

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  02/05/2014
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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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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/05/14</p> <p>Facility Number: 000614 Provider Number: 15G068 AIM Number: 100272120</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Gaston was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), 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 (111) construction and was fully sprinklered except for the enclosed space behind the dryers. The facility has a fire alarm system with smoke detection in the corridors and in spaces</p>	K010000	<p>The Plan of Correction constitutes the written allegation of compliance for the deficiencies 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. Hickory Creek at Gaston desires this Plan of Correction to be considered the facility's Allegation of Compliance.</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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K010046	<p>open to the corridors. Battery powered smoke detectors were used in all resident rooms. The facility has a capacity of 75 and had a census of 64 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the enclosed space behind the dryers and the three sheds which were used for maintenance equipment and dietary supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/17/14.</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 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 11 battery operated lights was maintained to</p>	K010046	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY	03/07/2014			

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	<p>provide emergency powered illumination. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours, arranged to provide not less than an average of 1 foot candle and not less than 0.1 foot candles, measured along the path of egress at floor level. This deficient practice could affect 24 residents on east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/05/14 at 1:39 p.m. with the Maintenance Director, the battery powered emergency light located in the Kitchen adjacent to the main lounge area on east hall did not illuminate when tested. Based on interview on 02/05/14 at 1:41 p.m. with the Maintenance Director, it was confirmed the aforementioned battery powered emergency light did not illuminate when tested.</p> <p>3.1-19(b)</p>		<p>THE DEFICIENT PRACTICE: No client was affected. The batteries in the battery powered emergency light located in the Kitchen adjacent to the main lounge area on east hall have been replaced. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:All clients could be affected. The battery operated lights will be checked every 30 days for at least 30 seconds. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:A preventative maintenance program has been established to check all battery powered lights weekly and to replace batteries as needed. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:The Maintenance Director will discuss this procedure at the monthly QA meetings to assure compliance.</p>		

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K010056	<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 1 of 38 rooms was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 24 residents on east hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 02/05/14 at 2:10 p.m. with the Maintenance Director, the enclosed three by eight foot space behind the two dryers in the laundry room was not provided with sprinkler protection. Based on interview on 02/05/14 concurrent with the observation, it was acknowledge by the Maintenance Director the</p>	K010056	<p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:No client was affected. The company who provides our sprinkler system has installed the needed sprinkler heads in the enclosed three by eight foot space behind the two dryers in the laundry room.HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:All clients could be affected. The company who provides our sprinkler system has installed the needed sprinkler heads in the enclosed 3 X 8 space behind the two dryers in the laundry room.WHAT</p>	03/07/2014			

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K010062	<p>aforementioned space was not equipped with sprinkler protection in order to provide complete sprinkler coverage to all areas of the facility.</p> <p>3.1-19(b) 3.1-19(ff)</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 Based on observation, record review and interview; the facility failed to ensure 3 of 3 pressure gauges for the sprinkler system in the Riser room were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or</p>	K010062	<p>MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:A test of all sprinklers will be conducted according to the state guidelines by the company who is contracted to do this. Any issues found will be addressed immediately.HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:The Maintenance Director will give a report to the QA committee regarding the placement and functioning of sprinklers.</p> <p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:No resident was affected. The gauges in the riser room next to the front entrance have all been replaced and are now in compliance.HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT</p>	03/07/2014	

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	<p>replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 02/05/14 at 1:38 p.m. with the Maintenance Director, three pressure gauges in the sprinkler riser room next to the front entrance had marked dates of the previous five year inspection date of 01/13/09. Based on Sprinkler Inspection Records review on 02/05/14 at 03:15 p.m. with the Maintenance Director, documentation did not reveal the sprinkler system gauges had been calibrated since the last date. Based on interview on 02/05/14 at 3:16 p.m. with the Maintenance Director and the Sprinkler System Maintenance provider, it was acknowledged the pressure gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p>		<p>CORRECTIVE ACTION WILL BE TAKEN:All clients could be affected. The gauges will be replaced and/or recalibrated every two years as required by the state department of health. The Maintenance Director will monitor to assure compliance.WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:The Maintenance Director will keep the date of the most recent calibration/replacement and the date by which is must be done again in his Preventative Maintenance book to assure compliance.HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:Maintenance Director will discuss any issues during the monthly QA meeting.</p>		

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K010070	<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 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to regulate the use of 4 of 4 portable space heaters in nonresident rooms. This deficient practice could affect all residents in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 02/05/14 during the tour between 1:05 p.m. to 3:00 p.m. with the Maintenance Director, a portable space heater which was plugged in for use was located in the following areas:</p> <ol style="list-style-type: none"> <li>Dietary office east hall</li> <li>Laundry room east hall</li> <li>Class room A east hall</li> <li>West hall in the corridor next to resident room # 2</li> </ol> <p>Based on interview on 02/05/14 concurrent with the observations, it was acknowledged by the Maintenance Director space heaters were allowed in the facility during periods of extreme cold weather conditions. Based on interview on 02/05/14 at 3:30 p.m. with</p>	K010070	<p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:No resident was affected. Only portable space heaters that have substantiated documentation from the manufacturer that the heating elements do not exceed 212 degrees Fahrenheit will be used in non-sleeping staff and employee areas. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:All clients could be affected. Only portable space heaters that have substantiated documentation from the manufacturer that the heating elements do not exceed 212 degrees Fahrenheit will be used in non-sleeping staff and employee areas. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:The Maintenance</p>	03/07/2014			

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	<p>the Maintenance Supervisor it was stated the facility had not drafted a space heater policy and the facility could not document the space heaters used were equipped with heating elements which would not exceed 212 degrees Fahrenheit.</p> <p>3.1-19(b)</p>		<p>Director will be responsible for monitoring this to assure that documentation is available for any portable space heaters in use. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:The Maintenance Director will give a report to the QA committee any time a portable space heater is being used.</p>				