STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155664	A. BUILDING -- B. WING	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/01/19 Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930 At this Emergency Preparedness survey, Eagle Creek Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 83. Quality Review completed on 07/08/19	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and Life Safety survey on July 1, 2019. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/01/19 Facility Number: 010666 Provider Number: 155664	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	AIM Number: 200229930 At this Life Safety Code survey, Eagle Creek Healthcare 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 one 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 corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 83 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 07/08/19		and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and Life Safety survey on July 1, 2019. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, 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 all resident sleeping rooms. LSC 9.2.1 requires air	K 0521	No residents are affected by this alleged deficient practice. We are requesting an extension of annual waiver for K 521 due to unreasonable financial hardship.	07/29/2019

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	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 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Life Safety Code Waiver Request" documentation dated 06/08/18 with the Maintenance Director during record review from 9:30 a.m. to 12:45 p.m. on 07/01/19, the facility requested of ISDH an annual (continuing) waiver to not install a return air vent in all resident sleeping rooms. Based on interview at the time of record review, the Maintenance Director stated the facility has not installed return air vents in the rooms on or after 06/08/18 based on the costs stated in DEEM Mechanical's 06/07/18 proposal. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:00 p.m. on 07/01/19, all resident sleeping rooms are provided with an operable wall mounted Packaged Terminal Air Conditioning (PTAC) unit to provide heating and cooling for the room. Each resident sleeping room was also provided with a ceiling mounted supply vent for attic mounted HVAC units throughout the facility. Each resident sleeping room was not provided with a return air vent. Ductwork in the attic was affixed to the supply vents in the 100 Hall and the 200 Hall and the attic mounted HVAC units above the 100 Hall and the 200 Hall were in operation. Each of the supply vents was also equipped with a fire			

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	damper. It could not be assured all shutters for the fire dampers in resident sleeping rooms were in the fully closed position. Based on interview at the time of the observations, the Maintenance Director stated the resident room supply vents are a backup to the PTAC units should the PTAC not function, the fire dampers can be closed to restrict HVAC air supply to the room but agreed each of the resident sleeping rooms were not provided with return air vent in the room. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the			

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	components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review, observation and interview; the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were affected by this alleged deficient practice. Generator contractor returned on 7/9/2019 to the facility and performed load bank on the generator for 90 minutes at 75%. Other requirements of the NFAP load bank regulation were already met on the annual load bank reviewed during survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: All residents have the potential to be affected by the alleged deficient practice. TELS PM task sheet modified to reflect the requirements 8.4.2.3 of the NFAP 110 for annual load bank testing Regulation.	07/29/2019

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	Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator: Monthly Generator Exercise & Inspection (under load)" documentation dated 01/25/19, 02/28/19, 04/19/19, 05/23/19 and 06/28/19 with the Maintenance Director during record review from 9:30 a.m. to 12:45 p.m. on 07/01/19, monthly load testing documentation for the facility's emergency generator for 5 months of the most recent 6 month period did not state the generator was run under operating temperature conditions and at not less than 30 percent of the EPS nameplate rating or at a loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Director stated the facility has one diesel fired emergency generator which does not consistently achieve at or above 30% load during monthly load testing and a contractor performs annual load bank testing. Based on review of the emergency generator load testing contractor's "3 Phase Load Bank Test (1)" documentation dated 03/21/19, annual load bank testing documentation indicated the emergency generator was run at 31% load for fifteen minutes, 51% load for 15 minutes and at 77% load for 30 minutes. Based on interview at the time of record review, the Maintenance Director stated additional load bank testing documentation for the most recent twelve month period was not available for review and agreed the 03/21/19 annual load bank testing was not conducted in conformance with NFPA 110. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:00 p.m. on 07/01/19, the facility has one emergency generator which was diesel fired. Manufacturer's nameplate documentation indicated it was rated at 100 kW.		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director or designee will in-service the Maintenance Director on: 1.NFPA 110 generator load bank testing regulation. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Executive Director/Designee Load Bank testing will be reviewed by QAPI team during the monthly meetings for continued compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	3.1-19(b)			