| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 04/12/2012 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY CREEK AT LEBANON | 1585 PERRY WORTH RD<br>LEBANON, IN 46052 |

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| K0000 | 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).<br><br>Survey Date: 04/12/12<br><br>Facility Number: 000118<br>Provider Number: 155211<br>AIM Number: 100290470<br><br>Surveyor: Bridget Brown, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Hickory Creek at Lebanon 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.<br><br>This one story facility was determined to be of Type V (000) construction and was fully | K0000 | This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the 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 Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on May 12, 2012. | |

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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| | sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are located in resident rooms. The facility has the capacity for 64 residents and had a census of 40 at the time of this survey.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/16/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by: | | | |

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| K0021 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:<br><br>a) the required manual fire alarm system;<br><br>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>c) the automatic sprinkler system, if installed.<br>19.2.2.2.6, 7.2.1.8.2<br><br>Based on observation and interview, the facility failed to ensure 1 of 8 doors to hazardous areas such as a boiler room was held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 19 residents in the Unit 2 smoke compartment.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 04/12/12 at 1:50 p.m., the self closing corridor door to the boiler room near the dining room was prevented from closing when the | K0021 | **K 021**<br><br>1. What corrective action will be done by the facility?<br><br>A new self closing door located in the boiler room near the 200 nurse station was ordered 4/19/12. The door will be delivered by 5/14/12 and installed by 5/18/12.<br><br>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?<br><br>No residents were adversely affected by this | 05/18/2012 |

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| | door was fully opened. The door caught on the floor and stood open until it was pushed closed. The maintenance director acknowledged at the time of observation, the doors would not automatically close when opened wide.<br><br>3.1-19 | | practice.<br><br>3. What measures will be put into place to ensure this practice does not recur?<br><br>The Maintenance Director will monitor all doors to hazardous areas in the building to ensure that the doors automatically close. The findings will be documented on the Weekly Facility Safety Inspection report.<br><br>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?<br><br>The Maintenance Director will report any findings to the monthly QA meeting. | |

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| K0029 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br><br>Based on observation and interview, the facility failed to provide and maintain latches and self closing devices on doors to 2 of 8 hazardous areas, such as the oxygen supply storage and transfer room and storage rooms larger than 50 square feet with combustibles were maintained. 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 and latch into the door frame when closed to keep the door tightly closed. This deficient practice could affect visitors, staff, and 19 residents on Unit 2.<br><br>Findings include: | K0029 | **K 029** 1. What corrective action will be done by the facility? All staff will be educated that a magnet or any other item cannot be utilized to prevent the door to the oxygen room near the 200 nurse station from latching. The storage room behind the nurses station located on the closed 300 hall has been emptied and will no longer be utilized as a storage area. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. 3. What measures will be put into place to ensure this practice does not recur? The Maintenance Director will monitor all doors that latch and ensure that there is not an obstruction preventing the door from latching. The room located behind the nurse station on the closed 300 unit will be monitored to assure that it | 05/12/2012 |

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| | a. Based on observation with the maintenance director on 04/12/12 at 2:25 p.m., the self closing oxygen supply storage and transfer room door separating the room from the exit corridor was equipped with a positive latch, however, the door was not latched and opened without turning the door knob. Upon closer inspection it was found a magnet had been placed over the latch to prevent it from working. The maintenance director agreed at the time of observation, the door was deliberately prevented from latching.<br>b. Based on observation with the maintenance director on 04/12/12 at 2:40 p.m., the door separating the storage room behind the old 300 hall unit nurses station and the exit corridor had no self closer and the door was damaged. The wood around the latch and door frame had been torn away and the door could not be latched. The maintenance director acknowledged at the time of observation, the door to the room, larger than 50 square feet and filled with combustible cardboard | | remains empty. The findings will be documented on the Weekly Facility Safety Inspection Report.<br>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director will report the outcomes to the QA Committee on a monthly basis. | |

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| | and plastic combustible materials, did not provide separation from the exit corridor.<br><br>3.1-19(b) | | | |

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| K0038 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>Based on observation and interview, the facility failed to ensure 1 of 5 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 19 residents on Unit 2.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 04/12/12 at 3:00 p.m., the sidewalk exit discharge surface from the old 300 hall lounge to the parking lot evacuation point was damaged by pitting and there were level changes of one half to one inch between some of the concrete pads which made the | K0038 | **K 029** 1. What corrective action will be done by the facility? All staff will be educated that a magnet or any other item cannot be utilized to prevent the door to the oxygen room near the 200 nurse station from latching. The storage room behind the nurses station located on the closed 300 hall has been emptied and will no longer be utilized as a storage area. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. 3. What measures will be put into place to ensure this practice does not recur? The Maintenance Director will monitor all doors that latch and ensure that there is not an obstruction preventing the door from latching. The room located behind the nurse station on the closed 300 unit will be monitored to assure that it remains empty. The findings will be documented on the Weekly Facility Safety Inspection Report. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director will report the outcomes to the QA | 05/31/2012 |

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| | surface unlevel. The maintenance director acknowledged at the time of observation, the surfaces were unlevel and said the damage was weather related.<br><br>3.1-19(b) | | Committee on a monthly basis. | |