

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 09/24/2012
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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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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 09/24/12</p> <p>Facility Number: 000415 Provider Number: 155587 AIM Number: 100291250</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this Quality Assurance Walk-thru survey, Summerfield Health Care was found not in compliance with 410 IAC 16.2-3.1-19(ff)</p> <p>This one story facility with a laundry, maintenance shop, storage room and employee lounge in two separate partial basements was determined to be of Type V (000) construction and fully sprinklered except for the areas noted. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in 24 resident rooms. The facility has a capacity for 43 and had a census of 37 at the time of this survey.</p> <p>The facility was found not in compliance</p>	K0000	<p>This plan of correction represents the facility allegation of compliance. The following combined plan of correction of compliance is not an admission to the alleged deficiency and is submitted at the request of the Indiana State Department of 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>with state law in regard to sprinkler coverage and in compliance in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the medical records room, the canopy over the staff smoking area and the wood mini barn used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler coverage throughout the facility before July 1, 2012. This deficient practice could affect any occupant within the facility.</p> <p>Findings include:</p>	K9999	<p>I.a. The Medical Records Room has sprinkler coverage. b. The canopy has been removed to allow at least 6 feet between the wood canopy and the facility. II. All residents have the potential to be affected by the alleged deficient practice. III. Sprinkler coverage has been added to the Medical Records Room and the wood canopy has been removed. IV. The Maintenance Supervisor/Designee will monitor the facility for appropriate sprinkler coverage and maintain the outside structures to prevent them from being connected to the facility by any wood product at least 1 time weekly. The QA committee will monitor at least quarterly until substantial compliance has been achieved.</p>	10/24/2012			

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	<p>Based on observation with the Maintenance Supervisor on 09/24/12 between 12:00 p.m. to 1:00 p.m., the following was noted:</p> <p>a) The medical records storage room lacked sprinkler coverage.</p> <p>b) The staff smoking area was covered by a canopy of wood construction exceeding 4 feet in width abutting the facility and connecting the facility to a wooden mini barn used for storage. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the medical records storage room, the canopy of wood construction and the wood mini barn lacked sprinkler coverage.</p> <p>3.1-19(ff)</p>			