

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  10/22/2012
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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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K0000	<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: 10/22/12</p> <p>Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Winamac 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 facility was determined to be of Type II (222) construction and was fully sprinklered. The facility</p>	K0000	<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 laws.</p> <p>Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on November 6, 2012.</p>	

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>has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors were located in resident rooms. The facility has the capacity for 36 and had a census of 21 residents at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had one detached wood shed for maintenance storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/26/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 2 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the front smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/22/12 at 12:35 p.m., the latching mechanism for the door providing access to the physical therapy room was tested twice. Each time</p>	K0018	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>No residents were affected by this practice; however, the door latch and hinge were replaced and are in proper working order as of 10/23/12.</p> <p>- 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;</p>	11/06/2012

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	<p>the latch failed to secure the door into the door frame. The maintenance director acknowledged at the time of observations, the latch was not working.</p> <p>3.1-19(b)</p>		<p>All residents had the potential to be affected; however, no residents were affected.</p> <p>All doors in facility have been inspected to ensure they are in proper working condition.</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;</p> <p>Maintenance or designee will monitor all doors monthly to ensure they are in proper working order.</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>Random checks of the doors will be done weekly to include at least 3 doors for at least 3 months or until compliance. Results of the</p>	

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			<p>random door checks and monthly audits will be brought to QA&amp;A and discussed as necessary for 6 months or until compliant.</p> <p>-</p> <p>-</p> <p>- by what date the systemic changes will be completed.</p>	

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K0050 SS=F	<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 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 ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters and included information about which staff participated. LSC 4.7.2 requires drills include suitable procedures to ensure that all persons subject to the drill participate. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Monthly Fire Drill records and interview with the administrator and maintenance director on 10/22/12 at 2:55 p.m., there was no record of a third shift fire drill for the fourth quarter of 2011 or</p>	K0050	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>no residents were affected and annual schedule for fire drills has been implement to ensure compliance from this date forward.</p> <p>- 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;</p>	11/06/2012			

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	<p>for the second shift during the first quarter of 2012. The administrator immediately reviewed the records and acknowledged drills for these periods were missing. In addition, the fire drill record for the drill conducted on 09/18/12 at 5:10 a.m. had no signatures to indicate which staff participated. The maintenance director acknowledged there was no way to tell who had participated in the drill.</p> <p>3.1-9(b) 3.1-51(c)</p>		<p>all residents had the potential to be affected, however no residents were affected. Annual fire drill schedule has been implemented to ensure compliance.</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;</p> <p>Fire drill schedule has been implemented to ensure compliance with one fire drill per shift per quarter per regulation.</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>-</p> <p>-</p> <p>Administrator or designee will</p>		

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			<p>conducted monthly audits to ensure drills were done per schedule and with time frame to ensure compliance for three months then quarterly for 1 year. The results of monitoring will be brought to QA&amp;A monthly and discuss as necessary.</p> <p>-</p> <p>-</p> <p>-</p> <p>- by what date the systemic changes will be completed.</p>	

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K0051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to identify the circuit panel serving 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p>	K0051	<p>K051 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; While no residents were affected, the circuit panel has been marked appropriately and is clearly identifiable. - 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; No resident were affected, however circuit breaker has been marked appropriately in red and is clearly identifiable and all authorized employees (Administrator, Director of Nursing, and Maintenance) have been in</p>	10/31/2012			

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	<p>Based on observation with the maintenance director and administrator on 10/22/12 at 1:50 p.m., the maintenance director was asked to identify the fire alarm emergency circuit control connected to the emergency generator. After reading the legend inside the panel door, he identified an unmarked circuit breaker as the circuit control. He acknowledged at the time of observation the circuit control would have been quickly identified with the required red marking.</p> <p>3.1-19(b)</p>		<p>serviced on the emergency power circuit breaker and the procedure to follow. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Authorized employees (Administrator, Director of Nursing, and Maintenance) will be in serviced annually and upon change of personnel on the emergency power circuit breaker and the procedure to follow. - 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 _ Regional Staff will monitor quarterly to ensure compliance with identifiable marking and procedure any identified issues will be discussed with QA&amp;A committee on going.</p>		

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K0056 SS=E	<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 insure 1 of 2 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. NFPA 13, 4-7.3.3 requires sprinklers shall be located a minimum of four inches from a wall. This deficient practice could affect visitors, staff and 10 or more residents in the front smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 10/22/12 at 1:20 p.m. with the</p>	K0056	<p>K056</p> <p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>while no resident were affected, the sprinkler was extended by Maintenance and Regional Maintenance Consultant on 10/29/12</p> <p>- 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;</p>	10/31/2012			

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	<p>maintenance director and administrator, a pendant sprinkler head in the corridor near the administrator's office abutted a wall assembly constructed to hide exposed pipes. The maintenance director acknowledged at the time of observation, the minimum four inch clearance between the wall and sprinkler head was not maintained.</p> <p>3.1-19(b)</p>		<p>All residents had the potential to be affected, however no residents were, all facility sprinkler heads were examined by maintenance and regional maintenance consultant on 10/29 and no additional issues were identified.</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;</p> <p>Maintenance will ensure compliance with all future remodeling when changing the cosmetic looks of the facility</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>-</p> <p>Random checks will be</p>		

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			<p>performed by Administrator or designee and addressed at QA&amp;A on a monthly basis for 3 months then quarterly thereafter until compliant.</p> <p>-</p> <p>-</p> <p>-</p> <p>- by what date the systemic changes will be completed.</p> <p>10/31/12</p>		

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K0062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/22/12 at 1:10 p.m., cables and miscellaneous wiring were zip tied to a sprinkler pipe in the laundry and adjacent exit corridor in lieu of separate hangers thus increasing the load on the pipe. The maintenance director acknowledged at the time of observation, the pipes were not to be used as hangers for other equipment installations.</p>	K0062	<p>K062</p> <p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>No residents were affected, however Maintenance has rerouted or eliminated all wires that were attached to sprinkler system and fire caulked and replaced escutcheons as necessary.</p> <p>- 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;</p>	11/06/2012			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 2 smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents in the front smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 10/22/12 at 1:20 p.m. with the maintenance director and administrator, a pendant sprinkler head in the corridor near the administrator's office abutted a wall assembly constructed to hide exposed pipes. The installation prevented the use of an escutcheon, part of the sprinkler assembly, and a quarter inch annular gap remained. The maintenance director acknowledged at the time of observation, the escutcheon should have been in place.</p> <p>3.1-19(b)</p>		<p>While no resident were affected; Maintenance inspected facility and examined all pipes related to sprinkler system and has fixed areas identified for compliance.</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;</p> <p>All contractors will work with Maintenance direction to ensure compliance with regulation and alternate methods of securing wires thru facility</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>-</p>		

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			Administrator will conduct random audits to ensure compliance and any areas identified will be discussed at QA&A monthly for 3 months then quarterly for 1 year.	

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  10/22/2012
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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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(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
K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to provide 1 of 1 portable K class fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone</p>	K0064	<p>K064</p> <p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>No residents were affected however the K extinguisher was replaced by vendor on 10/23/12.</p> <p>- 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;</p> <p>All resident had the potential to be affected; all extinguishers are serviced annually by vendor and checked monthly by Maintenance or designee monthly.</p>	10/25/2012

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  10/22/2012
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	<p>the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, staff and 10 or more residents in the front smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/22/12 at 12:20 p.m., the portable K- class fire extinguisher in the kitchen lacked a verification of service collar. The cylinder was inspected closely with the maintenance director and a 2006 date was noted. The administrator immediately called the fire extinguisher contractor who had done annual fire extinguisher maintenance in July 2012. The contractor reported "they missed it" after reviewing their records for the next time a six year maintenance was due.</p> <p>3.1-19(b)</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;</p> <p>Maintenance or designee will monitor monthly for compliance and do rounds annually with vendor to ensure compliance.</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>- random audits will be done by Administrator or designee to ensure compliance with extinguishers and discussed at QA&amp;A on a monthly basis for 3 months then quarterly for 1 year or until compliant.</p>	

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  10/22/2012
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