

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/08/12</p> <p>Facility Number: 000346 Provider Number: 155543 AIM Number: 100288320</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Huntington 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</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 law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 9/6/2012.</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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 38 and had a census of 31 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. The facility had three detached sheds providing facility services including storage of maintenance supplies, lawn care and miscellaneous supplies which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/14/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 resident room corridor doors closed and latched into the door frame. This deficient practice could affect the 17 residents in the back smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/08/12 at 11:12 a.m., the corridor door to resident room 8 failed to latch into the door frame. This was acknowledged by the Maintenance Director at the time of observation.</p>	K0018	<p>K018</p> <p>It is the policy of this facility to ensure that the resident room doors latch into the doorframe. <u>What corrective action will be done by the facility?</u></p> <p>The maintenance director will replace the door hardware to ensure that the door closes appropriately.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>No residents were affected by the deficient practice; however the hardware on the door will be changed so it will shut properly.</p> <p><u>What measures will be put into place to ensure this practice does not recur?</u></p> <p>The Maintenance Director will</p>	09/06/2012

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	3.1-19(b)		make weekly rounds and ensure that all resident room doors close appropriately. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Maintenance man or designee will make rounds weekly to ensure that the doors close appropriately. Any issues will be brought to the monthly QA meeting and handled accordingly. <u>Compliance date: August 30, 2012</u>		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with ventilation. This deficient practice could affect seventeen residents evacuated through the back exit door.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/08/12 at 11:10 a.m., the enclosed plastic container used for the transfilling and storage of oxygen was filled to capacity with three large containers of liquid oxygen and it was not vented to the outside. This was confirmed by the Maintenance Director at the time of observation.</p>	K0076	<p><u>K076</u> It is the policy of this facility to ensure that areas used for transferring oxygen are vented. <u>What corrective action will be done by the facility?</u> The facility will put a vent in the existing outdoor plastic storage shed to provide further ventilation. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No residents were affected by the alleged deficient practice, however a vent will be placed in the shed to provide ventilation. <u>What measures will be put into place to ensure this practice does not recur?</u> The Maintenance Director will place a vent in the storage shed to provide ventilation. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what</u></p>	09/06/2012

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	3.1-19(b)		<p><u>QA will be put into place?</u> The Maintenance man or designee will randomly check the oxygen storage building weekly to ensure that the vent is still in place.</p> <p>Any issues will be brought to the monthly QA meeting and handled accordingly. <u>Compliance date: August 30, 2012</u></p>		