

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155419	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2015
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/09/15</p> <p>Facility Number: 000533 Provider Number: 155419 AIM Number: 100267230</p> <p>At this Life Safety Code survey, Hickory Creek at Crawfordsville 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 (000) 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. Resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 36 and had a census of 33 at the time</p>	K 0000	<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 Crawfordsville desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective January 8, 2016.</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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K 0038 SS=E Bldg. 01	<p>of this survey.</p> <p>All areas within the facility where residents have customary access were sprinklered. A detached shelter was unsprinklered. All areas providing facility services were sprinklered except three detached buildings used for oxygen storage, maintenance, and miscellaneous equipment storage.</p> <p>Quality Review completed on 12/14/15 by Lex Brashear, LSC Specialist</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit doors was readily accessible at all times. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient</p>	K 0038	<p>K038 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The exit door by resident room #11 was reprogrammed to have 5 second delay to allow the door to have longer access. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. The Environmental Manager will</p>	01/08/2016
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K 0044 SS=E Bldg. 01	<p>practice could affect 17 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/09/15 at 12:30 p.m., the Administrator timed and confirmed that once the code for the magnetic locking device was entered, the magnetic lock at the exit door near resident room 11 released for only two seconds before reengaging and locking the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was properly maintained. NFPA 80, Section 15-2.5.4 requires when holes are left in a door or frame due to changes or removal of hardware or plant-ons, the holes shall be repaired by the following methods: install steel fasteners that adequately fill the holes or fill the screw or bolt holes with the same material as the door or frame. This deficient practice could affect all residents in both smoke compartments.</p> <p>Findings include:</p>	K 0044	<p><i>check the exit doors during daily rounds to assure the doors lock after 5 seconds, 3 times a week for a month, then once a week during daily rounds. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will report findings during monthly QA meeting for compliance.</i></p> <p>K044 Describe what the facility did to correct the deficient practice for each resident in the deficiency. The penetration in the fire door has been repaired 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. The Environmental Manager will check the doors throughout the facility to include fire doors for</p>	01/08/2016

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K 0045 SS=C Bldg. 01	<p>Based on observation with the Administrator, Administrator in Training and the Environmental Manager on 12/09/15 at 12:06 p.m., there was a small three eights inch hole in the back side of the fire door near resident room 13. The Environmental Manage acknowledged the small hole in the fire door at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to provide continuous illumination for 3 of 3 exit discharges. LSC Sections 7.8 requires continuous illumination during the time the conditions of occupancy require the means of egress be available for use. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations and interview on 12/09/14 at 12:36 p.m., the Administrator, Administrator in Training</p>	K 0045	<p><i>openings or penetrations weekly for 1 month and monthly thereafter. Any holes or other evidence of penetration will be repaired as quickly as possible.</i></p> <p>4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will monitor the condition of doors and report findings during monthly QA meeting for compliance.</p> <p>K045 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. It was confirmed that the emergency exterior egress lighting receives power from the emergency generator in the event of a power outage. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make</p>	01/08/2016			

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K 0046 SS=C Bldg. 01	<p>and the Environmental Manager were unable to confirm the emergency exterior egress lights would receive power from the emergency generator in the event of a power outage.</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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting fixtures at the emergency generator would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect all occupants in the event of emergency generator failed to operate.</p> <p>Findings include:</p> <p>Based on observation with Administrator,</p>	K 0046	<p>to ensure that the deficient practice does not recur. When the Environmental Manager runs the monthly load test, documentation will be completed to assure the emergency exterior egress lights are in working order.</p> <p>4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will confirm all emergency exterior egress lights are in working order and if not, they will be repaired immediately. He will report findings during the monthly QA meeting for compliance.</p> <p>K046 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The battery was replaced in the battery powered emergency lighting fixture at the emergency generator. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the</p>	01/08/2016	

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K 0047 SS=E Bldg. 01	<p>Administrator in Training and the Environmental Manager on 12/09/15 at 12:13 p.m., the battery operated emergency light at the emergency generator failed to illuminate when tested. The Environmental Manager acknowledged the battery powered light failed to illuminate after he pressed the test button.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 exit signs near resident room 14 lead to an exit door. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect any of residents who might choose to evacuate through the center corridor. Findings include: Based on an observation with the</p>			K 0047	<p>deficient practice does not recur. The Environmental Manager will test the function of the battery operated emergency light weekly and test the volts on the battery quarterly and replace as needed. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will confirm the battery operated emergency light at the generator is in working order and if not will be repaired immediately and report findings during the monthly QA meeting for compliance.</p> <p>K047 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The Environmental Manager removed the arrow on the exit sign near resident room #14. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient</p>		01/08/2016

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K 0050 SS=F Bldg. 01	<p>Administrator, Administrator in Training and the Environmental Manager on 12/09/15 at 11:56 a.m., the direction arrow for the exit sign near resident room 14 indicated the path of egress must continue through the center corridor. Based on an interview with the Environmental Manager at the time of observation, the center corridor measured forty four inches in clear width and had two medication carts stored in the corridor. Based on an interview with the Administrator at the time of observation, the center corridor is not used as a path of egress in an emergency situation.</p> <p>3.1-19(b)</p> <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 1 of the last 4 completed quarters and fire drills for 4 of the last 4 quarters included the verification of transmission</p>	K 0050	<p>practice does not recur. The Environmental Manager will check all exit signs for proper direction during monthly rounds.</p> <p>4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will report any issues during the monthly QA meeting for compliance.</p> <p>K050 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The Environmental Manager was re-educated on proper fire drill scheduling to ensure quarterly fire</p>	01/08/2016			

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	<p>of the fire alarm signal to the monitoring station and fire simulation. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and record review of the "Monthly Fire Drill Reports" on 12/09/15 from 10:25 a.m. to 11:35 a.m., the Administrator, Administrator in Training and the Environmental Manager confirmed a fire drill was not conducted on the third shift for the second quarter of 2015. Additionally, the documentation for all fire drills performed for the past twelve months lacked verification of the transmission of the signal to the fire alarm system monitoring company. Based on interview at the time of record review, the Environmental Manager acknowledged a third shift fire drill was not conducted in the second quarter of 2015 and the transmission of the fire alarm signal to the monitoring station was not documented.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p><i>drills on each shift, to call monitoring station to verify that the alarm transmitted, and to record outcome on fire drill record. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. Prior to scheduling a fire drill the Environmental Manager will check his records from the month before and communicate with the administrator to assure the timeliness of the fire drills. The fire drill record has been revised to include the date, time, and response of the signal to monitoring station. The documentation will be placed on the Fire Drill Review form monthly for 3 months and continue thereafter. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will report any issues during the monthly QA meeting for compliance.</i></p>				

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K 0062 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 electrical room sprinkler heads was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 16 residents near the electrical room.</p> <p>Findings include:</p> <p>Based on observation on 12/09/15 at 12:18 p.m. with the Environmental Manager, the spray pattern for the sprinkler head in the electrical room was obstructed by a four inch conduit located near the ceiling and adjacent to the sprinkler head. This was acknowledged by the Environmental Manager at the time of observation.</p> <p>3.1-19(b)</p>	K 0062	<p>K062 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The sprinkler head in the electrical room was changed to redirect the spray pattern so there would not be any obstructions. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. The Environmental Manager will check all sprinkler heads weekly for 4 weeks, monthly for 3 months and quarterly thereafter. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will report any issues during the monthly QA meeting for compliance.</p>	01/08/2016			

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K 0144 SS=F Bldg. 01	<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 maintain a complete written record of monthly generator load testing for 2 of the last 12 months and provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection,</p>	K 0144	<p>K144 1. Describe what the facility did to correct the deficient practice for each resident in the deficiency. The Environmental Manager was re-educated on monthly documentation of the generator load test, to document the time of the transfer of power from the main source to the generator and to document the voltage. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents could have been affected although no residents were affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. The Environmental Manager will bring the weekly generator inspection sheet to the administrator to be reviewed and initialed to assure the time of the transfer of power from the main source to the generator and that the voltage is documented. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will</p>	01/08/2016

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K 0147 SS=D Bldg. 01	<p>performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log titled "Weekly Generator Inspection Sheet" with the Administrator, Administrator in Training and the Environmental Manager on 12/09/15 from 11:01 a.m. to 11:09 a.m., documentation of a generator load test for January and March 2015 were not available for review. Based on an interview with the Environmental Manager at the time of record review, no other documentation was available for review. Additionally, the Environmental Manager acknowledged the generator log did not include the time for the transfer of power from the main source to the generator and the voltage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the</p>	K 0147	<i>report any issues during the monthly QA meeting for compliance.</i>	01/08/2016			

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	<p>facility failed to ensure the receptacles in 1 of 1 medication rooms were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff with access to the medication room.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Environmental Manager on 12/09/15 at 12:00 p.m., there were two lights mounted underneath the cabinets above the head sink in the medication room. Each light had a built in electrical receptacle. Based on an interview with the Administrator the electrical receptacle measured sixteen inches from the hand sink. When tested with a GFCI testing device, the</p>		<p>facility did to correct the deficient practice for each resident in the deficiency. The Environmental Manager removed the 2 lights that were mounted underneath the cabinets above the hand sink in the medication room. 2. Describe how the facility reviewed all residents in the facility that could be affected by the same deficient practice. All residents or staff could have been affected although no one was affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur. The Environmental Manager will inspect electrical receptacles that are 16 inches from the hand sink to determine if a GFCI protection is needed, weekly for 4 weeks, monthly for 3 months and quarterly thereafter. 4. Describe how the corrective action will be monitored to ensure the deficient practice will not recur. The Environmental Manager will report any issues during the monthly QA meeting for compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155419	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2015
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	Administrator confirmed the receptacles lacked GFCI protection. 3.1-19(b)				