

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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(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
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K010000	<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: 04/02/14</p> <p>Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Peru 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated detectors in resident sleeping rooms. The facility has a</p>	K010000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiency 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 Peru desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on April 3, 2014.</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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	<p>capacity of 36 and had a census of 35 at the time of this survey.</p> <p>All areas providing customary access to residents were sprinklered. All areas providing facility services were sprinklered except for the detached oxygen storage building and detached maintenance shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 2 of 2 steel armover sprinkler pipes observed in the laundry were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observations on 04/02/14 during the tour between 1:36 p.m. and</p>	K010056	<p>K056 It is the policy of this facility to ensure that sprinklers are installed in accordance with the requirements of NFPA 13. 1. What corrective action will be accomplished for residents affected? The Maintenance Director added a support to each steel pipe affected so as not to exceed 24 inches from the end of the armover. 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? All residents had the potential to be affected. The sprinkler piping was inspected throughout the building to ensure that there were no other pipes affected by this practice. 3. What measures will be put into place to ensure this practice does not recur? The Administrator and Maintenance Director will tour the facility monthly to ensure that the</p>	04/03/2014			

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	<p>1:45 p.m. with the Maintenance Supervisor, the south wall in laundry room on middle hall had an unsupported steel armover which measured thirty four inches in length and the water heater room in the laundry room on middle hall had an unsupported steel armover which measured thirty one inches in length. Based on interview on 04/02/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armovers exceeded twenty four inches in length and were unsupported.</p> <p>3.1-19(b)</p>		<p>sprinkler system meets the requirements of NFPA 13. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Findings from the Administrator's tour will be forwarded to the QA&A committee for further review at the monthly meeting. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&A committee. <u>Date of compliance:</u> April3, 2014</p>		