

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/21/2015
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/21/15</p> <p>Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550</p> <p>At this Life Safety Code survey, Hickory Creek at Winamac 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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms were equipped with battery powered smoke detectors. The facility has the capacity</p>	K 0000	<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. Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective 01/15/2016</p>	
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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 0025 SS=C Bldg. 01	<p>for 36 and had a census of 27 at the time of this survey.</p> <p>All areas within the facility where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached buildings used for oxygen storage, maintenance, and miscellaneous equipment storage.</p> <p>Quality Review completed 01/04/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke</p>	K 0025	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the penetrations caused by the passage of a wire and/or conduit thru 1 of 1 smoke barrier walls. Maintenance utilized fire	01/15/2016

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K 0050 SS=C Bldg. 01	<p>barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects both smoke compartments.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/21/15 at 12:59 p.m., the Director of Maintenance acknowledged there was an unsealed penetration measuring three inches by two inches above the ceiling tile at the smoke barrier door near resident room 4.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part</p>		<p>rated material and repaired opening. - 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 residents have the potential to be affected by the penetration caused by the passage of a wire and/or conduit thru smoke barrier wall. Maintenance has added this to his rounds on a weekly basis to ensure compliance going forward.</p> <p>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Random audit of sealed smoke barriers will be conducted by the Administrator or designee monthly and any issues will be addressed with Maintenance.</p> <p>- 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; and Any issues identified by the Administrator or designee will be discussed with the facility maintenance and will be addressed in QAA, plan of action developed and monitored on a monthly basis for 3 months then quarterly. _</p>		

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	<p>of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Analysis of Monthly Fire Drill" forms with the Administrator and the Director of Maintenance on 12/21/15 at 11:45 a.m., all fire drills took place between the 20th and 31st of each month for the previous year. Based on an interview with the Administrator at the time of record review, she was told not to conduct fire drill more then 30 days apart.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by fire drills occurring each month between the 20th and 31st of the month. Maintenance has implemented the fire drills effective 01/2016 per our policy and will continue to ensure compliance. - 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 residents had the potential to be affected by the fire drills being conducted from the 20th to the 31st of each month. Maintenance has implemented the fire drill timeline as directed in our Life Safety Policy. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator or designee will ensure compliance with the fire drill schedule per the Life Safety Policy effective January 2016 and going forward by randomly auditing and signing fire drills. If concerns are noted a plan of action will be created and</p>	01/15/2016	

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K 0056 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 1 Business offices. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment</p>	K 0056	<p>a new fire drill will be done.</p> <p>- 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; and</p> <p>_ Administrator or designee will address any issues identified with facility Maintenance which will share all concerns with the QAA committee monthly regarding fire drills to ensure compliance. _</p> <p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by quick response and standard sprinkler heads mixed in a smoke compartment. This issue had been identified on 12/10/2015 by SafeCare and parts were ordered on 12/10/2015 by facility maintenance to be installed upon</p>	01/15/2016

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K 0144 SS=C Bldg. 01	<p>shall be changed. This deficient practice could affect staff and 1 or 2 residents in the Business office.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Administrator in Training and the Director of Maintenance on 12/21/15 at 12:36 p.m., the Business office had a mixture of quick response sprinkler heads and standard response sprinkler heads. Based on an interview with the Director of Maintenance at the time of observation, the issue had been identified by SafeCare and the facility will be scheduling the work in the near future.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per</p>		<p>receipt. - 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 residents had the potential to be affected by the mixer of quick response and standard sprinkler heads within the same compartment. This had been previously identified on 12/10/2015 and parts were on order as of 12/10/2015. Parts arrived and were installed on 01/06/2016 by the Regional Maintenance Director and facility Maintenance. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator or designee and facility Maintenance will do rounds monthly to ensure that all sprinklers within the same compartments are not mixed and are replaced if any issues are found. - 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; and _ Administrator or designee will address any issues noted with facility maintenance which will be discussed at QAA monthly and a plan of action put in place to continue compliance.</p>		

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	<p>month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Director of Maintenance on 12/21/15 at 11:23 a.m., the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a</p>	K 0144	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the generator log showing no documentation that the generator had a cool down time following the load test. - 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 residents had the potential to be affected by the generator log showing no documentation that the generator had a cool down time following the load test. The generator log has been updated to include documentation of a cool down time on the generator following the 30minute load test monthly.</p> <p>- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator or designee will audit monthly generator log to ensure compliance with documentation being recorded of the cool down time after the monthly load test on generator.</p> <p>- 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; and Any issues identified by Administrator or designee will be</p>	01/15/2016

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	cool down time following the load test. During an interview at the time of record review, the Maintenance Director confirmed the monthly generator log did not include documentation of a cool down time being recorded. 3.1-19(b)				discussed with the facility maintenance director and the Administrator, these issues will then be discussed in QAA and a plan of action put into place to ensure compliance going forward. --		