

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/06/2014
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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: 02/06/14</p> <p>Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Winamac 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 facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke</p>	K010000	<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 laws. Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on 02/28/2014</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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	<p>detectors were located in resident rooms. The facility has a capacity of 36 and had a census of 29 residents at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached unsprinklered sheds for maintenance and general storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/10/14.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K010021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure one door in 2 of 2 smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/06/14 between 12:15 p.m. and 3:15 p.m., one door in each of the two smoke barrier double door sets failed to close when tested twice manually to ensure their proper operation. The door coordinators on each door frame held the door with the astragal open, the second door closed and the coordinator failed to release the</p>	K010021	<p>- whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; While all residents have thepotential to be affected, no residents were affected. Maintenance has ordered replacement closures foreach of the doors. Upon arrival thesecurrent closures will installed - howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; Both doors were affected andclosures will be replaced as soon as they arrive.</p> <p>- whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; Maintenance will install theclosures properly and will check for accuracy on a</p>	02/28/2014

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	<p>first door leaving a six inch gap. The maintenance director acknowledged at the time of observations, the coordinators were malfunctioning.</p> <p>3.1-19(b)</p>		<p>weekly basis. - howthe corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;and Maintenance will monitor closuresto ensure they are properly working weekly for 1 month then monthly . Regional Maintenance will test for compliancerandomly on visits. - bywhat date the systemic changes will be completed.02/28/2014</p>		