

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2015
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NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
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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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K 0000 Bldg. 01	<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: 08/11/15</p> <p>Facility Number: 000373 Provider Number: 15E209 AIM Number: 100288730</p> <p>At this Life Safety Code survey, Summit Convalescent Center was found not in compliance with Requirements for Participation in 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 one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 34 and had a census of 26 at the time of this survey.</p>	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Convalescent Center that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Convalescent Center. The facility requests the following plan of correction be considered its allegation of compliance the facility also respectfully requests paper compliance due to the low scope and severity and number of tags written	
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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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K 0144 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator which would indicate generator function conditions during a test. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply</p>	K 0144	<p>The alarm annunciator panel was fixed on 8/19/15. The maintenance director will add checking of the emergency generator alarm annunciator panel to his monthly preventative maintenance rounds. Charge nurses aware that any issues or malfunction of the annunciator panel maintenance supervisor or administrator are to be notified immediately. Any problems with the panel will be immediately addressed by the maintenance supervisor/designee. POC Date: 9/10/15</p>	08/19/2015

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	<p>power to load.</p> <p>2. When the battery charger is malfunctioning.</p> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/11/15 at 2:55 p.m. with the Maintenance Supervisor, the alarm annunciator panel for the generator located at the nursing station would not illuminate any of the functions</p>				

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	<p>when the test button was depressed..</p> <p>During an interview on 08/11/15 at 2:56 p.m. with the Maintenance Supervisor, it was acknowledged the generator annunciator panel was not functioning and the reason was unknown.</p> <p>3.1-19(b)</p>				