

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
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: 05/16/16</p> <p>Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940</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 rooms. The facility has a capacity of 189 and had a census of 81 at</p>	K 0000	The facility respectfully requests a desk review. 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 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.

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0018 SS=E Bldg. 01	<p>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 completed on 05/20/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 90 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing,</p>	K 0018	1.Maintenance Director or designee will implement corrective actions for those affected by this practice including repairing the door to ensure latching by June 15, 2016.	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0020 SS=E Bldg. 01	<p>latching and would resist the passage of smoke. This deficient practice could affect eight residents, staff and visitors by Room 414.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor door to Room 414 failed to latch into the door frame because the latching mechanism would not protrude into the latching plate. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door had an impediment to closing, latching and would not resist the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1</p>		<p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including testing all doors ability to latch properly to resident rooms by June 15, 2016.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including auditing door latching on a monthly basis for 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of doors latching correctly on a monthly basis for 6 months and reviewing during monthly QA process for 6 months.</p>	

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  05/16/2016	
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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			
	<p>Based on observation and interview, the facility failed to enclose 1 of 4 vertical openings with construction having a fire resistance rating of at least one hour. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, 1999 Edition, at 2-1.4.1 requires swinging doors to be equipped with self-closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Laundry chute room in the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor door to the Laundry chute room in the 300 Hall had no affixed fire resistance rating label affixed to the door. The laundry chute door in the Laundry chute room had no affixed fire resistance rating label and was not self-closing and did not latch into</p>	K 0020	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including placing an order to replace laundry chute door with an affixed fire resistance rating label by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including installing door properly ensuring it is closing and latching correctly.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months and reviewing during monthly QA process for 6 months.</p>	06/15/2016			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0025 SS=E Bldg. 01	<p>the chute door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the Laundry chute room did not provide the vertical opening with a fire resistance rating of at least one hour.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure doors in 2 of 5 attic smoke barrier walls were locked or latched to maintain the one hour fire resistance rating of the smoke barrier. LSC 8.2.3.2.1 states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, 1999 edition, section 2-1.2 states a fire door assembly shall include a lock or a latch. Section</p>	K 0025	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including latching smoke barrier doors and filling open areas in smoke barriers with smoke resistance caulk by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including verifying all smoke barrier doors are fully operational and in locked position by June 15, 2016.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this</p>	06/15/2016

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  05/16/2016
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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	
	<p>2-1.4 states all swinging doors shall be closed and latched at the time of fire. This deficient practice could affect 28 residents, staff and visitors in the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, a three foot by four foot access panel in the attic smoke barrier wall above the corridor door set by Room 301 was in the fully open position. In addition, a three foot by four foot access panel in the attic smoke barrier wall above the corridor door set by Room 311 was also in the fully open position. Each of the aforementioned attic smoke barrier walls consisted of four layers of five-eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned open access doors were not locked or latched which did not ensure the attic smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 5</p>		<p>practice does not recur including random audits confirming smoke barrier doors are in locked position for 6 months.</p> <p>4. Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of smoke barrier doors in locked position for 6 months and reviewing during monthly QA process for 6 months.</p>		

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>openings through 1 of 15 smoke barrier walls were protected to maintain the smoke 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 that 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 28 residents, staff and visitors in the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, a three foot by four foot access panel in the attic smoke barrier wall above the corridor door set by Room 301 was in the fully open position and had five data cables passing through the open doorway. In addition, a three foot by four foot access panel in the attic smoke barrier wall above the corridor door set by Room 311 was also in the fully open position and had six data cables passing through the open doorway. Each of the aforementioned attic smoke barrier walls consisted of four layers of five-eighths</p>			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>inch thick drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned open access doors and allowing the passage of data cables through the doorways did not ensure the attic smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the north mechanical room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, a four inch by two inch "L"</p>			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0029 SS=E Bldg. 01	<p>shaped hole for the passage of a two inch in diameter conduit was noted in the north mechanical room ceiling. In addition, two three inch in diameter holes for the passage of two separate two inch in diameter conduits were also noted in the ceiling of the north mechanical room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the north mechanical room ceiling smoke barrier were not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 9 hazardous areas such as laundries greater than 100 square feet in size, combustible storage</p>	K 0029	1.Maintenance Director or designee will implement corrective actions for those affected by this practice including removing door wedges from use	06/15/2016

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  05/16/2016
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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	
	<p>locations greater than 50 square feet in size and kitchens were separated from other spaces by smoke resistant partitions and doors. Doors to hazardous areas are self-closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Dietary entrance.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor door to Dietary, to the basement locker room and to the east door in the door set to the Laundry were each propped in the fully open position by the use of a wedge placed on the floor. In addition, the corridor door to the locker room was warped and would not latch into the door frame. The basement locker room measured greater than 50 square feet in size and was used to store combustible supplies and soiled linen in two 32 gallon carts. The magnetic holding device affixed to the wall for the east door in the Laundry room door set was inoperable. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor door to the locker room and the use of wedges to prop open the</p>		<p>in the building and placing order to replace corridor door to the locker room by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including conducting random audits throughout facility for door wedges and removing when necessary.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including repairing or replacing magnetic holding devices by June 15, 2016.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting floor rounds looking for door wedges and verifying work has been completed as instructed for door replacement and magnetic holding devices and reviewing during monthly QA process for 6 months.</p>		

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0038 SS=E Bldg. 01	<p>aforementioned hazardous area doors failed to separate these areas from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p> <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 means of egress through 6 of 9 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 states 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 patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 120 residents, staff and visitors.</p> <p>Findings include:</p>	K 0038	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including posting door code next to doors indicated by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including conducting random audits of door code labels monthly for 6 months.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including conducting floor rounds and verifying door code labels are in place and replacing label if found to be missing.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of door code labels monthly for 6 months and reviewing during monthly QA process for 6 months.</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0046 SS=E	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, each of the following exit door locations were marked as a facility exit and each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted:</p> <ul style="list-style-type: none"> <li>a. new exit door set by the Caring Hands entry door set.</li> <li>b. by Room 100.</li> <li>c. by Room 126.</li> <li>d. by Room 201.</li> <li>e. Stepping Forward west exit.</li> <li>f. by Physical Therapy.</li> </ul> <p>Based on interview at the time of the observations, the Maintenance Director stated residents who have a clinical diagnosis to be in a secure building reside in the Alzheimer's Wing in Caring Hands Hall and acknowledged the four digit code was not posted at the aforementioned six exit doors. 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.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
Bldg. 01	<p>Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1 1/2 hour duration for 1 of 8 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 10 residents, staff and visitors if required to evacuate the facility using the exit by Physical Therapy.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the exit discharge to the exterior of the facility by Physical Therapy was not provided with exterior lighting. Electrical junction boxes were located at the aforementioned exit discharge but the associated lighting fixtures had been removed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned exit discharge to the exterior of the facility was not provided with exterior lighting.</p> <p>3.1-19(b)</p>	K 0046	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including installing exterior lighting next to exit indicated by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including verifying exit door lighting is in place and functional at all exits of the building by June 15, 2016.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including conducting exit door lighting audits monthly for 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting exit door lighting audits monthly for 6 months and reviewing during monthly QA process for 6 months.</p>	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155215	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/16/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
--------------------	--	---------------	---	----------------------

K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the first and second shift for 1 of 4 quarters and on the third shift for 2 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:40 a.m. on 05/16/16, documentation of a fire drill conducted on the first and second shift in the fourth quarter (October, November, December) 2015 was not available for review. In addition, documentation of a fire drill conducted on the third shift in the third</p>	K 0050	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including conducting a fire drill before June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including providing education to staff when appropriate during fire drills.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including documenting completion of fire drills in TELS monitoring software.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including auditing completion of fire drills in TELS monitoring software and reviewing during</p>	06/15/2016
----------------------------	--	--------	---	------------

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0052 SS=C Bldg. 01	<p>quarter (July, August, September) 2015 and fourth quarter 2015 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the aforementioned shifts and quarters of 2015 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit</p>	K 0052	<p>monthly QA process for 6 months.</p> <p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including locking fire alarm system breaker enclosure immediately. 2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including replacing combination lock with keyed lock for fire alarm system breaker enclosure by June 15, 2016. 3.Maintenance Director or designee will implement measures to ensure that this</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the fire alarm system breaker located in the basement by the downstairs generator was not enclosed in a locked or sealed cabinet. The breaker box containing the fire alarm breaker was provided with a combination lock which was not locked. Based on interview at the time of observation, the Maintenance Director stated the combination lock for the fire alarm system breaker cabinet is left unlocked because the combination to open the lock is not known and acknowledged the fire alarm system</p>		<p>practice does not recur including random audits to verify lock is in place and locked monthly for 6 months.</p> <p>4. Administrator will monitor corrective actions to ensure the effectiveness of these actions including random audits to verify lock is in place and locked monthly for 6 months and reviewing during monthly QA process for 6 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155215	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/16/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0062 SS=C Bldg. 01	<p>breaker located in the basement by the downstairs generator was not enclosed in a locked or sealed cabinet.</p> <p>3.1-19(b)</p> <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>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. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Notes" documentation dated 11/17/15 with the Maintenance Director during</p>	K 0062	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including repairing or receiving quote for repair for two new Tyco Accelerators, 4" OS&amp;Y control valve, two moisture separators, two 1/2" air regulators with assembly, new 1/2" air line and two horizontal air compressors with tank by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including conducting in-house fire sprinkler system checks weekly.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including documenting completion of fire sprinkler system checks in TELS monitoring system.</p> <p>4.Administrator will monitor corrective actions to ensure the</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>record review from 9:30 a.m. to 11:40 a.m. on 05/16/16, the following was stated in the SafeCare report:</p> <p>a. During inspection found that Reliable Accelerator on 4" CSC Dry Valve and on 4" Reliable Dry Valve are not working. (Trip Test Failed). 4" Reliable Dry Valve took 105 seconds to trip and 4" CSC Dry Valve took 164 seconds to trip!</p> <p>b. Also both Dry Pipe Valves air pressure is controlled by tankless gas + air compressors with pressure switch! Maintenance want to replace gas + air compressors with air compressor with tank!</p> <p>c. 4" OS&amp;Y control valve packing is leaking on 4" Reliable Dry Valve! Maintenance want OS&amp;Y valve replaced!</p> <p>d. Send quote to install two new Tyco Accelerators, 4" OS&amp;Y control valve, two moisture separators, two 1/2" air regulators with assembly, new 1/2" air line and two horizontal air compressors with tank!</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the OS&amp;Y control valve packing on the 4" Reliable Dry Valve was leaking water. Based on interview at the time of record review and of the observation, the Maintenance Director stated repairs to the sprinkler system on or after 11/17/15 had not been performed</p>		effectiveness of these actions including reviewing TELS software for completion of fire sprinkler system checks and reviewing during monthly QA process for 6 months.	

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0064 SS=E Bldg. 01	<p>and acknowledged documentation of sprinkler system repair on or after 11/17/15 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>1. Based on observation and interview, the facility failed to install 1 of 31 portable fire extinguishers in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Caring Hands nurse's station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the portable fire extinguisher at</p>	K 0064	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including mounting fire extinguisher at nurse's station in Caring Hands by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including documenting location of all 31 fire extinguishers in the building to be inspected with a "quick check" on a monthly basis.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including auditing completion of "quick check" on tags of fire extinguishers monthly and documenting in TELS monitoring software.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>the Caring Hands nurse's station was on the floor and was not mounted on the wall. Based on interview at the time of observation, the Maintenance Director stated the Caring Hands nurse's station was recently remodeled, the fire extinguisher mount was removed for wall painting and acknowledged the portable fire extinguisher was placed on the floor and not correctly mounted on the wall above the floor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to document inspection of 1 of 31 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 10 residents, staff</p>		including random audits of completion of "quick check" on tags of fire extinguishers monthly and reviewing documentation of completion in TELS and reviewing during monthly QA process for 6 months.	

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0067 SS=F Bldg. 01	<p>and visitors in the vicinity of the Caring Hands nurse's station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the inspection tag affixed to the portable fire extinguisher at the Caring Hands nurse's station indicated a monthly inspection was not documented for March and April 2016. Based on interview at the time of observation, the Maintenance Director acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for March and April 2016.</p> <p>3.1-19(b)</p> <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</p>	K 0067	Life Safety Code Waiver Request Submitted June 3, 2016	06/03/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0069 SS=D Bldg. 01	<p>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 11:40 a.m. to 2:40 p.m. on 05/16/16, 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 acknowledged all resident rooms were using the egress corridor as a return air system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p>			

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  05/16/2016	
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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			
	<p>Based on record review, observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p>	K 0069	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including having kitchen hood cleaned as scheduled in July 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including ensuring company places sticker of completion directly on the hood indicating the month and year at time of service.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including documenting completion of hood cleaning in TELS monitoring software.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including reviewing TELS software for completion of cleaning kitchen hoods and reviewing during monthly QA process for 6 months.</p>	06/15/2016			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0071	<p>Based on review of Hoodz "Job Service Report" documentation dated 01/29/16 with the Maintenance Director during record review from 9:30 a.m. to 11:40 a.m. on 05/16/16, documentation of semiannual kitchen exhaust systems inspection six months prior to 01/29/16 was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, a sticker affixed to the kitchen range hood indicated the most recent hood inspection was performed by Hoodz in January 2016. No other kitchen exhaust systems inspection documentation prior to January 2016 was available for review. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of semiannual kitchen exhaust systems inspection six months prior to January 2016 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			

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  05/16/2016	
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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			
SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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 2 laundry chutes rooms were provided with a fire door with a fire protection rating of one hour which were self-closing and latching. NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 1999 Edition at 3-2.4.3 states openings into chute rooms shall be protected by self-closing doors that are appropriate for protecting the openings and suitable for Class B openings, or not less than 1-hour</p>	K 0071	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including placing an order to replace laundry chute door with an affixed fire resistance rating label by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including installing door properly ensuring it is closing and latching correctly.</p> <p>3.Maintenance Director or designee will implement</p>	06/15/2016			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0076 SS=E Bldg. 01	<p>partition rating with a 3/4-hour door. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Laundry chute room in the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor door the Laundry chute room in the 300 Hall had no affixed fire resistance rating label affixed to the door. The laundry chute door in the Laundry chute room had no affixed fire resistance rating label and was not self-closing and did not latch into the chute door frame. Based on an interview at the time of observation, the with the Maintenance Director acknowledged it was not known if the fire resistance rating of the corridor door to the Laundry chute room was constructed of one hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p>		<p>measures to ensure that this practice does not recur including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months and reviewing during monthly QA process for 6 months.</p>	

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by Room 101.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor entry door to the oxygen storage and transfilling room by Room 101 had no fire resistance rating label affixed to the door. The aforementioned room contained nine liquid oxygen containers. Based on interview at the time of observation, the Maintenance Director stated he was unaware of the fire resistance rating of the corridor entry door and acknowledged it could not be assured the oxygen storage room and transfilling room was enclosed</p>	K 0076	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including placing an order to replace oxygen storage door with an affixed fire resistance rating label by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including installing door properly ensuring it is closing and latching correctly.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months and reviewing during monthly QA process for 6 months.</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0130 SS=F Bldg. 01	<p>with one hour fire resistive construction.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 93 of 93 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015 &amp; 2016" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:40 a.m. on 05/16/16, documentation of resident sleeping room battery operated smoke detector cleaning was not available for review for the most recent twelve month period. Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, manufacturer's information</p>	K 0130	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including cleaning all battery operated smoke detectors in resident rooms as scheduled in July 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including cleaning all battery operated smoke detectors in resident rooms annually.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including documenting completion of cleaning battery operated smoke detectors on annual cleaning log.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including reviewing log for completion of cleaning battery operated smoke detectors annually and reviewing during QA process.</p>	06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
K 0143 SS=E Bldg. 01	<p>affixed to the back of the Kidde Model i9050 ionization battery operated smoke detector installed in Room 413 stated to "clean the smoke alarm annually." Based on interview at the time of observation, the Maintenance Director stated Kidde Model i9050 battery operated smoke detectors are installed in each of 93 resident sleeping rooms in the facility and acknowledged documentation of resident sleeping room battery operated smoke detector cleaning was not available for review for the most recent twelve month period.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</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; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p>			

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  05/16/2016	
NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>8-6.2.5.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by Room 101.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:40 p.m. on 05/16/16, the corridor entry door to the oxygen storage and transfilling room by Room 101 had no fire resistance rating label affixed to the door. The aforementioned room contained nine liquid oxygen containers. Based on interview at the time of observation, the Maintenance Director stated he was unaware of the fire resistance rating of the corridor entry door and acknowledged it could not be assured the oxygen storage room and transfilling room was enclosed with one hour fire resistive construction.</p> <p>3.1-19(b)</p>			K 0143	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including placing an order to replace oxygen storage door with an affixed fire resistance rating label by June 15, 2016.</p> <p>2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including installing door properly ensuring it is closing and latching correctly.</p> <p>3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months.</p> <p>4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including conducting random audits of doors verifying fire resistance rating label is still in place monthly for next 6 months and reviewing during monthly QA process for 6 months.</p>		06/15/2016

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
--------------------	--	---------------	---	----------------------

K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure a monthly load test for 2 of 2 emergency generators was conducted for 7 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required</p>	K 0144	<p>1.Maintenance Director or designee will implement corrective actions for those affected by this practice including conducting weekly generator tests along with a monthly load test up to June 15, 2016 and going forward. 2.Maintenance Director or designee will assess residents having the potential to be affected by this practice including conducting weekly generator tests along with a monthly load test as required by the Life Safety Code. 3.Maintenance Director or designee will implement measures to ensure that this practice does not recur including documenting completion of weekly and monthly generator tests in TELS monitoring software. 4.Administrator will monitor corrective actions to ensure the effectiveness of these actions including auditing completion of weekly and monthly generator tests in TELS monitoring software and reviewing during monthly QA process for 6 months.</p>	06/15/2016
----------------------------	---	--------	---	------------

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Load Test" documentation for the "Downstairs Unit" and the "Shed Unit" with the Maintenance Director during record review from 9:30 a.m. to 11:40 a.m. on 05/16/16, the following was noted:</p> <p>a. documentation for monthly load testing for each of the two emergency generators for the period of September 2015 through December 2015 was not available for review.</p> <p>b. weekly load testing documentation for each of the two emergency generators for the period of 02/02/16 through 05/10/16 did not include each generator was load tested at least once per month for at least 30 minutes.</p> <p>c. weekly load testing documentation for each of the two emergency generators for the period of 02/02/16 through 05/10/16 did not document if each generator was load tested under operating temperature</p>			

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  05/16/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD 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
	<p>conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>Based on interview at the time of record review, the Maintenance Director stated each emergency generator is load tested on a weekly basis but acknowledged monthly load testing documentation for September 2015 through December 2015 was not available for review and did not state each emergency generator was load tested for a minimum of 30 minutes under operating conditions for the period of 02/02/16 through 05/10/16.</p> <p>3.1-19(b)</p>			