

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15E209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/15/2013
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NAME OF PROVIDER OR SUPPLIER  SUMMIT CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/15/13</p> <p>Facility Number: 000373 Provider Number: 15E209 AIM Number: 100288730</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Summit Convalescent Center was found not in compliance with Requirements for Participation in 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 was determined to be of Type II (000) construction and 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</p>	K010000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Convalescent Center that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Convalescent Center. The facility requests the following plan of correction be considered its allegation of compliance.	

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>rooms. The facility has a capacity of 34 and had a census of 27 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached wooden storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=D	<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 provide 2 of over 40 corridor room doors with a positive latching device. This deficient practice could affect 2 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Director of Nursing during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 10/15/13, the corridor door to the Men's restroom and to the Women's restroom in the Main Lobby each had a deadbolt lock on the door and required a key to unlock the door from each side of the door. Based on interview at the time of the observation, the Maintenance Supervisor</p>	K010018	<p>K 018- LIFE SAFETY CODE STANDARD: This alleged deficient practice has the potential to affect staff and visitors. New locks were placed on both bathroom doors with a positive locking device. Maintenance supervisor will check the locks as part of his quarterly preventative maintenance audits. POC Date: 10/31/13</p>	10/31/2013

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	and the Director of Nursing stated the aforementioned restrooms are for the use of staff and visitors and acknowledged the aforementioned corridor door to each restroom was not provided with a positive latching device.  3-1.19(b)				

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>1. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 19 of 19 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency &amp; Disaster Plan: Fire Policy &amp; Procedure" documentation with the Maintenance Supervisor and the Director of Nursing during record review from 9:15 a.m. to 11:15 a.m. on 10/15/13, the facility's</p>	K010048	<p>K 048- LIFE SAFETY CODE STANDARD The Policy and Procedure was updated to include staff response to the alarming of the battery operated smoke detectors. The Policy and Procedure was updated to include appropriate use of K class extinguisher in the dietary department. Policy was distributed to Maintenance Supervisor and updated in facility policy books. All staff was in-serviced regarding the aforementioned policy and procedure updates. POC Date: 11/14/13</p>	11/14/2013

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	<p>written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in each of 19 resident sleeping rooms. Based on observations with the Maintenance Supervisor and the Director of Nursing during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 10/15/13, battery operated smoke detectors were installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>2. Based on record review, observation and interview; the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> </ol>			

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	<p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire This deficient practice could affect two kitchen staff.</p> <p>Findings include:</p> <p>Based on review of "Emergency &amp; Disaster Plan: Fire Policy &amp; Procedure" documentation with the Maintenance Supervisor and the Director of Nursing during record review from 9:15 a.m. to 11:15 a.m. on 10/15/13, the fire disaster plan did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on observation with the Maintenance Supervisor and the Director of Nursing during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 10/15/13, a K-class fire extinguisher was located in the kitchen. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher.</p> <p>3.1-19(a)</p>			

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K010050 SS=F	<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 activate the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report for Summitville Convalescent Center" documentation with the Maintenance Supervisor and the Director of Nursing during record review from 9:15 a.m. to</p>	K010050	<p>K 050- LIFE SAFETY CODE STANDARD It is the practice of Summit Convalescent Center to activate the fire alarm between the hours of 6:00 AM and 9:00 PM. A coded announcement will only be allowed between 9:00 PM and 6:00 AM. A new form was put in place that will include the time of the alarm and the time of transmission of the fire alarm signal. Maintenance supervisor was re-educated regarding times of audible alarms versus coded alarms, and including exact times of the fire drill on the facility documentation. Administrator/designee will review each monthly fire drill for accuracy and completion. Additionally the QAA committee will review the fire drill documentation at quarterly QAA meetings. POC DATE: 11/14/13</p>	11/14/2013			

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	<p>11:15 a.m. on 10/15/13, documentation for the second shift fire drill conducted at 7:30 p.m. on 02/27/13 stated "No" in response to "Transmission of Alarm." Based on interview at the time of record review, the Maintenance Supervisor acknowledged 1 of 4 second shift fire drills conducted before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report for Summitville Convalescent Center" documentation with the Maintenance Supervisor and the Director of Nursing during record review from 9:15 a.m. to 11:15 a.m. on 10/15/13, documentation for the third shift fire drill conducted on 09/15/13 stated "11:00 p.m. to 7:00 a.m." as the "Time" the drill was conducted. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of the time of day the third shift fire drill on 09/15/13</p>			

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	was conducted was not available for review.  3.1-19(b)			

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K010051 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panels in an area that was not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.1.4 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all residents, staff and visitors.</p>	K010051	<p>K 051- LIFE SAFETY CODE STANDARD This alleged deficient practice has the potential to affect all residents, staff, and visitors. The facility fire protection company will install a hardwired smoke detection unit in the utility room by 11/14/13. The hardwired unit will be checked and maintained per the facility regular policy and schedules. POC Date: 11/14/13</p>	11/14/2013

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Director of Nursing during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 10/15/13, the fire alarm system main fire alarm panel which was located in the Utility Room by the Conference Room was not provided with smoke detection hard wired to the fire alarm system. Based on interview at the time of observation, the Maintenance Supervisor stated the aforementioned room has a battery operated smoke detector installed in the room which is not continuously occupied and acknowledged automatic smoke detection hard wired to the fire alarm system was not provided at the main fire panel location.</p> <p>3.1-19(b)</p>				

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect two staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Elwood Fire &amp; Equipment Company" documentation dated 07/22/13 with the Maintenance Supervisor and the Director of Nursing during record review from 9:15 a.m. to 11:15 a.m. on 10/15/13, documentation of a semiannual kitchen hood extinguishing system service record prior to 07/22/13 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated Elwood Fire &amp; Equipment Company did not perform a semiannual range hood system service prior to 07/22/13 and acknowledged documentation of a semiannual kitchen exhaust system</p>	K010069	K 069- LIFE SAFETY CODE STANDARD This alleged deficient practice has the potential to affect staff and visitors in the kitchen. The facility fire protection company was contacted on 10/15/13 and placed the hood extinguishing system on a semiannual servicing schedule. The next servicing is due January 2014. The maintenance supervisor/designee will review all documentation on a semiannual basis in regard to the servicing of the range hood. The facility does not have a deep fryer, or fry any type of foods in grease. New baffles for the dietary hood were ordered and will be placed to run vertically when they arrive. The Maintenance Supervisor will ensure baffles are placed correctly during monthly preventative maintenance rounds. POC Date: 11/14/13	11/14/2013			

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	<p>inspection and service prior to 07/22/13 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles were installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect two staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 12:55 p.m. on 10/15/13, all four baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the four baffles in the kitchen range exhaust hood are aligned horizontally and would not drain grease properly in the present configuration.</p> <p>3.1-19(b)</p>			

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