

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 04/07/2015
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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 000 Bldg. 01	<p>An investigation of Complaint Number IN001169941 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Complaint Number IN001169941</p> <p>Substantiated, Federal/State deficiency related to the allegation is cited at K147</p> <p>Unrelated deficiencies cited at K29, K56, K64, K66 and K76</p> <p>Date of Survey: 04/07/15</p> <p>Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720</p> <p>Census: 44</p> <p>At this Complaint 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</p>	K 000	We respectfully ask for a desk review.	
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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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K 029 SS=E Bldg. 01	<p>16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and fully sprinkled except for the area cited in K56. 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 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 for the area cited in K56. The facility had two detached storage buildings, a detached maintenance shop, and a detached shed where the sprinkler riser was located which were not sprinklered.</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</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</p>			

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	<p>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 1 of 2 sets of doors serving hazardous areas, such as a laundry, closed and latched to prevent the passage of smoke. This deficient practice could affect at least 22 residents as well as an undetermined number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, the dryer side laundry door was provided with a door closer but did not have a latching mechanism provided. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the door lacks the hardware necessary to latch into the frame when closed.</p> <p>3.1-19(b)</p>	K 029	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. K29- (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: All doors requiring to be closed and latched will remain closed and latched at all times. No direct injury was seen as a result from this noncompliance to any resident. Door latching mechanism will be put in place. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: 22 Residents had the potential to be effected by this non-compliance © What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur: All staff in-serviced on the importance of closing and latching all doors. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be</p>	05/01/2015

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K 056 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in 1 of 1 closets in the Business Office in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA</p>	K 056	<p>put into place: The Administrator or designee will audit 5 times weekly that all doors requiring to be closed and latched are closed and latched. The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance (e) Date of compliance: 05/01/2015</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. K56 (a) What corrective action(s) will be</p>	05/15/2015

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	<p>13, Section 5-1.1 states sprinklers shall be installed throughout the premises. This deficient practice could affect at least 3 residents, staff and/or visitors in the vicinity of the Business Office.</p> <p>Findings include:</p> <p>Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, the Business Office closet lacked sprinkler protection. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the lack of sprinkler protection in the Business Office closet.</p> <p>3.1-19(b)</p>		<p>accomplished for those residents found to have been affected by the practice: A sprinkler head will be installed in 1/1 closets No residents or staff were directed affected as a result of this non-compliance (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: 3 residents had the potential to be affected by this non-compliance as well as staff assigned to the office (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur: The maintenance director and administrator were educated on the importance of all facility areas being covered by a sprinkler Ryan Fire Protection INC. will install one sprinkler head in the Business Office (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or designee will audit the entire facility for any further areas not having sprinkler coverage and have a plan to correct the non-compliance by the date of compliance The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is</p>	

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K 064 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers within the fire alarm panel/telephone room enclosure in the shower room across from the Administrator's office was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect at least 1 resident and staff.</p> <p>Findings include:</p> <p>Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, the fire extinguisher located within the fire alarm panel/telephone room enclosure bore a</p>	K 064	<p>recommended to maintain compliance (e) Date of compliance: 05/15/2015</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 64</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>The fire extinguisher placed in the fire alarm/telephone room will be inspected.</p> <p>No residents or staff were directly affected by this non-compliance</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>At least one resident while taking a shower and 1 staff member giving the shower could potentially be</p>	04/30/2015	

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K 066 SS=B Bldg. 01	<p>tag indicating the most recent annual inspection occurred in March of 2014. All other fire extinguishers within the facility had tags indicating an annual inspection occurred in March of 2015. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the fire extinguisher located within the fire alarm panel/telephone room enclosure was missed on the 2015 inspection.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and</p>		<p>affected by this non-compliance</p> <p>(C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>The maintenance director and Administrator were in-serviced on the importance of checking fire extinguishers for proper inspection dates and calling in a service when they are not compliant.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The maintenance director will call in a service to correct the current non-compliance and check all fire extinguishers for up to date inspection.</p> <p>The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance</p> <p>(e) Date of compliance: 4/30/15</p>		

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	<p>include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 2 areas where cigarettes may have been smoked. This deficient practice could affect any number of residents while in this area where smoking may have occurred.</p> <p>Findings include:</p> <p>Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, the north end of the west parking lot was littered with at least 100 cigarette butts. Based on interview at the time of observation, the</p>	K 066	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 66</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>All cigarette butts will be disposed of properly after each smoke time</p>	05/01/2015

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	<p>Regional Maintenance Director acknowledged the north end of the west parking lot is not a designated smoking area.</p> <p>3.1-19(b)</p>		<p>No residents or staff were directly affected by this non-compliance</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>All residents who smoke had the potential to be affected as well as any staff who conduct the smoke times with the residents.</p> <p>(C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>All staff were in-serviced on the importance of ensuring all cigarette butts are disposed of properly.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The maintenance director or designee will walk the premises daily to ensure any stray cigarette butts are disposed of properly.</p> <p>The maintenance director or designee will monitor a designated smoke time 1 day weekly x 60 days to ensure cigarette butts are being disposed of properly.</p> <p>The Facility Risk Manager will report results at the next QA/Risk</p>	

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K 076 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases in a resident room closet was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect at least 1 resident, staff and/or visitors in room 22.</p>	K 076	<p>Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance</p> <p>(e) Date of compliance: 5/1/15</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 76</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>All oxygen cylinders will be secured</p>	05/01/2015

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	<p>Findings include:</p> <p>Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, one of two oxygen e-cylinders was laying on the closet floor in room 22. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the cylinder on the floor should have been in a cart.</p> <p>3.1-19(b)</p>		<p>properly while in use/not in use.</p> <p>No residents or staff were directly affected by this non-compliance</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>1 resident in room 22 had the potential to be affected. Any staff or visitors had the potential to be affected.</p> <p>(C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>All staff were in-serviced on the importance of ensuring all oxygen devices including portable cylinders are properly secured by a chain or cart at all time.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Director of Nursing or designee will audit to ensure all oxygen devices including cylinders are properly secured. Audit will take place 3 times per week x 60 days</p> <p>The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly</p>	

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K 147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure electrical wiring and equipment in 16 of 25 resident rooms was in accordance with NFPA 70, the 199 National Electrical Code. NFPA 70, 90-1 states the following:</p> <p>(a) Practical Safeguarding. The purpose of this Code is the practical safeguarding of persons and property from hazards arising from the use of electricity.</p> <p>(b) Adequacy. This Code contains provisions that are considered necessary for safety. Compliance therewith and proper maintenance will result in an installation that is essentially free from hazard but not necessarily efficient, convenient, or adequate for good service or future expansion of electrical use.</p> <p>NFPA 70, at 110-31, (a) Indoor Installations states the following:</p> <p>(1) In Places Accessible to Unqualified Persons. Indoor electrical installations</p>	K 147	<p>thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance</p> <p>(e) Date of compliance: 5/1/15</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 147</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>All electrical wiring and equipment has been repaired</p> <p>Corrected 4-14-15 Rooms 2, 4, 6, 8, 11, 18, 21, 21, 26, 28, 30, 32,</p> <p>Corrected 4-15-15 Rooms 35, 37, 39, 41, 43</p> <p>No residents or staff were directly</p>	05/01/2015

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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			
	<p>that are open to unqualified persons shall be made with metal-enclosed equipment or shall be enclosed in a vault or in an area to which access is controlled by a lock. Metal-enclosed switchgear, unit substations, transformers, pull boxes, connection boxes, and other similar associated equipment shall be marked with appropriate caution signs. Openings in ventilated dry-type transformers or similar openings in other equipment shall be designed so that foreign objects inserted through these openings will be deflected from energized parts. This deficient practice could affect at least 32 residents, staff and/or visitors throughout the facility.</p> <p>Findings include:</p> <p>1) Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, resident rooms 2, 4, 6, 8, 11, 18, 21, 26, 28, 30, 32, 35, 37, 39, 41 and 43 had electrical breaker panels in the resident room closets that were accessible to the residents; lacked metal covers and were in an area to which access was not controlled by a lock. The breaker panels in the closets of resident rooms 37 and 39 had unprotected openings within the open breaker panel box. Based on interview during the time of observation, the</p>		<p>affected by this non-compliance</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>At least 32 residents could have been affected by the non-compliance</p> <p>An unknown number of staff and visitors could be affected</p> <p>(C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur:</p> <p>Administrator and Maintenance Director were in-serviced on the importance of all electrical wiring and equipment being up to code standards.</p> <p>(c) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The maintenance director or designee will ensure that all electrical wiring and equipment is up to code going forward. Maintenance Director or designee with audit each room found to be non-complaint for continued compliance 2 times weekly x 60 days.</p> <p>The Facility Risk Manager will report results at the next QA/Risk</p>				

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	<p>Regional Maintenance Director acknowledged the aforementioned breaker panels in the resident room closets lacked covers and the unprotected openings in the breaker panel boxes in rooms 37 and 39.</p> <p>2) Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, resident rooms 12, 37 and 39 had exposed call light wiring loose and the west nurses' station call light panel was loose. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the aforementioned conditions.</p> <p>3) Based on observation with the Regional Maintenance Director from 9:45 a.m. to 12:45 p.m. on 04/07/15, an outlet next to the washer in the laundry and two electrical outlets behind a bed in room 6 were missing outlet covers. Based on interview during the time of observation, the Regional Maintenance Director acknowledged the aforementioned conditions.</p> <p>This Federal tag relates to complaint IN00169941.</p> <p>3.1-19(b)</p>		<p>Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring by the RDO is recommended to maintain compliance</p> <p>(e) Date of compliance: 5/1/15</p>	