

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155211	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/01/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
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K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/06/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/01/15</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>At this PSR survey, Hickory Creek at Lebanon was found in substantial 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 smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors installed in three of thirty two resident</p>	K 0000		
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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 9999 Bldg. 01	<p>sleeping rooms. The facility has a capacity of 64 and had a census of 27 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings each housing an emergency generator, two detached storage buildings and one detached sprinkler system fire pump building which were each not sprinklered.</p> <p>Quality Review completed 12/02/15 - DA</p> <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under IC 16-28 and this rule must do the following:</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>3.1-19(a) The facility must be designed, constructed, equipped and maintained to</p>	K 9999	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited.</p> <p>This Plan of correction is submitted to meet requirements established by state and federal law. Hickory Creek at Lebanon desires this Plan of correction to be considered the facility's Allegation of Compliance effective December 1, 2015.</p> <p>There were working Smoke Detectors in each room during the annual survey. The Surveyor found the Smoke Detectors in good working order, however they were 10 years old and needed to</p>	12/01/2015

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	<p>protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to continuously provide smoke detectors in 29 of 32 resident sleeping rooms. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 9:30 a.m. to 10:15 a.m. on 12/01/15, a smoke detector was not installed in 29 of 32 resident sleeping rooms in the facility. Based on interview at the time of the observations, the Maintenance Director stated resident sleeping room smoke detectors had been taken out of 29 rooms and are to be replaced but acknowledged no replacement detectors had been procured and smoke detectors were not installed in 29 of 32 resident sleeping rooms in the facility.</p> <p>3.1-19(a) 3.1-19(ff)(3)</p>		<p>be replaced due to age.</p> <p><b>K9999</b></p> <p><b>What correctiveaction will be accomplished for those residents found to have been affected bythe deficient practice?</b></p> <p>Smoke Detectors were installed December 1, 2015.</p> <p><b>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken?</b></p> <p>All residents have the potential to be affected by thedeficient practice. Smoke Detectors wereinstalled in each resident room December 1, 2015.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?</b></p> <p>The Smoke Detectors will be on the annual preventivemaintenance schedule to check and to replace batteries.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; and</b></p> <p>The Smoke Detectors and the annual maintenance program ofthe Smoke Detectors will be discussed in the Quality Assurance Meetingannually.</p> <p><b>By what date thesystemic</b></p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			<b>changes will be completed?</b> December 1, 2015		