

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/17/12</p> <p>Facility Number: 000614 Provider Number: 15G068 AIM Number: 100272120</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Hickory Creek at Gaston was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, with battery powered smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 68 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage, however, it was not in compliance with state law in regard to smoke detector</p>	K0000		

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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	<p>coverage.</p> <p>All areas where the residents have customary access were sprinklered. The facility had three sheds which were used for maintenance equipment and dietary supplies which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date of this rule.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure 4 of 26 smoke detectors in resident rooms were installed in a location which would allow the smoke detector to function to its fullest capability. Life Safety Code 4.6.12.2 requires Existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. NFPA 72, National Fire Alarm Code, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 8 residents as well as visitors or staff.</p>	K9999	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Hickory Creek at Gaston desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on August 16, 2012.</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p>	08/16/2012			

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	<p>Findings include:</p> <p>Based on observation on 07/17/12 at 12:13 p.m. with the Receptionist, the smoke detectors installed in resident rooms 3, 9, 13, and 25 were within two feet of an air supply duct. Based on interview on 07/17/12 at 12:15 p.m., it was acknowledged by the Receptionist the aforementioned smoke detectors were installed within two feet of an air supply duct in the ceiling which would not allow the smoke detector to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>		<p><u>1. What corrective action will be done by the facility?</u></p> <p>The facility had proper working smoke detectors in all of the resident rooms that were fully functional at the time of the walk-thru conducted on 7/17/12. The smoke detectors in rooms 3, 9, 13, and 25 have been relocated so they are a distance greater than 2 feet from air handling systems to ensure that the smoke detectors function to their fullest capacity.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>The smoke detector location will be checked in all resident rooms by facility managers to identify any other residents who might be affected by a smoke detector located with-in two</p>				

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			<p>feet of an air handler system. Any smoke detectors so identified, will be re-located to a proper distance from the air handler.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>Once all resident smoke detector locations in resident rooms have been assessed, and any smoke detectors requiring re-location has been accomplished, the facility Administrator will complete an audit of each resident room to assess for compliance.</p> <p>-</p> <p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator will review the completed re-location of smoke</p>		

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			<p>detectors and the follow-up audit with the Interdisciplinary Team to ensure ongoing compliance.</p> <p>Completed: 8/16/12</p> <p>Maintenance Director responsible.</p>		