

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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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: 06/27/16</p> <p>Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770</p> <p>At this Life Safety Code survey, Hickory Creek at Rochester 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 33 at</p>	K 0000		
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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 0021 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services which were not sprinklered. One building was used for miscellaneous storage and the other was used for oxygen storage and transfilling.</p> <p>Quality Review completed on 07/08/16-DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p>			
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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen corridor doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system.. This deficient practice could affect at least 10 residents in the dining room area, and residents in the corridor near the kitchen area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/27/2016 at 11:34 a.m., a plastic bag containing mop heads was laying on the floor within the self-closing doorway to the kitchen. While testing the door, the bag prevented the door from closing. The Maintenance Director acknowledged and removed the bag.</p> <p>3.1-19(b)</p>	K 0021	<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.</p> <p>Hickory Creek at Rochester respectively requests that this Plan of Correction be accepted and considered for paper compliance.</p> <p>Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 07/26/2016</p> <p>K021. It is the policy of this facility to comply with NFPA 101 Life Safety Code Standard regarding proper closing of the kitchen corridor door.</p>	06/27/2016

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			<p><u>What corrective action will bedone by the facility?</u> On 06/27/2016, the Maintenance staff immediatelyremoved bag of mop heads. Maintenance staff will monitor daily during walk throughto ensure door closing is not obstructed.</p> <p><u>How will the facility identifyother residents having the potential to be affected by the same practice andwhat corrective action will be taken?</u> No residents were found to beaffected by this condition. All doorways have been inspected and there werenone identified as having items obstructing closure.</p> <p><u>What measures will be put intoplace to ensure that this practice does not recur?</u> Maintenance educated dietarystaff on practice of mop head storage. Maintenance/designeewill monitor daily during walkthroughs.</p>	

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K 0025 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 2 smoke barrier	K 0025	<p><u>How will corrective action be monitored?</u></p> <p>- Maintenance/designee will monitor daily during walkthroughs. Results of the Environmental inspections will be reviewed at the monthly QA&A committee meeting for 6 months or until 100% compliance is attained.</p> <p>Maintenance manager will report his findings to the QAA Committee at its monthly meeting.</p> <p>-</p> <p><u>Date of compliance: 06/27/2016</u></p> <p>-</p> <p>K025. It is the policy of this facility to comply with NFPA 101 Life Safety Code Standard</p>	07/25/2016
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	<p>walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect both smoke compartments and therefore all residents and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/27/2016 at 12:40 p.m., the smoke barrier wall above the ceiling tiles outside resident room # 14 had several filled penetrations. When asked what was used to seal these penetrations, the Maintenance Director could not provide any documentation for the materials used, but stated expandable foam was used.</p> <p>3.1-19(b)</p>		<p>regarding documentation of material used on smoke barriers.</p> <p><u>What corrective action will be done by the facility?</u> The Maintenance staff removed older material, replaced with material used throughout facility that meets current standards and has appropriated documentation.</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> No residents were found to be affected by this condition. All smoke barriers have been inspected and verified all documentation.</p> <p><u>What measures will be put in place to ensure that this practice does not recur?</u> Foam used was from several years prior. Maintenance currently uses only material that meets current standards and</p>	

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K 0045 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 Based on observation and interview, the facility failed to provide continuous emergency lighting at 1 of 3 emergency exits. This deficient practice could affect	K 0045	has appropriate documentation. <u>How will corrective action be monitored?</u> Maintenance/designee will monitor all fire rating paper work. Results of the Environmental inspections will be reviewed at the monthly QA&A committee meeting for 6 months or until 100% compliance is attained. Maintenance manager will report his findings to the QAA Committee at its monthly meeting. - <u>Date of compliance: 07/25/16/2016</u> - K045. It is the policy of this facility to comply with NFPA 101 Life Safety Code Standard regarding exit	06/27/2016	

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	<p>at least 10 residents in the main dining room and occupants evacuating through the main entrance to this facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/27/16 at 11:30 a.m., the light switch near the main entrance doors was covered with a note reading do not turn off. When asked why the switch could not be turned off, the Maintenance Director replied that it would turn off the emergency lighting in the canopy area.</p> <p>3.1-19(b)</p>		<p>illumination.</p> <p><u>What corrective action will bedone by the facility?</u> On 06/27/2016,the Maintenance staff immediately removed the switch and wired exit lightinginto the emergency power source.</p> <p><u>How will the facility identifyother residents having the potential to be affected by the same practice andwhat corrective action will be taken?</u> No residents were found to beaffected by this condition. All exit illumination lights were inspected nonewere identified on switches.</p> <p><u>What measures will be put intoplace to ensure that this practice does not recur?</u> All emergency lighting updates for exit lightingwill by monitored by maintenance staff to assure all are connected to emergencypower source.</p> <p><u>How will corrective action</u></p>		

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K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.		<u>bemonitored?</u> - Maintenance/designee will monitor daily during walkthroughs that all exit lights are working and are one emergency power source. Results of the Environmental inspections will be reviewed at the monthly QA&A committee meeting for 6 months and until 100% compliance is attained. Maintenance manager will report his findings to the QAA Committee at its monthly meeting. - <u>Date of compliance: 06/27/2016</u>		

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	<p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview the facility failed to properly maintain 1 of 1 staff smoking area. This deficient practice could affect up to 8 residents and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/27/2016, the staff smoking area had at least 15 cigarette butts laying on the ground. These were acknowledged by the Maintenance Director at the aforementioned time.</p> <p>3.1-19(b)</p>	K 0066	<p>K066. It is the policy of this facility to comply with NFPA 101 Life Safety Code Standard regarding maintenance of smoking area.</p> <p><u>What corrective action will be done by the facility?</u> On 06/27/2016, Housekeeping immediately picked up cigarette butts and placed into proper cigarette disposal container. Administrator spoke to staff concerning proper placement of cigarette butts. Maintenance/designee staff will monitor daily during walk through to ensure cigarette butts are placed in proper container.</p> <p><u>How will the facility identify other residents having the potential to be affected by the same practice and what</u></p>	06/27/2016

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K 0072	NFPA 101		<p><u>corrective action will be taken?</u> No residents were found to beaffected by this condition.</p> <p><u>What measures will be put intoplace to ensure that this practice does not recur?</u></p> <p>Maintenance/designee willmonitor daily during walkthroughs.</p> <p><u>How will corrective action bemonitored?</u></p> <p>- Maintenance/designee willmonitor daily during walkthroughs. Results of the Environmentalinspections will be reviewed at the monthly QA&A committee meeting for 6months or until 100%, compliance is attained.</p> <p>Maintenancemanager will report his findings to the QAA Committee at its monthly meeting.</p> <p>-</p> <p><u>Date ofcompliance: 06/27/2016</u></p>	

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to maintain 4 of 4 corridors were free of obstructions. This deficient practice could affect all occupants within the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/27/2016 at 12:30 p.m., there was furniture placed in every corridor. Based on interview at the time of observation, the Maintenance Director confirmed the furniture stayed where it was found in the corridor.</p> <p>3.1-19(b)</p>	K 0072	<p>K072. It is the policy of this facility to comply with NFPA 101 Life Safety Code Standard regarding Corridor obstructions.</p> <p><u>What corrective action will be done by the facility?</u> On 07/01/2016, the Maintenance staff attached all moveable furniture to facility inner walls as per new Life Safety guidelines. Maintenance staff will monitor five days a week during walk through to ensure all furniture remains attached to inner walls.</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> No residents were found to</p>	07/01/2016

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K 0076 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.		<p>beaffected by this condition.</p> <p><u>What measures will be put intoplace to ensure that this practice does not recur?</u> Maintenance/designee willinspect five days per week all furniture to ensure furniture remains attached.</p> <p><u>How will corrective action bemonitored?</u> - Maintenance/designee willmonitor five days per week during walkthroughs. Results of the Environmentalinspections will be reviewed at the monthly QA&A committee meeting for 6months and until 100%, compliance is attained.</p> <p>Maintenancemanager will report his findings to the QAA Committee at its monthly</p> <p><u>Date ofcompliance: 07/01/2016</u></p> <p>-</p>	

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	<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. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen were provided with natural ventilation. NFPA 99, 1999 Edition Section 8-3.1.11.1 states storage of nonflammable gases greater than 3000 cubic feet shall comply with 4-3.1.1.2. Section 4-3.1.1.2 (b)4 states if natural venting is used, the vent opening or openings shall be a minimum of 72 inches squared in total free area. This deficient practice could affect at least 9 resident evacuated through the back exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/27/16 at 12:06 p.m., the oxygen transfilling/storage plastic shed containing at least three large liquid oxygen cylinders was not vented to the outside. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0076	<p>K076. It is the policy of this facility to comply with NFPA 101 Life Safety Code for Medical gas storage.</p> <p><u>What corrective action will be done by the facility?</u> Maintenance staff will place a vent in the Oxygen storage shed to maintain proper ventilation. All combustibles were promptly removed from shed.</p> <p>-</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> No residents were found to be affected by this condition.</p> <p><u>What measures will be put in place to ensure that this practice does not recur?</u></p>	07/26/2016

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K 0144 SS=F Bldg. 01	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was proper maintained. NFPA 99, 1999 Edition Section 8-3.1.11.1 states combustible material must be stored a minimum distance of 20 feet from the oxygen transfilling area. This deficiencies practice could affect at least 9 residents evacuated through the back exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/27/16 at 12:05 p.m., there were four cardboard boxes containing floor buffer head stored in the plastic shed used for oxygen transfilling. The Maintenance Director confirmed and removed the cardboard boxes from the plastic shed at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and</p>		<p>Maintenance/designee will monitor Oxygen shed during daily walkthroughs for compliance on an ongoing basis.</p> <p><u>How will corrective action be monitored?</u></p> <p>- Maintenance/designee will monitor Oxygen shed during daily walkthroughs for compliance on an ongoing basis. Results of the Environmental inspections will be reviewed at the monthly QA&A committee meeting for 6 months and until 100% compliance is attained.</p> <p>Maintenance manager will report findings to the QAAC committee at its monthly meeting.</p> <p>-</p> <p><u>Date of compliance: 07/26/2016</u></p> <p>-</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/27/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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	<p>NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to conduct a for monthly load test on 1 of 1 replacement emergency generators. 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. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, 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, the facility failed to provide monthly load test documentation on the replacement emergency generator for the months of February and March of 2016. Based on</p>	K 0144	<p>K144. It is the policy of this facility to comply with NFPA 101 Life Safety Code generator inspections.</p> <p><u>What corrective action will be done by the facility?</u> Maintenance staff was instructed on timeliness of inspections of rental and permanent generators.</p> <p>-</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> No residents were found to be affected by this condition.</p> <p><u>What measures will be put in place to ensure that this practice does not recur?</u> Maintenance staff was instructed on providing documentation of inspections on rentals and permanent generators. Administrator/designee</p>	07/01/2016

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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	<p>an interview with the Maintenance Supervisor at the time of record review, he was unaware of the requirement to perform monthly inspections on the temporary emergency generator.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected on a weekly basis. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b) 1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log with the Maintenance Director on 06/27/2016 at 10:45 a.m., the facility was unable to provide weekly inspections for the weeks between 2/3/16 and 3/16/16. Based on an interview with the</p>		<p>will monitor for completion on an ongoing basis.</p> <p><u>How will corrective action be monitored?</u></p> <p>- Administrator/designee will monitor for completion weekly for 8 weeks and thereafter until 100%, compliance is met. Results of the Environmental inspections will be reviewed at the monthly QA&A committee meeting for 6 months and until 100%, compliance is attained.</p> <p>Administrator/designee will report findings to the QA Committee at its monthly meeting.</p> <p>-</p> <p><u>Date of compliance: 07/01/2016</u></p> <p>-</p> <p>-</p> <p>-</p>	

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	Maintenance Director at the time of record review, he was unaware of the requirement to perform weekly inspections on the temporary emergency generator. 3.1-19(b)			