

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 05/25/2016
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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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K 0000 Bldg. 01	<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: 05/25/16</p> <p>Facility Number: 000319 Provider Number: 155434 AIM Number: 100286530</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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, 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 36 at the time of this visit.</p>	K 0000		

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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K 0027 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has four detached wooden storage sheds and one detached metal liquid oxygen storage building which were not sprinkled.</p> <p>Quality Review completed on 06/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 2 smoke barrier doors would restrict the movement of smoke for at least 20 minutes or were provided with a coordinator that allowed the non-astragal door to close first. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for</p>	K 0027	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. K 027 It is the standard of this facility that smoke barriers have at least a	06/22/2016

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	<p>proper operation which is defined as 1/8 inch to restrict the movement of smoke. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door that must close first always closes first. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/25/16 during a tour of the facility from 10:50 a.m. to 12:30 p.m. with the maintenance supervisor, the East Hall set of smoke barrier doors and the West Hall set of smoke barrier doors each had four, one quarter inch diameter holes in the smoke barrier doors. Based on an interview with the maintenance supervisor on 05/25/16 at 11:30 a.m., the doors had hardware removed and the screw holes were not repaired. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/26/16 at 12:40 p.m.</p> <p>3.1-19(b)</p>		<p>20-minute fire protection rating or are at least 10 – inch thick solid bonded wood core. 1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> The holes in the East Hall and West hall smoke barrier doors have been repaired with fire caulking. 2. <i>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.</i> The Maintenance Director and Administrator have rounded the building to ensure all areas of the building have appropriate smoke barriers. 3. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> The Maintenance Director has been re-educated regarding smoke barrier code, and need to ensure holes are filled on all smoke barrier doors. Maintenance Director re-educated to ensure whenever hardware removed from smoke barrier door the screw holes must be filled / repaired. The Maintenance Director will continue with daily preventative maintenance program per company policy. 4. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</i></p>	

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K 0066 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted used a noncombustible ashtray and metal self closing containers for discarded smoking materials. This deficient practice could</p>	K 0066	<p><i>i.e. what quality assurance program will be put into place?</i> The Maintenance Director will review preventative maintenance checks / finding to monthly QA Committee for review and discussion. <i>Completion Date: 6/22/16</i></p> <p>K 066 It is the standard of this facility to ensure all smoking regulations are followed. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All cigarette butts have been</p>	06/22/2016

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	<p>affect 8 residents if a fire occurred at the outside locations where smoking is permitted.</p> <p>Findings include:</p> <p>Based on observations on 05/25/16 during a tour of the facility from 10:55 a.m. to 12:40 p.m. with the maintenance supervisor, the outside back exit smoking location had thirty three discarded cigarette butts on the ground surface where the eight residents who smoke and staff discarded their smoking materials on the ground surface instead of using the noncombustible plastic smoker oasis cigarette receptacle and metal smoking container. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/25/16 at 12:40 p.m.</p> <p>3.1-19(b)</p>		<p>picked up off the ground and discarded into metal smoking container. 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 staff received in-service training on 6/3/16 regarding smoking policy related to discarding of cigarette butts. A letter was mailed to all resident responsible parties regarding smoking policy in relation to discarding of cigarette butts. 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 Administrator and Maintenance Director will round the outside of the building daily to ensure cigarette butts are being discarded per policy. Any cigarette butts found on the ground will be picked up and discarded in facility metal smoking container. 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? The Daily rounds conducted by Administrator and Maintenance Director will be brought to the monthly QA Committee for review and discussion. Completion Date: 6/22/16</p>		

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K 0072 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects all residents who in the facility.</p> <p>Findings include:</p> <p>Based on an observations with the maintenance supervisor on 05/25/16 during a tour of the facility from 10:50 a.m. to 12:30 p.m., front entrance corridor next to the exit door had two chairs stored next to the exit door, the West Hall corridor had two chairs and a table stored near the main dining room, two chairs and a table in the corridor outside resident room 15, three wheel chairs in the corridor near the back exit door, and the East Hall corridor had a table, a lounge chair and a wooden hutch stored near the kitchen. This was verified by the maintenance supervisor at the time of observations and acknowledged by the</p>	K 0072	<p>K 072 It is the standard of this facility to ensure the means of egress is continuously maintained free of obstructions or impediments to allow full instant use in case of fire or other emergency.</p> <p><i>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The two chairs next to front entrance have been removed. One chair has been removed from the West Hall and there is now only one chair and a table that has been secured to the wall. Two chairs and a table have been removed from the corridor outside of room 15. The three wheelchairs near the back exit door have been removed. The lounge chair,table and hutch have been removed from the East Hall corridor.</p> <p><i>1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</i></p>	06/22/2016

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	<p>administrator at the exit conference on 05/25/16 at 12:40 p.m.</p> <p>3.1-19(b)</p>		<p><i>action(s) will be taken.</i></p> <p>The Administrator and Maintenance Director have rounded the building to ensure all areas have at least 6 foot clearance and that all furniture in corridors is affixed to the wall. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Administrator and Maintenance Director have reviewed the 2012 Life Safety Regulations related to means of egress. All staff has received training regarding the requirement to ensure furniture is not stored in the hallway. Residents and Family members were informed via mail of LSC means of egress requirement and the need to ensure chairs and other furniture are not brought out into the hallways. The Maintenance Director and Administrator will complete daily rounds to ensure all corridors meet means of egress requirements. 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? The Maintenance Director and Administrator's daily rounds will be brought to monthly Quality Assurance Meeting for review and discussion.</p>	

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K 0147 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 43 rooms did not use flexible cords as a substitute for fixed wiring to provide power for high power electrical devices. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all residents in the facility if a fire occurred in the business office or the nurses storage room.</p> <p>Findings include: Based on observation during a tour of the facility with the maintenance supervisor on 05/25/16 from 10:50 a.m. to 12:30 p.m., the business office used a power strip extension cord to power an air conditioner and the nurse storage room used a power strip extension cord to power a refrigerator. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/25/16 at 12:40 p.m. 3.1-19(b)</p>	K 0147	<p><i>Completion Date 6/22/16</i></p> <p>K 147 It is the standard of this facility to be in compliance with all regulations related to electrical wiring and equipment. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Business Office air conditioner is now plugged directly into an electrical wall outlet. The refrigerator in the medication room is now also plugged directly into an electrical wall outlet. 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 staff has been in-serviced regarding equipment and electrical wiring requirement. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director will complete weekly rounds checking equipment to ensure equipment remains directly plugged into electrical wall outlets. 4. How the corrective action(s) will be monitored to</p>	06/22/2016			

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			<p><i>ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</i> Maintenance Director will bring weekly rounds report to monthly QA meeting for review and discussion. Completion Date: 6/22/16</p>		