

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 03/08/2016
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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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K 0000 Bldg. 01	<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: 03/08/16</p> <p>Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720</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. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detection in all resident sleeping rooms. The facility has a capacity of 60 and had a census of</p>	K 0000	<p>This plan of correction is to serve as Sugar Creek Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by SugarCreek Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.</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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K 0050 SS=F Bldg. 01	<p>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 completed on 03/14/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p>	K 0050	<p>K050- FIRE DRILLS HELD ATUNEXPECTED TIMES Fire drills are held atunexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part ofestablished routine.</p>	04/07/2016			

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	<p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 03/08/16 at 9:55 a.m., there was no fire drill documenting for the first shift, fourth quarter of the year 2015. Additionally, based on interview with the maintenance supervisor during the review of the Monthly Fire Drill Reports, 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 03/08/16 at 1:40 p.m.</p> <p>3.1-19(b)</p>		<p>Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the practice? The facility is required for 1 fire drill per quarter, per shift to equal 12 annually. The maintenance director has been given a quarterly fire drill form to be completed after every drill. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice, but none were identified. What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur? Maintenance Director has been in-serviced as to the required components of this tag. A report of every month's fire drills will be submitted to the Administrator or designee for review. How the corrective actions will be monitored to ensure the practice will not reoccur?</p>		

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K 0062 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to replace 4 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 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 reside on the North Hall and would use the front exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 03/08/16 at 11:50 a.m. with the maintenance supervisor, the front porch overhang had four sprinklers completely covered in</p>	K 0062	<p>This will be reviewed monthly for the next 6 months by the Administrator and Director of Plant Operations. Results will be reviewed during QA meeting monthly.</p> <p>K062 AUTOMATIC SPRINKLER Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the practice? The sprinklers in question (4) have been replaced with new sprinklers. Maintenance has inspected all sprinklers for paint and/or corrosion and none were found. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken? All residents had the potential to be affected; however, none were identified. What measures will be put into places or what systematic</p>	04/07/2016

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K 0067 SS=F Bldg. 01	<p>green corrosion. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/08/16 at 1:40 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 air conditioning, heating, ventilating ductwork and related equipment to be</p>	K 0067	<p>changes you will make to ensure that the practice does not reoccur? Maintenance Director has been in-serviced as to therequired components of this tag. Thefacility life safety were verified to the inclusion of monthly inspections tocheck for paint or corrosion on sprinklers to be in compliance with thisstandard. How the corrective actions will be monitored toensure the practice will not reoccur? The monitoring of this tag will be a joint effortbetween Administrator and the maintenance director as they do monthly rounds toinspect the sprinklers. This will be inspected 1x week for 4 weeks andmonthly as they review the life safety checklist. Results will be reviewed during QA meetingmonthly.</p> <p>K067 RETURN AIR PLENUM Heating, ventilating, and air conditioningshall comply with 9.2 and shall be installed in accordance with the manufacturer'sspecifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2</p>	04/07/2016

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K 0144 SS=F Bldg. 01	<p>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 03/08/16 during the tour of the facility from 9:15 a.m. to 1:20 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 03/08/16 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to document monthly</p>	K 0144	<p>What corrective actions will be accomplished for those residents found to have been affected by the practice? Please see waiver attachment</p> <p>What corrective actions will be accomplished for those residents</p>	04/07/2016			

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	<p>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:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Monthly Generator System Check Log with the maintenance supervisor on 03/08/16 at 10:35 a.m., the monthly load tests from 05/19/15 to 02/29/16 each lacked a percent of load or the exhaust gas temperatures for the ten month period.</p>		<p>found to have been affected by the practice? The facility now uses the correct method to testload on generator when performing a load test. How you will identify other residents havingpotential to be affected by the same practice and what corrective action will be taken? All resident residing in the facility had thepotential to be affected, but none were identified. What measures will be put into places or whatsystematic changes you will make to ensure that the practice does not reoccur? The maintenance director will use the new formula toobtain a load test rating of at least 30% when generator is under load. How the corrective actions will be monitored toensure the practice will not reoccur? Monthly load test documentation will be reviewed byAdministrator or designee for the next 3 months and quarterly for 6 months. All reports will be submitted to Director of PlantOperations for review. Any issues identified will be fixed and reported on site.Results will be reviewed during QA meeting monthly.</p>				

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	<p>Based on an interview with the maintenance supervisor on 03/08/16 at 10:40 a.m., the maintenance supervisor stated the monthly load tests only list the amperage output. The lack of monthly load tests over the past ten months lacking the percent of load or the exhaust gas temperatures was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 03/08/16 at 1:40 p.m.</p> <p>3.1-19(b)</p>				