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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155434 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 04/22/2014 |
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| NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CONNERSVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 2600 N GRAND AVE CONNERSVILLE, IN 47331 |
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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 |
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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 483.70(a).</p> <p>Survey Date: 04/22/14</p> <p>Facility Number: 000319 Provider Number: 155434 AIM Number: 100286530</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Connerville 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 (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38 and had a census of 35 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except four detached wooden storage sheds and one</p> | K010000 | | |

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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| K010018 SS=E | <p>detached metal liquid oxygen storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 18 resident room corridor doors would latch and resist the passage of smoke. This deficient practice affects 2 residents who reside in room 11 and 2 residents who reside in room 18.</p> <p>Findings include:</p> <p>Based on observations on 04/22/14 during a tour of the facility from 10:05 a.m. to 1:00 p.m. with the maintenance supervisor, the</p> | K010018 | <p>This Plan of Correction constitutes the written allegation of compliance for 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.</p> <p>K018</p> <p>1. It is the policy of this facility to ensure doors resist the passage of</p> | 05/05/2014 |

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| | doors to resident room 11 and resident room 18 each had a one inch gap along the top and latching sides of the doors with the doors closed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 1:00 p.m. exit conference on 04/22/14. 3.1-19(b) | | smoke. Room 11 and room 18 door gaps have been fixed with weather stripping. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All doors in the building have been inspected to ensure all doors meet requirement to resist passage of smoke. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance has been re-educated regarding the requirement related to doors resisting the passage of smoke. The Director of Maintenance will be responsible to ensure all doors are checked monthly for gaps that could prevent the resistance of passage of smoke. Door checks will be documented in Preventative Maintenance Log and will be reviewed monthly by the Administrator. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put | |

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| K010046 SS=F | <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 record review and interview; the facility failed to ensure 1 of 1 battery backup lights was tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents if the emergency generator battery backup light failed during a power outage.</p> <p>Findings include: Based on review of the Emergency Lighting Log on 04/22/14 at 10:15 a.m. with the</p> | K010046 | <p>into place?</p> <p>The Director of Maintenance will bring door check observations to the monthly Quality Assurance Meeting to discuss with the QA Committee.</p> <p>K046</p> <p>1. It is the policy of this facility to ensure all battery powered emergency lighting is tested for at least 90 minutes annually.</p> <p>The battery powered emergency lighting was tested on 4/28/14 and ran without problems for 90 minutes.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>There is no other battery powered emergency lighting at this facility.</p> <p>The Maintenance Director has been re-educated on the requirement to test battery powered emergency lighting for at least 90 minutes annually (which means within 365 days of the previous test).</p> | 05/05/2014 |

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| | <p>maintenance supervisor, the last annual ninety minute test conducted on the outside emergency generator battery backup light was conducted on 02/21/13, which was a period over one year. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 04/22/14 at 1:00 p.m.</p> <p>3.1-19(b)</p> | | <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The Director of Maintenance will complete annual tests as outlined in Preventative Maintenance Book. The Administrator will be responsible to work with Maintenance Director on an annual projected date for all annual tests. Projected test dates will be put on Administrator and Director of Maintenance Calendar. The Administrator will check compliance with all Preventative Maintenance Checks on a monthly basis.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Director of Maintenance will bring annual calendar and monthly checks to the monthly Quality Assurance Committee Meetings for discussion.</p> | |