

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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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: 05/17/13</p> <p>Facility Number: 000418 Provider Number: 155565 AIM Number: 100274870</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Sunset 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in resident rooms.</p>	K010000	<p>This 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.</p> <p>Hickory Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 31, 2013.</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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	<p>The facility has the capacity for 68 and had a census of 44 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached buildings for the employee lounge, maintenance, and storage which are not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 05/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K010018 SS=E	<p>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 1¾ 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. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 5 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 15 or more residents in the northeast compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 2:45 p.m., the door to resident room 16 on the east wing failed to latch when tested by the maintenance director three times. The maintenance director said at the time of observation, he had not know the door latch was not working.</p>	K010018	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Maintenance Director readjusted the strike plate to room 16 East on 5/20/13. The door now latches properly.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All doors in the facility have the potential to be affected by this deficiency. On 5/28/13 the Maintenance Director conducted the weekly preventative maintenance checks, including door latch tests on all rooms. No additional deficiencies were</p>	05/31/2013	

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	3.1-19(b)		<p>found.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>On 5/31/13, the housekeeping daily task list was updated to include checking all door latches during daily room cleans. Housekeepers were in-serviced on 5/31/13 regarding the procedure for checking door latches. If any problems are found, housekeepers will immediately fill out a work order request and submit to the Maintenance Director for prompt corrective action.</p> <p>4. Describe 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>Any doors found during daily housekeeping rounds to not be latching properly will be noted on a work order request and submitted to the Maintenance Director. Any issues identified will be brought to attention during daily QA meetings, at least 5x per week. Maintenance Director will continue to check all doors in the facility for proper latching during weekly preventative maintenance checks. Concerns identified will be reviewed during the monthly Safety Committee/Quality</p>		

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			Assurance meetings and immediate action will be taken on recommendations to ensure compliance.	

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K010022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 paths in the exit means of egress from the kitchen storage area was clearly identified. This deficient practice affects 3 kitchen staff and any resident in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 2:05 p.m., no exit sign was posted for the emergency exit from the kitchen which was identified on the emergency evacuation plan as an emergency exit. The maintenance director identified the exit at the time of observation and said he had not realized the exit was unmarked.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be</p>	K010022	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5/20/13 Maintenance Director posted an "Exit" sign for the emergency exit from the kitchen. On 5/21/13 a "Not an Exit" sign was also posted on the glass double door in the dining room leading into the Courtyard.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All doors in the facility are now clearly identified with appropriate signs.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. In the future, any remodels or door installations in the facility will be immediately posted with the appropriate sign; the fire evacuation plan will be updated as necessary. The Regional Maintenance Director will</p>	05/31/2013

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	<p>mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects visitors, staff and 10 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 2:15 p.m., a glass double door set opened from the dining room onto a patio with a sidewalk leading away from the building. There was no sign identifying the door as an exit and no sign to identify it as "No Exit" for emergency purposes. The maintenance director agreed at the time of observation, the door could be mistaken for a means of exit. The emergency evacuation diagram did not identify the doors as part of the emergency exit plan.</p> <p>3.1-19(b)</p>		<p>promptly conduct an inspection on any and all remodels within the facility to ensure compliance and report any issues found to the Maintenance Director.</p> <p>4. Describe 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>All future structural remodels of the facility will be thoroughly discussed during monthly Safety Committee/Quality Assurance meetings to identify and prevent any potential deficiencies. The Regional Maintenance Consultant will provide a written report identifying any concerns found to the Maintenance Director and that report will be brought to the Quarterly QA meeting for review and follow up. Immediate action will be taken on recommendations to ensure compliance.</p>				

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K010029 SS=E	<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 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 provide an automatic door closer on 1 of 2 doors providing access to the hazardous kitchen area. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 1:25 p.m., the door separating the dining room was protected by a door which was secured by a lock. The door was not self closing. The maintenance director said at the time of observation, the door was to be kept locked. He acknowledged the</p>	K010029	<ol style="list-style-type: none"> Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5/21/13, an automatic door closer was installed on the door separating the dining room from the kitchen. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. A walk-through of the facility was done by the Maintenance Director and Regional Maintenance Consultant on 5/31/2013, to ensure that all doors in the facility are appropriately equipped with the necessary hardware in compliance with regulations. Describe the steps or systemic changes the facility has made or 	05/31/2013

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	<p>requirement for a self closing door was not met.</p> <p>3.1-19(b)</p>		<p>will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>In the future, any remodels, including door installations, in the facility will be immediately equipped with the appropriate hardware. The Regional Maintenance Director will promptly conduct an inspection on any and all remodels within the facility to ensure compliance and report any issues found to the Maintenance Director.</p> <p>4. Describe 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>All future remodels, including door installations, in the facility will be thoroughly discussed during monthly Safety Committee/Quality Assurance meetings to identify and prevent any potential deficiencies. The Regional Maintenance Consultant will provide a written report identifying any concerns found and that report will be forwarded to the QA Committee for review and follow-up. Immediate action will be taken on recommendations to ensure compliance.</p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 20 residents in the southeast smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 2:40 p.m., the exit discharge surface for the southeast exterior exit from the east wing was damaged. The step along the concrete path had been modified to make a slope between the top of the step and the sidewalk surface. The concrete used to make the modification had cracked and separated and a section of the concrete was missing to leave a two inch by three inch gap in the irregular surface. The maintenance director acknowledged the condition of the exit discharge at the time</p>	K010038	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5/29/13 the cracked concrete leading from the southeast exterior exit was repaired by the Maintenance Director.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The section of concrete missing from the southeast exit discharge surface was the only area identified by the surveyor as a possible tripping hazard during the facility inspection. The area was repaired on 5/29/13.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Maintenance Director will note any unlevel walking surfaces found during monthly preventative maintenance checks. Needed repairs that are within the Maintenance Director's</p>	05/31/2013			

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	of observation and said there was a plan to repair the damage but no date had been set. 3.1-19(b)		capabilities will be made promptly. Areas requiring assistance from an outside source will be brought to the Administrator's attention for development of a plan of action. 4. Describe 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. Concerns identified during monthly preventative maintenance checks will be reviewed during the monthly Safety Committee/Quality Assurance meetings. Immediate action will be taken on recommendations to ensure compliance.		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 1 of 5 smoke compartments, was properly separated from an air supply. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010051	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The corridor smoke detector was relocated to an appropriate distance from the ceiling fan by Safe Care on 5/22/13.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All facility smoke detectors located in a space served by air handling systems are now in position for which airflow will not</p>	05/31/2013

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	<p>maintenance director on 05/17/13 at 2:25 p.m., a corridor smoke detector was located 24 inches from the spinning blades of an overhead ceiling fan at the east nurses' station. The maintenance director confirmed the distance measurement and acknowledged at the time of observation, the air flow could impede the function of the smoke detector by deflecting smoke away from the device.</p> <p>3.1-19(b)</p>		<p>prevent proper operation.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>All newly installed smoke detectors will be properly separated from any air supply where airflow could prevent operation of the detectors. Placement of ceiling fans in the future will be considered for proper distance from smoke detectors prior to instillation.</p> <p>4. Describe 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>Any future facility remodels that include instillation or relocation of a smoke detector or air supply such as ceiling fans will be discussed during monthly Safety Committee/Quality Assurance meetings to identify and prevent any potential deficiencies. Immediate action will be taken on recommendations to ensure compliance. The Regional Maintenance Director will promptly conduct an inspection on any and all remodels within the facility to ensure compliance.</p>	

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K010147 SS=D	<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 1 of 1 electrical wiring junction boxes was maintained in a safe operating condition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and any resident in room 8 on the west wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/17/13 at 1:10 p.m., a junction box above the doorway exiting the service corridor was left uncovered with multiple wires exposed. An insect's nest was visible. The electrical wiring was located near the emergency generator and outside the unoccupied resident room 8. The maintenance director said at the time of observation, he hadn't noticed the uncovered box and acknowledged any damage to the wiring resulting in fire might affect the adjacent generator and resident room.</p> <p>3.1-19(b)</p>	K010147	<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 5/20/13, the insect nest was removed from the junction box and a cover plate was installed. Wiring in the junction box was inspected to ensure safe operation.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All exterior facility junction boxes were inspected by the Maintenance Director on 5/28/13, and found to have a compatible cover in place.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Inspections of junction boxes have been added to the weekly preventative maintenance checklist. All junction boxes will be checked weekly to ensure a compatible cover is in place, ensuring safe operating condition</p>	05/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2013
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			<p>of the wiring.</p> <p>4. Describe 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>Any deficiencies found during weekly preventative maintenance checks will be immediately corrected. Considerable issues found will be reviewed during monthly Safety Committee/Quality Assurance meetings. Immediate action will be taken on recommendations to ensure compliance.</p>	