

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 05/22/2013
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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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K010000	<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: 05/22/13</p> <p>Facility Number: 000415 Provider Number: 155587 AIM Number: 100291250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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.</p> <p>This one story, fully sprinklered facility with a laundry and maintenance shop, storage room and employee lounge in two separate partial basements was determined to be of Type V (000) construction. The facility has a fire alarm system with hardwired smoke detection in</p>	K010000	<p>The plan of correction represents the facility allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to the alleged deficiency and is submitted at the request of the Indiana State Department of Public Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider as 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 the provision of federal and state law requires it. Summerfield Health Care Center submits that it was in substantial compliance with certification requirements at the time of the survey.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>the corridors, spaces open to the corridors, and resident rooms. The facility has the capacity for 43 and had a census of 37 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. A detached storage building and smoke hut which were not sprinklered. All other areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill. Life Safety Code Supervisor on 05/24/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through smoke barriers in 1 of 7 smoke compartments 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 could affect visitors, staff and 15 or more residents in the north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 between 11:50 a.m. and 3:40 p.m., two</p>	K010025	<p>I. The two 6 inch duct systems in the water heater room have been fire chaulked to seal the penetration. The wires in the Business Office penetrating the ceiling have been sealed with fire chaulking. II. All other residents and visitors and staff have the potential to be affected by the alleged deficient practice. III. All ceiling's will be inspected to ensure that there are no other penetrations that are unsealed. All new work projects will have any penetrations sealed at the time the work is completed. IV. The Maintenance Supervisor/designee will inspect the ceilings monthly to ensure no penetrations have occurred. Staff will be inserviced on the "Work Order Process" to ensure that all potential penetrations will be reported. The QA committee will monitor for compliance and will monitor until substantial compliance has been achieved.</p>	06/21/2013	

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	<p>six inch duct ceiling penetrations in the water heater room were unsealed leaving one half inch gaps into the attic space above. In addition wiring penetrations in the ceiling of the business office were unsealed into the attic above. The maintenance director acknowledged at the time of observations the gaps should have been sealed with a fire rated material.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 kitchen wall in 1 of 7 smoke compartments was complete. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and wall to wall with openings providing fire resistance equal to that of the smoke barrier. This deficient practice could affect staff, visitors and 5 or more residents in the adjacent lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 at 2:30 p.m., the kitchen wall had a 24 by 24 inch cut out on the interior wall leaving the untreated wood studs exposed to kitchen. The maintenance director agreed at the time of observation, the wall opening should have been enclosed.</p>	K010029	<p>I. The 24 in. by 24 in. opening in the kitchen has been sealed with a one hour fire rated construction.II. All residents, staff and visitors have the potential to be affected by the alleged deficient practice.III. The identified area has been sealed in the kitchen. The administrator will inspect the construction when complete. All walls are inspected weekly by the Housekeeping/Laundry Supervisor for accidental penetrations.IV. The QA committee will monitor and review until substantial compliance has been acheived.</p>	06/21/2013			

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K010068 SS=E	<p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and 9 residents in the sleeping corridor above the laundry.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 at 3:00 p.m., the laundry room had one, gas fueled dryer with no fresh air intake. The maintenance director acknowledged at the time of observation the gas fueled dryer did not have a fresh air intake.</p> <p>3.1-19(b)</p>	K010068	<p>I. The gas dryer in the laundry room now has a fresh air intake.II. All residents, staff and visitors have the potential to be affected by the alleged deficient practice.III. The gas dryer has been vented to fresh air.IV. The maintenance supervisor will place the Gas Dryer and fresh air intake on a monthly "Preventative Maintenance" schedule. The QA committee will monitor until substantial compliance has been achieved.</p>	06/21/2013			

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K010070 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure a policy and procedure was available for the operation 1 of 1 space heaters to ensure the unit was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could visitors, staff and 20 or more residents in the dining room adjacent to the activities office.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 at 12:40 p.m., a portable space heater was located adjacent to a desk amid storage in the activities office. The device was not in use. The maintenance director said at the time of observation, he was unaware there was a space heater in the facility. The administrator was interviewed on 05/22/13 at 3:20 p.m. and said there was no policy available for the use of space heaters to identify where they might be used and any restriction related to their use in the facility</p>	K010070	<p>I. A policy has been written to allow portable space heaters in the employee areas that do not exceed 212 degrees F. Portable space heaters have never been allowed in resident care areas. II. No residents were affected due to the space heater was unplugged and stored. III. There is an existing policy in regards to electrical devices in the resident care areas. A policy has been written to allow space heaters under 212 degrees F in employee areas. The Maintenance Supervisor will inspect and approve all space heaters, before use, that are in use in the employee areas.IV. The QA committee will monitor until substantial compliance has been achieved.</p>	06/21/2013	

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with ceramic or concrete flooring. This deficient practice affects visitors, staff and 9 residents on the south wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 at 2:15 p.m., the oxygen transfer and storage room was identified by signage on the door and confirmed by the maintenance director. The the oxygen room floor consisted of three different materials. One half was wood covered by vinyl tiles, a three by 42 inch section consisted of</p>	K010143	<p>I.a. The floor in the O2 transfer room has had ceramic tile placed. b. The light switch has been removed and made a continuous circuit. II. All residents, staff and visitors have the potential to be affected by the alleged deficient practice. III. The floor has been replaced and the light switch has been removed and made a continuous circuit. IV. The QA committee will monitor until substantial compliance has been achieved.</p>	06/21/2013			

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	<p>exposed wood slats, and the remaining floor was covered with vinyl linoleum. The maintenance director identified the flooring materials at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations, was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires that storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect visitors, staff and 9 residents on the south wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/22/13 at 2:15 p.m., the oxygen storage and transfer room had four 181 liter capacity liquid oxygen storage tanks stored in the room. An electrical light switch on the wall 46 inches above the floor. The maintenance</p>			

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	director said at the time of observation he was unaware the light switch location could cause a problem. 3.1-19(b)				

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 30 or more residents in smoke compartments protected by the 2 north and 1 north smoke barriers.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/22/13 at 12:40 p.m., a ceiling junction box was incompletely covered by a metal plate. The plate was positioned to expose the wiring and had been secured by a single screw in one of four screw hole openings. The maintenance director said at the time of observation, he hadn't noticed the covering was not completely secured.</p> <p>b. Based on observation with the maintenance director on 05/22/13 at 3:15 p.m., conduit from a ceiling light fixture in the laundry ran to a junction box for another light fixture. The wiring had not</p>	K010147	<p>I.a. The junction box has been completely covered. b. The wiring in the laundry has been enclosed properly in a junction box. c. The wires running from the laundry to an adjacent storage room have been properly terminated and covered appropriately.II. All residents and staff and visitors have the potential to be affected by the alleged deficient practice. III. All areas of the building have been inspected by the Maintenance Supervisor, Hsk/Laundry Supervisor and Administrator to ensure all wiring is appropriately covered and contained.IV. The QA committee will monitor until substantial compliance has been achieved.</p>	06/21/2013			

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	<p>been enclosed in the junction box. Instead, wires coming from within the junction box were tied and covered with electrical tape to conduit wiring outside the junction box. The maintenance director acknowledged at the time of observation the wire connections should have been made inside the junction box.</p> <p>c. Based on observation with the maintenance director on 05/22/13 at 3:25 p.m., conduit in the laundry ran from a ceiling light fixture over a wall partition into an adjacent storage room. The conduit terminated above the storage room with wires which had been cut off but not covered. The maintenance director acknowledged at the time of observation the light fixture wiring was "hot" when the light was turned on.</p> <p>3.1-19(b)</p>			