

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155254	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2014
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NAME OF PROVIDER OR SUPPLIER  SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140
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K010000	<p>A Life Safety 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: 12/17/14</p> <p>Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sugar Creek Rehabilitation and Convalescent Center 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 was determined to be of Type II (000) construction and fully sprinkled except the two main dining room furnace rooms. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the</p>	K010000		
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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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K010014 SS=E	<p>corridors, and battery operated smoke detection in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 46 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled except the two main dining room furnace rooms. The facility had two detached storage buildings, a detached maintenance shop, and a detached shed where the sprinkler riser was located which were not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/08/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exitway was provided with an interior finish with a flame spread rating of Class A or Class</p>	K010014	No residents were found to be directly affected by this deficient practice.	01/20/2015

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K010025 SS=E	<p>B. This deficient practice could affect 14 residents who reside on the Southwest Hall and would use the Southwest Hall corridor for an exitway.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 1:45 p.m. with the maintenance supervisor, the Southwest corridor exit foyer ceiling was covered with a painted wood paneling interior finish. Based on an interview with the maintenance supervisor on 12/17/14 at 1:50 p.m., there is no documentation to indicate the flame spread rating of the wood paneling ceiling interior finish located at the Southwest corridor exit foyer. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <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</p>		<p>Fourteen residents residing on the Southwest hall had the potential to be affected by the deficient practice. Drywall ceiling, meeting the interior flame spread ratings was installed in the entry/exit way.</p> <p>The drywall ceiling will remain in place to meet interior finish flame spread ratings.</p> <p>The entry/exit way will be inspected during the monthly QA rounds, by the Maintenance Director or designee, for proper interior finish, to ensure proper interior flame spread ratings are met. This will be an on-going process. Attachment G-6 pages</p>	

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	<p>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 observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 4 of 54 room walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so 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 practice affects 12 residents who use reside in rooms 3, resident room 18, resident room 28, resident room 35, resident room 37, resident room 39 and 14 residents who reside on the East Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 12/17/14 from 9:45 a.m. to 2:20 p.m., the following locations had ceiling and wall penetrations not firestopped or had missing drywall;</p> <p>1. Resident room 3 furnace room ceiling had a three inch gap around an exhaust duct and four, one inch gaps around</p>	K010025	<p>No residents were found to be directly affected by this deficient practice. Twenty-six residents residing in the facility had the potential to be affected by this deficient practice. 1. Resident room 3 furnace room ceiling had a three inch gap around the exhaust duct, which was sealed with properly rated fire resistant insulation and caulk; four-one inch gaps were sealed around the electrical conduit with properly rated fire resistant insulation and caulk; additionally three-two foot areas of missing drywall were repaired to meet the proper fire resistant ratings, with drywall and fire caulk. 2. The East Hall soiled linen room ceiling had a two inch gap repaired to ensure it met proper fire resistant ratings with fire resistant insulation and caulk. 3. The East Hall clean linen room ceiling had six-two inch gaps around electrical conduit, these areas were repaired with proper fire resistant rated insulation and caulk. 4. Resident room 18 ceiling had a one half inch gap around electrical conduit that was repaired with proper fire resistant rated insulation and caulk. 5. Resident room 28 furnace room ceiling had a three inch gap around the exhaust duct, which was sealed with properly rated fire resistant caulk; six-one inch</p>	01/20/2015	

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	<p>electrical conduit penetration not fire stopped and the south wall had three, two foot areas of missing drywall with wooden studs exposed.</p> <p>2. The East Hall soiled linen room ceiling had a two inch gap around a water pipe penetration not firestopped.</p> <p>3. The East Hall clean linen room ceiling had six, two inch gaps around electrical conduit with no fire stopping.</p> <p>4. Resident room 18 ceiling had a one half inch gap around a electrical conduit penetration not firestopped.</p> <p>5. Resident room 28 furnace room ceiling had a three inch gap around an exhaust duct and six, one inch gaps around electrical conduit penetration not fire stopped and the south wall had two, two foot areas of missing drywall with wooden studs exposed.</p> <p>6. Resident room 35 ceiling above bed 2 had a six foot by ten foot area of drywall separating from the ceiling with two,one half inch gaps where the drywall was taped together.</p> <p>7. Resident room 37 furnace room ceiling had a three inch gap around an exhaust duct and six, one inch gaps around electrical conduit penetration not fire stopped and the south wall had two, two foot areas of missing drywall with wooden studs exposed.</p> <p>8. The laundry room ceiling had a six foot by four foot area of drywall</p>		<p>gaps were sealed around the electrical conduit with properly rated fire resistant insulation and caulk; additionally two-two foot areas of missing drywall were repaired to meet the proper fire resistant ratings, with drywall and fire caulk. 6. Resident room 35 ceiling above bed 2 had a six foot by ten foot area of drywall which is scheduled to be repaired, by a local contractor. 7. Resident room 37 furnace room had a three inch gap around the exhaust duct, which was sealed with properly rated fire resistant insulation and caulk; six-one inch gaps were sealed around electrical conduit with properly rated fire resistant insulation and caulk; additionally two-two foot areas of missing drywall were repaired to meet the proper fire resistant ratings, with drywall and fire caulk. 8. The laundry room ceiling had a six foot by four foot area of drywall repaired to meet proper fire resistant ratings, with drywall. 9. The laundry room west wall had an eight inch by four inch area of drywall missing repaired to meet the proper fire resistant ratings, with drywall. 10. Resident room 39 furnace room ceiling had a three inch gap around the exhaust duct, which was sealed with properly rated fire resistant insulation and caulk; six-one inch gaps around were sealed around the electrical conduit with properly rated fire resistant insulation and caulk;</p>		

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K010027 SS=E	<p>separating from the ceiling with three, one half inch gaps where the drywall was taped together.</p> <p>9. The laundry room west wall had an eight inch by four inch area of drywall missing near the door.</p> <p>10. Resident room 39 furnace room ceiling had a three inch gap around an exhaust duct and six, one inch gaps around electrical conduit penetration not fire stopped and the south wall had two, two foot areas of missing drywall with wooden studs exposed.</p> <p>Resident room 3 furnace room ceiling and wall, the East Hall soiled linen room ceiling, resident room 18 ceiling, resident room 28 furnace room ceiling and wall, resident room 35 ceiling, resident room 37 furnace room ceiling and wall, resident room 39 furnace room ceiling and wall and the laundry room ceiling and wall not properly fire stopped or missing drywall was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood</p>		<p>additionally two-two foot sections of missing drywall were repaired to meet the proper fire resistant ratings, with drywall. An approved material will remain in place to ensure proper smoke barrier ratings are met. A monthly inspection will be conducted during QA rounds by the Maintenance Director or designee, to ensure continued compliance. This will be an on-going process. Attachment G-6 pages Addendum:Please see K-25 revision-attached-additional information.</p>		

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	<p>core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 14 residents who reside on the Southeast Hall.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 11:50 a.m. with the maintenance supervisor, the Southeast Hall set of smoke barrier doors by room 10 had a two inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the</p>	K010027	<p>No residents were found to be directly affected by this deficient practice.</p> <p>Fourteen residents residing on the Southeast Hall had the potential to be affected. The deficient practice has been corrected to allow minimum clearance for proper operation.</p> <p>Smoke barrier doors will be inspected monthly to ensure proper operation during the monthly fire drill.</p> <p>A monthly QA inspection will be conducted by the Maintenance Director or designee, to ensure continued compliance. This will be an on-going process. Attachment G -6 pages</p>	01/20/2015

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K010029 SS=E	<p>administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <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 corridor door to 6 of 8 hazardous areas, such as a fuel fire equipment rooms, and 1 of 2 laundry room over 100 square feet, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 12 residents who reside in resident rooms 3, 28, 30, 37, 39, and 14 residents who reside on the East Hall near the laundry room.</p> <p>Findings include:</p> <p>Based on observations on 12/17/14</p>	K010029	No residents were found to be directly affected by this deficient practice. Twelve residents residing in the facility had the potential to be affected by the deficient practice. Self-closures were installed on furnace room doors located in the following rooms, #3, #28, #30,, #37, #38 and additionally self-closure was installed on the housekeeping room. A new laundry door with latching hardware is on order and will be installed on the North laundry room exit door, after the completion of the custom made door. Attachment A-Laundry Door The self-closure devices and the latching hardware will remain in place on the areas mentioned above. A monthly QA	01/20/2015

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K010038 SS=E	<p>during a tour of the facility with the maintenance supervisor from 9:45 a.m. to 2:20 p.m., resident room 3, 28, 30, 37, 39 and the housekeeping room each had a natural gas furnace room in the back of the room and the doors to the natural gas furnace rooms lacked self closing devices. Furthermore, the north laundry room door lacked latching hardware. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the sidewalk surface on 3 of 7 exit sidewalks were maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect all residents in the facility.</p>	K010038	<p>inspection will be conducted by the Maintenance Director or designee, to ensure continued compliance. This will be an on-going process. Attachment G – 6 pages</p> <p>No residents were found to be directly affected by this deficient practice. All residents residing in the facility had the potential to be affected by this deficient practice. The sidewalk areas; Northwest side of the facility adjacent to Dining room, East exit, and Southeast exit will have the sidewalks repaired to meet LSC requirements. Attachment B – 8 pages—Life Safety Code Waiver Request for additional time. The sidewalks will remain in good repair; any issues will be reported to the Maintenance Director and immediately addressed. Sidewalks will be inspected</p>	04/30/2015

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	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/17/14 during a tour of the facility from 9:45 a.m. to 2:20 p.m. with the maintenance supervisor, the following sidewalk surfaces had changes in elevation;</p> <ol style="list-style-type: none"> <li>1. The dining room exit sidewalk had a twenty foot section of concrete sidewalk pitted with one inch depressions and heaving concrete with two inch elevation changes along the twenty foot sidewalk surface.</li> <li>2. The East Hall exit sidewalk had a ten foot by six foot section of sidewalk which was completely broken concrete and heaving with two inch elevation changes along the entire surface of the sidewalk.</li> <li>3. The Southeast Hall exit sidewalk had a twelve foot section of sidewalk pitted with one inch depressions and two inch wide cracks along the sidewalk surface where the sidewalk was heaving on each side.</li> </ol> <p>The dining room exit sidewalk, East Hall exit sidewalk, and Southeast Hall exit sidewalk surfaces pitting and heaving was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p>		<p>during the monthly QA rounds conducted by Maintenance Director or designee. This will be an on-going process. Attachment G -6 pages</p>				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 7 exits was readily accessible at all times. This deficient practice could affect 12 residents who reside on the East Hall and would use the East Hall exit during an evacuation in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 12/17/14 at 12:25 p.m., the East Hall exit door had yellow tape taped across the inside and outside of the exit door, which prevented the exit from being accessible. Based on an interview with the maintenance supervisor on 12/17/14 at 12:40 p.m., the East Hall exit is under construction for a new sidewalk and the facility taped the exit shut so it could not be used. The East Hall exit taped shut and inaccessible to residents and staff during an emergency evacuation was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>			

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K010046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exits was provided with emergency powered exterior lighting. This deficient practice could affect 39 residents who use the dining room and would use the dining room exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 1:00 p.m. with the maintenance supervisor, the main dining room exit discharged onto a sidewalk surface which extended one hundred feet on the west side of the facility to the parking lot. Furthermore, the one hundred foot long sidewalk surface lacked outside emergency lighting. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K010046	<p>No residents were found to be directly affected by this deficient practice. All residents residing the facility had the potential to be affected by this deficient practice. Emergency power exterior lighting will be installed along the Northwest sidewalk adjacent to the Dining room. This work has been approved and is scheduled to be completed within 90 days of day of survey. Attachment C The emergency power exterior lighting will remain in place. All emergency lighting will be inspected monthly during the QA rounds by the Maintenance Director or designee. This will be an on-going process. Attachment G -6 pages</p>	02/13/2015
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</p>			

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	<p>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>Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 2 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Records with the maintenance supervisor on 12/17/14 at 9:25 a.m., there was no fire drill documenting for the first shift, third quarter of the year 2014 and third shift fourth quarter for the year 2013. Additionally, based on interview with the maintenance supervisor during the review of the Fire Drill Records, there was no other documentation available for review to verify these drills were conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K010050	<p>No residents were found to be directly by this deficient practice.</p> <p>All residents had the potential to be affected by this deficient practice. A Fire Drill schedule has been developed to include a drill on each shift each quarter.</p> <p>The Fire Drill schedule will be followed to ensure compliance with quarterly fire drills. Drills will be documented and available for inspection.</p> <p>Fire Drill will be reviewed during the QA process, by the Administrator or designee, to ensure compliance is met. This will be an on-going process.</p>	01/20/2015

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K010056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 furnace rooms in the main dining room were sprinkled. This deficient practice affects 39 of 46 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 9:25 a.m. with the maintenance supervisor, the main dining room two furnace rooms lacked sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>	K010056	No residents were affected by this deficient practice. All residents residing had the potential to be affected by this deficient practice. Sprinklers will be installed in the furnace rooms located north side of dining room, and the furnace room near the employee entrance. Space heaters were removed from the detached sprinkler riser room, and permanent heat source will be installed in the detached sprinkler riser room. This work has been approved and will be scheduled to be completed within 90 days of the date of survey. Attachment D Sprinklers will remain in place in the furnace rooms located on the north side of the dining room, and the furnace room near the employee entrance. Permanent heat source will remain in place in the detached sprinkler riser room.	02/13/2015

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system valve room was provided with a permanently installed heat source. NFPA 13, 4-2.5.2 requires valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect dry pipe valve and supply pipe against freezing. This deficient practice could affect residents and staff if a fire occurred in the sprinkler riser building from the use of portable electric space heaters.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 1:40 p.m. with the maintenance supervisor, the detached sprinkler riser building was not equipped with a permanently installed heat source and used two electric metal space heaters to heat the detached building. Based on an interview with the maintenance supervisor on 12/17/14 at 1:50 p.m., the space heaters are used to heat the sprinkler riser building and prevent the sprinkler piping from freezing. The lack of a permanently installed heat source in the detached sprinkler riser building was verified by the maintenance supervisor at the time of observation and acknowledged by the</p>		The sprinklers will be maintained and inspected per the NFPA standards annually. This will be an on-going process. Attachment G -6 pages				

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K010062 SS=F	<p>administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the</p>	K010062	No residents were found to be affected by this deficient practice. All residents had the potential to be affected by this deficient practice. A contracted company performed a complete system flush and replaced the sprinkler head located in the Shower room. Annual sprinkler inspections will be conducted per NFPA standards. Any concerns will be relayed to the Maintenance Director and Administrator immediately, so they may be addressed appropriately. Annual sprinkler inspection documentation will be maintained and available to meet Life Safety regulations. This will be addressed as part of the facility's QA program after each yearly inspection. See attached K-62 revision--additional information	01/20/2015

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	<p>maintenance supervisor on 12/17/14 at 9:40 a.m., the most recent sprinkler system internal pipe inspection from Safecare was dated 04/04/14.</p> <p>Furthermore, the results of the inspection indicated "found rust and debris buildup and sprinkler system is in need of a complete flush." Based on an interview with the maintenance supervisor on 12/17/14 at 9:45 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 04/04/14, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance</p>			

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K010067 SS=F	<p>of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 22 residents who use the common shower room near room 22.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 11:30 a.m. with the maintenance supervisor, the common shower room next to resident room 22 had a sprinkler above the sink completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 24 of 25 resident rooms. LSC 19.5.2.1 requires</p>	K010067	No residents were found to be directly affected by this deficient practice. Residents residing in twenty-four of twenty-five resident rooms had the potential to be affected by this deficient practice. Fire /Smoke dampers will be	03/04/2015			

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K010070 SS=C	<p>air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect 44 of 46 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/17/14 during the tour of the facility from 9:45 a.m. to 2:20 p.m., resident rooms 1, 2, 3, 4, 6, 8, 11, 12, 14, 17, 18, 20, 21, 22, 25, 26, 28, 30, 32, 35, 37, 39, 41, and 43 used the corridor as a return air system. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <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</p>		<p>installed in the return air system for the twenty-four rooms affected by this deficient practice. Fire / Smoke dampers will remain in place in the return air system for the twenty-four rooms. The fire / smoke dampers will be inspected during the annual inspection of the fire suppression system. Any concerns will be related to the Maintenance Director and Administrator, and immediately addressed to remain in compliance. See attached K-67 revision--additional information--zip file-- will be email to Life Safety, as file is to large to upload. Life Safety Waiver has been submitted for approval with attachments.</p>	

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	<p>degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 space heaters were equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect residents and staff if a fire occurred in the sprinkler riser building, which was detached from the facility.</p> <p>Findings include:</p> <p>Based on observation on 12/17/14 at 1:40 p.m. with the maintenance supervisor, the detached sprinkler riser building had two electric metal space heaters in use. Based on an interview with the maintenance supervisor on 12/17/14 at 1:50 p.m., the space heaters are used to heat the sprinkler riser building and prevent the sprinkler piping from freezing. Furthermore, when asked if there is documentation to indicate the heating elements would not exceed 212 degrees Fahrenheit, the maintenance supervisor indicated there is no documentation or other evidence the space heater element would not exceed the 212 degree limit. The lack of documentation the heating elements would not exceed 212 degrees Fahrenheit for the use of two portable electric space heaters use was verified by the maintenance supervisor at the time of</p>	K010070	<p>No residents were found to be directly affected by this deficient practice. All residents residing in the facility had the potential to be affected by this deficient practice. The space heaters were removed from the detached sprinkler riser room. Attachment F A permanent heat source will be installed in the detached sprinkler riser room. This work has been approved and will be scheduled to be completed within 90 days from the date of survey. The riser room will be inspected during the monthly QA inspection. This will be an on-going process. Attachment G -6 pages</p>	02/13/2015

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K010144 SS=F	<p>observation and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to document monthly load tests for 10 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required</p>	K010144	<p>No residents were found to be directly affected by this deficient practice.</p> <p>All residents residing in the facility had the potential to be affected by this deficient practice. Weekly inspections and monthly load tests will continue to be conducted and documented by the facility Maintenance Director or designee.</p> <p>Weekly generator inspections and monthly load tests will be conducted per the preventative maintenance schedule, by the Maintenance Director or designee.</p> <p>The generator weekly inspections and monthly load test will be reviewed as part of the monthly QA process. This will be an on-going process.</p>	01/20/2015

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K010154 SS=F	<p>testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Weekly Generator Weekly Inspection Checklist and Monthly Load Test Checklist with the maintenance supervisor on 12/17/14 at 9:15 a.m., there was no record of monthly load tests from December 2013 to September 2014. Based on an interview with the maintenance supervisor on 12/17/14 at 9:20 a.m., the maintenance supervisor stated there are no records available for review to indicate a monthly load test was conducted from December 2013 to September 2014. This was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left</p>			

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	<p>unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Watch</p>	K010154	<p>No residents were found to be directly affected by this deficient practice.</p> <p>All residents residing the facility had the potential to be affected by this deficient practice. The facility's Fire Watch Status Policy was developed to include notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health, any time that the automatic sprinkler system is placed out of service for four or more hours in a 24 hour period.</p> <p>The fire watch policy includes notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health, any time that the automatic sprinkler system is placed out of service for four or more hours in a 24 hour period.</p> <p>Staff will be in-serviced on the fire policy including the fire watch policy, upon hire and at least annually thereafter to ensure continued compliance. This will be an on-going process.</p>	01/20/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010155 SS=F	<p>Status Policy on 12/17/14 at 9:15 a.m. with the maintenance supervisor, the written policy lacked notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 to protect 46 of 46 residents. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>	K010155	<p>No residents were found to be directly affected by this deficient practice.</p> <p>All residents residing the facility had the potential to be affected by this deficient practice. The facility's Fire Watch Status Policy was developed to include notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health, any time that the fire alarm system is placed out of service for</p>	01/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155254		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/17/2014	
NAME OF PROVIDER OR SUPPLIER  SUGAR CREEK REHABILITATION AND CONVALESCENT CENT				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 W US 40 GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Based on a review of the Fire Watch Status Policy on 12/17/14 at 9:15 a.m. with the maintenance supervisor, the written policy lacked notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>		<p>four or more hours in a 24 hour period.</p> <p>The fire watch policy includes notification of the local fire department, the alarm company, the insurance carrier and the Indiana State Department of Health, any time that the fire alarm system is placed out of service for four or more hours in a 24 hour period.</p> <p>Staff will be in-serviced on the fire policy including the fire watch policy, upon hire and at least annually thereafter to ensure continued compliance. This will be an on-going process.</p>				