed in resident sleeping Room 14. Based on interview at the time of observation, the Maintenance Director acknowledged an oxygen concentrator was plugged into a power strip in resident sleeping Room 14.</p> <p>3.1-19(b)</p>	K0147	<p>-What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The oxygen concentrator was immediately unplugged from the power strip and plugged directly into the wall outlet. -How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; As part of the facility Preventative Maintenance Program, all rooms will be audited monthly to verify medical equipment is plugged directly into the wall. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As part of the facility Preventative Maintenance Program, all rooms will be audited monthly to verify medical equipment is plugged directly into the wall. -How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Audit findings will be reported to the QAA committee monthly. -By what date the systemic changes will be completed. 1/16/2013</p>	01/16/2013