

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 08/31/2016
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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: 08/31/16</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	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective September 8, 2016, to the Life Safety Code Survey conducted August 31, 2016. The facility respectfully requests a desk review to demonstrate completion of the plan of correction and compliance with the Requirements of Participation cited; Supportive documentation is attached	

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 0029 SS=D 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>Quality Review completed on 09/06/16 - DA</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 the corridor doors to 1 of 5 hazardous areas, such as a soiled linen room, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any employees working in the north basement area.</p> <p>Findings include:</p>	K 0029	<p>The facility has, and had at the time of survey, policies and procedures to assure corridor doors to hazardous areas are provided with self-closing devices which cause a door to close automatically. A self-closing device was installed on the medical records room door by the maintenance staff on 9-8-2016. All corridor doors to hazardous areas were audited to assure compliance with auto-closing, without issues, to mitigate any potential effect on residents and</p>	09/08/2016

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K 0074 SS=F Bldg. 01	<p>Based on observation on 8/31/16 at 10:50 a.m. with the maintenance director, the north basement medical records room door lacked a self-closing device. This was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2</p>		<p>others. The maintenance director has reviewed the Requirement at K 029 and demonstrates understanding. The medical records room was added to the list of rooms with auto-closing devices to be checked daily for proper function per the preventative maintenance program. To assure compliance, preventative maintenance findings, corrective action, and completion rates are reported to the monthly Safety Committee meeting for ongoing quality assurance monitoring. Minutes of the Safety Committee meeting are reviewed for action by the QAPI Committee headed by the Administrator which meets monthly. 9-8-2016 <i>Attachment- Photograph "Summerfield Auto Close"; "PM Audit Form"</i></p>	

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	<p>(2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure window curtains in of 27 corridor resident rooms or resident common areas were flame retardant. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 8/31/16 during a tour of the facility from 10:40 a.m. to 12:30 p.m., resident room W 1, resident room W 2, resident room W 3, resident room W 4, resident room N 1, resident room N 2, resident room N 3, resident room N 4, resident room N 5, resident room N 6, resident room N 7, resident room N 8, resident room E 1, resident room E 2, resident room E 3, resident room E 4, resident room S 1, resident room S 2, resident room S 3, resident room S 4, resident room S 5, resident room S 6, resident room S 7, the administrators office, the dining room,</p>	K 0074	<p>The facility has, and had at the time of survey, policies and procedures to assure fabrics serving as furnishings are flame resistant in accordance with NFPA codes and standards.</p> <p>The documentation regarding flame retardant window curtains, available offsite, was obtained and is on file at the facility.</p> <p>Additionally, the maintenance director audited all window furnishings to assure they met NFPA standards and flame retardant records are on file. The maintenance director has reviewed the requirements at K 074 and demonstrated understanding. The preventative maintenance surveillance program includes weekly inspections to assure furnishings, including newly introduced items, meet the NFPA code and standards and documentation is present.</p> <p>To assure compliance, preventative maintenance findings, corrective action, and completion rates are reported to the monthly Safety Committee</p>	09/08/2016

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	<p>the therapy office, and the community room by the nursing station all had window curtains which lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the maintenance supervisor, there was no documentation regarding flame retardant window curtains throughout the facility. This was acknowledged by the administrator at the exit conference on 02/16/16 at 12:40 p.m.</p> <p>3.1-19(b)</p>		<p>meeting for ongoing quality assurance monitoring. Minutes of the Safety Committee meeting are reviewed for action by the QAPI Committee headed by the Administrator which meets monthly. 9-8-2016 <i>Attachments – Documents “Summerfield CurtainLiner”, “Summerfield Resident Rooms”, Summerfield Public”, “PM Audit Form</i></p>	