STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 01 B. WING	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/05/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/02/23 Facility Number: 000121 Provider Number: 155215 AIM Number: 100290940 At this PSR survey, Plainfield Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility was determined to be of Type V (111) construction and was 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 rooms. The facility has a capacity of 189 and had a census of 85 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/07/23	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of 3-3-2023. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mac McCallum	Regional Director of Ops	03/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect as many as 18 residents, 3 staff and 1 visitor. Findings include: Based on walk through of the facility's Memory Care Unit during the post survey revisit with the Regional Maintenance Director, the facility Maintenance Director, and the visiting Maintenance Director on 03/02/23 at 12:31 p.m., there was a large plastic barrier being held up in the corridor with three poles on the 500 Hall of the facility. This area was having the doors replaced and as a precaution to keep the residents out of the area, the barrier was put up. During the PSR visit as surveyors walked through the area, it was noted that this was an emergency exit as per the exit signage. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. During the exit conference with the Regional Maintenance	K 0211	**E211** **Means of Egress—General** **Immediate Intervention** The Facility has removed the temporary plastic barrier that was identified as an egress obstruction. **Compliance date** **3.2.2022** **Method to Assess Others** The director of plant operations will visually inspect all egress doors to ensure that they are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. **Systematic Process** The director of plant operations and Regional Director will continue to visually inspect all areas of egress doors on a routine and daily basis. **Quality Assurance** Executive Director/Designee will present results of any visual inspection to the QAPI committee for further recommendations and will continue until QAPI team	03/03/2023

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	Director, the facility Maintenance Director, and the visiting Maintenance Director on 03/02/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		determines substantial compliance has been achieved.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 2 of 2 portable space heaters were not used in the facility. This deficient practice could affect as many as 26 residents, 4 staff and 2 visitors in the facility. Findings include: Based on walk through of the facility's Memory Care Unit during the post survey revisit with the Regional Maintenance Director, the facility Maintenance Director, and the visiting Maintenance Director on 03/02/23 at 12:36 p.m. the following was noted: a) A faux fireplace / portable space heater was noted in the common area of the Memory Care unit. When plugged in and turned on, it produced heat. Manufacturer's documentation for the portable space heater was also not available for review, and the facility has a policy stating that they do not allow the use of portable space heaters within their facility.	K 0781	**K781** **Portable Space Heater** **Immediate intervention** The facility has removed faux fireplace on the memory care unit. The facility has removed the heating element in the faux fire place identified in the lobby. **Compliance date** **3.2.2023** **Method to Assess Others** The facility has evaluated all areas of the facility and has not identified any other portable heat sources. **Systematic Process** The director of plant operations and Regional Director will continue to visually inspect all areas of egress doors on a routine and daily basis. **Quality Assurance** Executive Director/Designee will	03/03/2023

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	b) A faux fireplace / portable space heater was noted in the main entry lobby seating area. When plugged in and turned on, it produced heat. Manufacturer's documentation for the portable space heater was also not available for review, and the facility has a policy stating that they do not allow the use of portable space heaters within their facility. Based on interview at the time of the observations, Regional Maintenance Director acknowledged the faux fireplace / portable space heaters were used in the aforementioned locations and added that they would be removed immediately. During the exit conference with the Regional Maintenance Director, the facility Maintenance Director, and the visiting Maintenance Director on 03/02/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		present results of visual inspections to the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	