

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/11/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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K 0000  Bldg. 01	<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: 12/11/15</p> <p>Facility Number: 000284 Provider Number: 155424 AIM Number: 100290690</p> <p>At this Life Safety Code survey, Hickory Creek at Columbus 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 35 at the time of this visit.</p>	K 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Hickory Creek at Columbus desires this Plan of Correction to be considered the facilities' allegation of Compliance.</p> <p>Compliance is effective December 31, 2015.</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 0015 SS=A Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached storage shed which was not sprinkled.</p> <p>Quality Review completed on 12/14/15 by Lex Brashear, LSC Specialist</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 44 rooms was provided with an interior finish with a flame spread rating of Class A, Class B or Class C. This deficient practice affects staff who work in the minimum data set coordinator office.</p> <p>Findings include:</p> <p>Based on observation on 12/11/15 at 10:30 a.m. with the maintenance supervisor, the minimum data set coordinator office south wall had a two</p>	K 0015	<p>1.) What corrective action will be made by the facility? Missing drywall in the minimum data set office was replaced with new drywall on 12-17-15. 2.) How will facility identify other residents affected by the deficient practice? Drywall replaced in office. No residents affected by the deficient practice. 3.) What measures will be put into place or what systemic changes will be to ensure the practice does not recur? Maintenance supervisor will inspect all rooms in facility for missing drywall on a monthly basis and repair any holes, gaps,</p>	12/31/2015

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K 0027 SS=E Bldg. 01	<p>foot by four foot section of drywall missing and was covered with a sheet of cardboard duct taped to the wall. Based on an interview with the maintenance supervisor on 12/11/15 at 10:35 a.m., the drywall was a duct used for supply air and was taken out and the section of wall has not been repaired. The missing drywall in the minimum data set coordinator office was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/11/15 at 12:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 2 smoke barrier doors would restrict the movement of smoke for at least 20 minutes or were provided with a coordinator that allowed the non-astragal</p>	K 0027	<p>or missing drywall as a part of his preventative maintenance program. 4.) How will corrective action be monitored for continued compliance? Maintenance supervisor will be responsible to check all offices and resident areas/rooms monthly for any holes, gaps or missing drywall as a part of his preventative maintenance program. He will also present his findings to the monthly QA meeting to ensure that checks are being done. Administrator will also check walls on rounds daily and observe for any holes, gaps or missing drywall and inform maintenance supervisor of any problems. 5. Systemic changes will be completed by 12/31/15</p> <p>1.) What corrective action will be done by facility? Door coordinators were repaired on 12-15-15 by maintenance supervisor and maintenance regional consultant and are now closing properly with no gaps. 2.)</p>	12/31/2015			

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	<p>door to close first. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door that must close first always closes first. This deficient practice affects 18 residents who reside on the West Hall and 17 residents who reside on the East Hall.</p> <p>Findings include:</p> <p>Based on observations on 12/11/15 during a tour of the facility from 9:40 a.m. to 12:35 p.m. with the maintenance supervisor, the following smoke barrier doors either failed to resist the passage of smoke or lacked coordination of the smoke barrier doors:</p> <p>a. The West Hall set of smoke barrier doors had a one half inch gap where the doors came together in the closed position and the coordinator failed to close the non astragal door on three separate attempts, leaving a one foot gap where the coordinator propped the doors open.</p> <p>b. The East Hall set of smoke barrier</p>		<p>How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Coordinators were repaired on 12-15-15. No residents affected by deficient practice. 3.) What measures will be put in place to ensure practice does not recur? Monthly door checks will be added to maintenance supervisor's preventative maintenance list. Maintenance supervisor will check doors monthly and ensure they are closing properly. Maintenance supervisor has also purchased back-up parts for coordinators if the doors do not close properly, and will have these on-hand for immediate fixes, if necessary. 4.) How will corrective action be monitored to prevent recurrence? Maintenance supervisor will ensure compliance via monthly test of doors and will document those tests on his preventative maintenance list. Administrator will ensure door checks are being done monthly by auditing maintenance supervisor via QA process. 5.) Systemic changes will be done by 12-31-15.</p>	

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K 0029 SS=E Bldg. 01	<p>doors coordinator failed to close the non astragal door on three separate attempts, leaving a one foot gap where the coordinator propped the doors open. The West Hall smoke barrier doors failing to resist the passage of smoke and the coordinator failing to allow the non astragal door to close first and the East Hall smoke barrier door coordinator failing to allow the non astragal door to close first were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/11/15 at 12:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas was separated from the corridor by smoke resistant partitions. This deficient</p>	K 0029	1.) What corrective action will be done by facility? Drywall in the boiler room that was missing and crumbling behind the door has been removed and has been	12/31/2015

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K 0046 SS=F Bldg. 01	<p>practice affects 17 residents who reside on the East Hall near the boiler room.</p> <p>Findings include:</p> <p>Based on observation on 12/11/15 at 11:35 a.m. with the maintenance supervisor, the boiler room north wall had a two foot by four foot area of drywall missing and crumbling behind the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/11/15 at 12:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation, record review and interview; the facility failed to ensure 1 of 1 battery backup light was tested annually for 90 minutes over the past</p>	K 0046	<p>replaced as of 12-17-15. 2.) How will the facility identify other residents affected by the deficient practice? Drywall was replaced. No residents affected by the deficient practice. 3.) What measures will be put in place to ensure practice does not recur? Maintenance supervisor will inspect drywall in hazardous areas and ensure that there is no gaps, holes or missing spaces and will add this to his preventative maintenance list to be done monthly. 4.) How will corrective action be monitored? Maintenance supervisor will inspect walls in hazardous areas (ex. boiler room, laundry) for gaps, holes or missing drywall and inform administrator of any areas that need to be fixed. Maintenance supervisor will also give a monthly inspection report to administrator, which will be reviewed in monthly QA meeting. Administrator will ensure compliance via daily rounds and monthly QA process. 5.) Systemic changes will be completed by 12-31-15.</p> <p>1. What corrective action will be done by facility? Battery backup light was tested on 12-15-15 for 90 minutes and is now complete. Maintenance supervisor updated</p>	12/31/2015	

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	<p>year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the event of the battery backup light failure in the emergency generator room during periods of power outages.</p> <p>Findings include:</p> <p>Based on record review on 12/11/15 at 9:40 a.m. with the maintenance supervisor, the Weekly Generator Inspection sheets, weekly thirty second tests were documented over the past year for the battery backup light located at the outside emergency generator location. Furthermore, the last annual ninety minute test was performed on 09/19/14, which is over the annual twelve month</p>		<p>his documentation records to remind him to complete the test timely next year in December. 2.) How will the facility identify other residents affected by the deficient practice? Test completed on 12-15-15. No residents affected by the deficient practice. 3.) What measures will be put in place to ensure practice does not recur? Maintenance supervisor has updated his documentation records to remind him to run the test on an annual basis. 4.) How will the corrective action be monitored? Maintenance supervisor will check his monthly documentation records and will be reminded to complete the test prior to December 15, 2016. Maintenance supervisor documentation was updated to reflect the test due date. The test has also been added to facility QA audit to ensure that it is completed every December. Administrator will ensure compliance by auditing maintenance supervisor documentation via monthly QA process. 5.) Systemic changes will be done by 12-31-15.</p>	

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K 0144 SS=F Bldg. 01	<p>testing requirement. The lack an annual ninety minute test of the emergency generator battery backup light was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/11/15 at 12:35 p.m.</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 month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generator was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following</p>	K 0144	<p>1.) What corrective action will be done by facility? Upon investigation by maintenance supervisor and regional maintenance consultant, it was discovered that the maintenance supervisor had the wrong formula for the percentage of load of the generator. After re-doing the figures for the load, it was discovered that the percentage was over 80% and well over the 30% minimum. See attached formula, marked exhibit A. No further corrective action required, as the generator load was in compliance at the time of the survey. 2.) How will the facility identify other residents having the potential to be affected by the deficient practice? No residents were affected by the deficient practice. 3.) What measures were put in place to ensure that</p>	12/31/2015

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	<p>methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an interview and review of the Weekly Generator Inspection sheets with the maintenance supervisor on 12/11/15 at 9:40 a.m., the Weekly Generator Inspection sheets documented a monthly load test during one of the four weekly tests. Furthermore, the monthly load test results for January, March, May, June, August, October and November of 2015 showed a percent of load of twenty eight percent, which is below the thirty percent minimum requirement. The lack of a thirty percent rated monthly load test for January, March, May, June August, October and November of 2015 was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 12/11/15 at 12:35</p>		<p>the deficient practice does not recur? Maintenance supervisor was given the correct formula by his regional maintenance consultant to test the load percentage of the generator. Formula attached as exhibit A.</p> <p>4.) How will the corrective action be monitored to ensure compliance? Maintenance supervisor will use new formula to ensure load is being tested correctly monthly and will present his findings at monthly QA meeting. Administrator will ensure compliance by auditing maintenance supervisor documentation via monthly QA process. 5.) Systemic changes will be effective by 12-31-15</p>	

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	p.m.  3.1-19(b)				