

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 07/06/2015
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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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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: 07/06/15</p> <p>Facility Number: 000415 Provider Number: 155587 AIM Number: 100291250</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 16.2.</p> <p>This one story facility with two partial basements was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 43 and had a census of 42 at the time of this</p>	K 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegation. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to regulatory obligations. The facility requests the plan of correction be considered the allegation of compliance effective August 5, 2015, to the Life Safety Code Survey conducted July 6, 2015.</p>	
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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 0018 SS=B Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached wood framed building used for facility storage.</p> <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. Based on observation and interview, the facility failed to ensure 2 of 2 sets of double doors to the corridor were equipped with positive latches and latched into the door frame. This deficient practice could affect any number of residents, as well as staff and visitors while in the South Hall and North Hall.</p> <p>Findings include:</p>	K 0018	K 018 It is the practice of this facility to assure doors to the corridor are equipped with a means suitable for keeping the doors closed. The doors to the linen closet on the north hall were modified to meet the applicable standard on July 7, 2015, by the maintenance director. The south hall linen closet doors will be replaced with doors that will meet the applicable standard on or before August 5, 2015, by maintenance director. All facility corridor doors have been audited	08/05/2015

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K 0038 SS=E Bldg. 01	<p>Based on observations on 07/06/15 between 11:30 a.m. and 1:00 p.m. during a tour of the facility with Maintenance Director, the set of double doors to the South Hall clean linen closet were sliding doors which did not latch into the door frame, furthermore, the set of double doors to the North Hall clean linen closet did not automatically latch positively into the door frame, it had to be manually latched with a built in slide bolt latch located at the top back side of the door. This was acknowledged by Maintenance Director at the time of each observation.</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 a handrail was provided for 2 of 2 exits with ramps. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. Exception No. 3 says existing ramps shall be permitted to have a handrail on one side only. This deficient</p>	K 0038	<p>for compliance on July 07, 2015, by the maintenance director. Residents, staff and visitors had the potential to be affected. The maintenance director has reviewed the requirements at K 018 and demonstrated understanding. All facility corridor doors have been added to the weekly preventive maintenance program to assure continued compliance. Preventative maintenance findings, corrective action, and completion rates have been added to the standing monthly safety committee meeting agenda for ongoing quality assurance monitoring. Minutes of the safety committee meeting are reviewed for potential action by the QAPI committee which meets monthly.</p> <p>K 038 It is the practice of the facility to assure entrance and egress ramps are accessible. Handrailsshall be added to the ramp at south hall westexit and east hall east exitby maintenance director on or before</p>	08/05/2015

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	<p>practice could affect any number of residents, as well as staff and visitors while exiting to the outside from the South Hall and East Hall.</p> <p>Findings include:</p> <p>Based on observations on 07/06/15 between 11:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <p>a. The South Hall west exit had a seven and one half foot long ramp which had a grade change of eight inches from top to bottom. There was no handrail on either side of the ramp.</p> <p>b. The East Hall east exit had a ten and one half foot long ramp which had a grade change of ten inches from top to bottom. There was no handrail on either side of the ramp.</p> <p>This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>		<p>August 5, 2015.</p> <p>Residents, staff and visitors have the potential to be affected. All facility exit access areas have been audited for compliance by maintenance director on July 7, 2015, with no issues to report.</p> <p>The maintenance director has reviewed the requirements at K 038 and demonstrated understanding. All facility exit access areas have been added to the weekly exterior preventive maintenance program to assure continued compliance.</p> <p>Preventative maintenance findings, corrective action, and completion rates have been added to the standing monthly safety committee meeting agenda for ongoing quality assurance monitoring. Minutes of the safety committee meeting are reviewed for potential</p>		

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 (equivalent) shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 07/06/15 at 9:45 a.m. with the Maintenance Director present, the facility's fire drills are set up as two, twelve hour shifts. The third quarter (July, August, and September of 2014) lacked a fire drill that would normally be considered an evening time frame fire drill. Fire drills were conducted on 07/16/15 at 10:00 a.m., 08/10/14 at 11:00</p>	K 0050	<p>action by the QAPI committee which meets monthly.</p> <p>K 050 It is the practice of the facility to conduct fire drills at least quarterly on each shift. The maintenance director amended the fire drill schedule on July 10, 2015, to include performing fire drills at unexpected times under varying conditions, including evening hours, at least quarterly on each shift. All residents, staff and visitors have the potential to be affected. Performing</p>	08/05/2015

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	<p>p.m., and 09/09/14 at 8:00 a.m. There was a lack of fire drill documentation during the hours of 10:00 a.m. and 11:00 p.m. during the third quarter of 2014. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 (equivalent) employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 07/06/15 at 9:45 a.m. with the Maintenance Director present, three of four second shift (3rd shift equivalent) fire drills were performed on 08/10/14 at 11:00 p.m., on 10/28/14 at 10:30 p.m. and 01/28/15 at 10:30 p.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p>		<p>fire drills at unexpected times under varying conditions, including evening hours, at least quarterly on each shift will mitigate the potential affect.</p> <p>The maintenance director has reviewed the requirements at K 050 and demonstrated understanding. The amended policy has been added to the monthly safety committee agenda for review scheduled for august 14, 2015. The administrator will audit the fire drill schedule and completion records monthly to assure compliance.</p> <p>Fire drill performance and effectiveness is an agenda item of the monthly safety committee, the minutes of which are reviewed bythe QAPI committee which meets monthly.</p>				

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K 0062 SS=E Bldg. 01	<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 2 of over 300 sprinkler heads were in the proper orientation (upright, pendent, or sidewall). NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is in the improper orientation. This deficient practice could affect mostly staff and visitors while in the basement laundry area.</p> <p>Findings include:</p> <p>Based on observation on 07/06/15 at 11:30 a.m. during a tour of the facility with Maintenance Director, two sprinkler heads in the basement laundry area were upright sprinkler heads installed on the bottom of the sprinkler pipe instead of a pendent type sprinkler head. This was acknowledged by the Maintenance Director at the time of observation.</p>	K 0062	<p>K 062 It is facility practice to inspect, test, and continuously maintain sprinkler systems in reliable condition. SafeCare, the facility vendor, has been contacted to replace the two sprinkler heads in the laundry room and one in the north hall shower room on or before August 5, 2015. Residents, staff and visitors are potentially affected. All facility sprinkler heads have been audited by maintenance director for proper orientation and free from paint, on July 10, 2015, to assure no further issues. The maintenance director has reviewed the</p>	08/05/2015

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K 0147 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 5 smoke compartments were free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect 1 resident and staff while in the North Hall women's shower room.</p> <p>Findings include:</p> <p>Based on observation on 07/06/15 at 11:55 a.m. during a tour of the facility with Maintenance Director, the sprinkler head in the North Hall women's shower room was partially covered with white paint. This was acknowledged by Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <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>requirements at K 062 and demonstrated understanding. Sprinkler heads are inspected monthly by maintenance director, and quarterly by outside vendor, for continued compliance. Inspection results are presented to safety committee monthly for ongoing quality assurance monitoring. Minutes of the safety committee meeting are reviewed for potential action by the QAPI committee which meets monthly.</p>	

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	<p>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 2 of 24 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 3 residents in rooms S4 and E2.</p> <p>Findings include:</p> <p>Based on observations on 07/06/15 between 11:30 a.m. and 1:00 p.m. during a tour of the facility the Maintenance Director, the following was noted:</p> <p>a. Resident room S4 had a small refrigerator plugged into a power strip b. Resident room E2 had a bed, CPAP machine, and an oxygen concentrator plugged into a power strip.</p> <p>This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>	K 0147	<p>K 147</p> <p>It is facility practice to assure power strips are not used unless specifically permitted.</p> <p>Power strips were removed from use in rooms S4 and E2 by maintenance director immediately following survey.</p> <p>Residents, staff and visitors are potentially affected.</p> <p>The facility has been inspected by maintenance director on 7-14-15 to assure the use of power strips is prohibited unless specifically permitted per Code</p> <p>The use of power strips was addressed at a meeting of the housekeeping department on July 15, 2015, at which housekeepers were asked to monitor their use on a daily basis and report to maintenance. Maintenance will inspect new occupancy rooms within 48</p>	08/05/2015			

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K 0154 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority		hours to assure power strips are not used unless specifically permitted. The maintenance director has reviewed the requirements at K 147 and demonstrated understanding. The use of power strips has been added to the weekly preventive maintenance program to assure continued compliance. Preventative maintenance findings, corrective action, and completion rates have been added to the standing monthly safety committee meeting agenda for ongoing quality assurance monitoring. Minutes of the safety committee meeting are reviewed for potential action by the QAPI committee which meets monthly.	

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	<p>having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection of 42 of 42 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Status plan on 07/06/15 at 10:30 a.m. with the Maintenance Director present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues</p>	K 0154	<p>K 154</p> <p>It is the facility practice to maintain written policies and procedures regarding Fire Watch when the automatic sprinkler system is out of service.</p> <p>The Fire Watch Policy has been revised on July 8, 2015, by the administrator to Include notification of the Indiana State Department of Health(ISDH)and the local Fire Department when the system is out of service for four hours or more within a 24-hour time period.The policy was also amended to include the following telephone numbers: ISDH, insurance carrier, and local Fire Department.</p> <p>All residents, staff and visitors could potentially</p>	08/05/2015

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K 0155 SS=C Bldg. 01	<p>required in a Fire Watch Policy such as: Notifying the Indiana State Department of Health (ISDH) and the local Fire Department when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the ISDH, insurance company, and local Fire Department. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy for the protection of 42 of 42</p>	K 0155	<p>be affected. The maintenance director has reviewed the requirements at K 154 and demonstrated understanding. The amended Fire Watch Policy was posted for all staff and will be reviewed at the August 4, 2015, all staff meeting. The Facility Disaster Preparedness and Management Manual, including Fire Watch, will be reviewed annually, and revised as needed, by the interdisciplinary team at the monthly QAPI meeting to assure compliance.</p> <p>K 155 It is the facility practice to</p>	08/05/2015			

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	<p>residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Status plan on 07/06/15 at 10:30 a.m. with the Maintenance Director present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the Indiana State Department</p>		<p>maintain written policies and procedure regarding Fire Watch when the fire alarm system is out of service.</p> <p>The Fire Watch Policy has been revised on July 8, 2015, by the administrator to Include notification of the Indiana State Department of Health (ISDH) and the local Fire Department when the system is out of service for four hours or more within a 24-hour time period. The policy was also amended to include the following telephone numbers: ISDH, insurance carrier, and local Fire Department.</p> <p>All residents, staff and visitors could potentially be affected.</p> <p>The maintenance director has reviewed the requirements at K 155 and demonstrated understanding. The amended Fire Watch</p>	

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 07/06/2015
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 34 S MAIN ST CLOVERDALE, IN 46120		
(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	
	of Health (ISDH) and the local Fire Department when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the ISDH and local Fire Department. This was acknowledged by the Maintenance Director at the time of record review. 3.1-19(b)		Policy was posted for all staff and will be reviewed at the August 4, 2015, all staff meeting. The Facility Disaster Preparedness and Management Manual, including Fire Watch, will be reviewed annually, and revised as needed, by the interdisciplinary team at the monthly QAPI meeting to assure compliance.		