STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT KENDALLVILLE	1433 S MAIN ST KENDALLVILLE, IN 46755

(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
K010000	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). Survey Date: 01/13/15 Facility Number: 000402 Provider Number: 155392 AIM Number: 100288120 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Hickory Creek at Kendallville 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. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a	K010000		

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 determined that other safegaurds 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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	capacity of 36 and had a census of 16 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a barn providing facility services that was not sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 01/22/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 6 of 13 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within	K010052	K 052 It is the practice of this facility to maintain smoke detectors in accordance with applicable requirements of NFPA Each smoke detector is tested by SafeCare in accordance with these requirements. Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned/recalibrated or replaced. The affected smoke detectors, (1,4,5,7,11,12) were replaced and tested by SafeCare on January	01/16/2015

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	its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number of occupants in the		16, 2015 (supporting document attached) The detectors will continue to be tested in accordance with the NFPA requirements and replaced immediately when not within the marked sensitivity range. The Maintenance Director will supervise this process completed by SafeCare and review the findings of the test on the day of completion with SafeCare to ensure any detectors not within the sensitivity range are replaced on the day of testing. This documentation will be submitted on an ongoing basis to the Quality Assurance Committee which meets monthly and is overseen by the Administrator.	

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	facility. Findings include: Based on record review with the Administrator on 01/13/15 at 1:10 p.m. the SafeCare smoke detector record dated 03/10/14 and titled "Sensitivity Test and Inspection" indicated six smoke detectors throughout the facility had failed the sensitivity test. Based on an interview at the time of record review, the Administrator stated the smoke detectors had not been repaired or replaced. 3.1-19(b)			
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was maintained in proper working order. NFPA 96, Section 3-2.6 states filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice was not in a resident area but could affect	K010069	K 069 It is the practice of this facility to ensure that cooking areas are protected in accordance with NFPA and Life Safety Standards. A drip try which drains into an enclosed metal container is being installed beneath the exhaust system filters. At the time of this deficient practice, no residents were affected. All future inspection reports from 360 Service will be submitted to the Administrator for review and evaluation with the Maintenance	02/11/2015

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	kitchen staff. Findings include: Based on record review with the Administrator on 01/13/15 at 2:28 p.m., the 360 Degree Services kitchen hood cleaning report titled "Service Report" dated 08/18/14 stated "No drip pan and need drain on through". Based on observation and interview during a tour of the facility from 2:23 p.m. to 2:45 p.m., the Administrator acknowledged the kitchen hood system lacked a drain from the baffle filter to a drip pan. 3.1-19(b)		Director. All inspection reports from 360 Services for the hood/exhaust system will be submitted x 4 inspections for review by the QA Committee which meets monthly and is overseen by the Administrator.	
K010130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:	K010130	It is the practice of this facility to ensure the required fire resistance of the barrier walls. The piece of 4 x 4 inch "hard plastic-type material", which, in fact, turned out to be metal, not plastic, was removed and the opening in that section of the fire wall, which measures approximately 3 x 3 and 1/2 inches was filled with SpecSeal Firestop Putty on Jan 14, 2015. The remainder of the barrier walls have been inspected by the Director of Maintenance and there are no other spots that require corrective action.	01/14/2015

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	(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect all residents in both smoke compartments. Findings include: Based on an observation with the Administrator on 01/13/15 at 2:45 p.m., there were two wires beneath a four inch by four inch piece of hard plastic type material that was attached to the block fire wall above the ceiling tile at the fire barrier wall near resident room 14. When asked why the hard plastic material was		The Director of Maintenance will supervise any future projects that would involve modifications to the barrier walls and submit a report to the Administrator showing the modification to ensure the required fire resistant barrier is in place. Weekly inspections will be done x 8 weeks and then randomly x 4 weeks. This report will be added to and monitored by the QA Committee which meets monthly and is overseen by the Administrator.	

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	attached to the fire barrier wall and if it was covering a hole the Administrator replied she didn't know. 3.1-19(b)			
K010144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow	K010144	It is the practice of this facility to ensure the off-sight fuel source liability statement is complete and accurate with the required signatures from energy source. The facility received the required letter with signature from NIPSCO on January 13, 2015. (supporting document attached) At the time of this deficient practice, not residents were affected. The renewal date for this letter has been submitted to the QA Committee for the November, 2015 agenda to ensure an updated letter is received and signed by January, 2016. (QA Committee meets monthly and is overseen by the Administrator)	01/13/2015

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	full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview on 01/13/15 at 1:35 p.m., the Administrator confirmed the fuel source for the emergency generator was natural gas. Based on record review at the time of interview, the Administrator confirmed the letter from			

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	the natural gas provider dated February 2, 2014 lacked a signature. 3.1-19(b)			