

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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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: 09/10/14</p> <p>Facility Number: 000418 Provider Number: 155565 AIM Number: 100274870</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Sunset 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in resident rooms.</p>	K010000	This plan of Correction constitutes the written allegation of compliance for the compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. Hickory Creek at Sunset desires this Plan of Correction to be the facilities Allegation of Compliance. Compliance is effective 9-11-14. At this time facility is requesting a desk review with paper compliance.	

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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K010130 SS=E	<p>The facility has the capacity for 68 and had a census of 39 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached buildings for the employee lounge, maintenance, and storage which are not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire door in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having</p>	K010130	<p>K-130 It is the policy and standard of practice for this facility that this facility requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. Describe what the facility did to correct the deficient practice for</p>	09/11/2014			

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	<p>jurisdiction. This deficient practice affects staff, visitors and 10 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/10/14 at 1:30 p.m., a vertical rolling fire door protected the service window between the service kitchen and adjacent dining. A review of fire equipment inspection and testing reports with the Maintenance Director on 09/10/14 at 2:10 p.m. included a report of testing for the rolling fire door dated 04/09/13 but nothing since then. The Maintenance Director said at the time of record review, he had been told by the inspecting contractor the inspection was not required annually.</p> <p>3.1-19(b)</p>		<p>each client in the deficiency.</p> <p>It is the desire of the facility to meet the standard of practice requiring all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Safecare was at facility 9-11-14 to do inspection of rolling fire doors and no issues were found upon inspection of doors. Safecare placed the appropriate signature tag on equipment with correct date of inspection and signature of person who performed inspection.</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility has identified as being affected.</p> <p>Any issues with the fire doors closing properly has the potential to affect staff, visitors and residents in the dining area. No staff, visitors or residents were affected from any deficient practice.</p> <p>Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any inservices, but this should also include any system changes you have made.</p> <p>Maintenance immediately contacted Safecare and they were at the facility 9-11-14 to do annual inspection of rolling fire doors. Safecare has facility set up on annual schedule.</p>	

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K010147	NFPA 101		<p>Safecare placed the appropriate signature tag on equipment with correct date of inspection and signature of person who performed inspection. Maintenance Director will review results of annual inspection with at life safety and QA meetings verifying tag on equipment for proper date/initial and completed on annual basis. Further action if needed will be taken at the direction of the QA Committee.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place.</p> <p>Maintenance Director will monitor inspection dates with tracking log. Safecare placed the appropriate signature tag on equipment with correct date of inspection and signature of person who performed inspection. Maintenance Director will review results of annual inspection with at life safety and QA meetings verifying tag on equipment for proper date/initial and completed on annual basis. Further action if needed will be taken at the direction of the QA Committee.</p> <p>By what date will the systematic changes be completed.</p> <p>Systematic changes were completed 9-11-14 and facility back in compliance</p>	

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SS=B	<p>LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents in the east wing at the nurses station.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/10/14 at 11:30 a.m., two power strip extension cords were piggy backed to supply power to the fax machine at the east nurses' station. The maintenance director said at the time of observation, he was unaware the fax machine had been powered this way.</p> <p>3.1-19(b)</p>	K010147	<p>K-147</p> <p>It is the policy and standard of practice for this facility that this facility require that unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure.</p> <p>Describe what the facility did to correct the deficient practice for each client in the deficiency.</p> <p>It is the desire of the facility to meet the standard of practice requiring that unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. Maintenance Director immediately removed the "piggy backed" power strip from the nurses station. Fax machine is no longer being used at East wing nurses station.</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility has identified as being affected.</p> <p>Any improper wiring of a structure in the east wing nurses station has the potential to affect staff, visitors and residents in the area around the east wing nurses station. No staff, visitors or residents were affected from any deficient practice.</p>	09/11/2014			

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			<p>Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any inservices, but this should also include any system changes you have made.</p> <p>Maintenance Director has added Power Cord Strips to his weekly checklist and also added to the monthly Environmental Safety Checklist. Maintenance Director will review results of annual inspection with at life safety and QA meetings verifying tag on equipment for proper date/initial and completed on annual basis. Further action if needed will be taken at the direction of the QA Committee.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place.</p> <p>Maintenance Director will monitor usage of power strips using daily checklist and monthly environmental safety checklist. Maintenance Director will review results of annual inspection with at life safety and QA meetings verifying tag on equipment for proper date/initial and completed on annual basis. Further action if needed will be taken at the direction of the QA Committee.</p> <p>By what date will the systematic changes be completed.</p> <p>Systematic changes were completed</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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