

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
--	---

(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
--------------------	--	---------------	---	----------------------

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: 09/16/14</p> <p>Facility Number: 000118 Provider Number: 155211 AIM Number: 100290470</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Lebanon 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 (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. Battery powered smoke detectors are located in resident rooms.</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 law. Hickory Creek at Lebanon desires this Plan of Correction to be considered the facility's Allegation of Compliance effective on 10/08/2014.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON				STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052			
(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			
K010018 SS=E	<p>The facility has the capacity for 64 residents and had a census of 28; the 200 and 100 halls were unoccupied at the time of this survey.</p> <p>The detached smoke hut where residents have customary access and a detached garage and shed housing the generator and fire pump were unsprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <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 1¼ 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. Based on observation and interview, the facility failed to ensure doors protecting</p>	K010018	<p>K018 1.Describewhat the facility did</p>	10/08/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
	<p>corridor openings in 1 of 5 smoke compartments would latch tightly into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the 100 hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/16/14 at 1:15 p.m., the door protecting the corridor opening between the scale room and 200 hall was tested twice to ensure the door would latch into the door frame. Each time the door was closed it could be opened by pushing on the door without turning the door knob. The maintenance director acknowledged at the time of observation, the door latch did not hold the door tightly in the door frame.</p> <p>3.1-19(b)</p>		<p>to correct the deficient practice for each client cited in the deficiency.</p> <p><i>It is the policy of this facility to have doors protecting corridor openings that have no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. A new door latch was installed on door frame and tested to ensure it closes correctly.</i></p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p><i>All residents had the potential to be affected. All doors have been checked and all of them latch correctly.</i></p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p><i>All staff to be in service by 10/08/2014 to complete a "Maintenance Request" form any time a door is found not to latch as it should when closed. Maintenance Director has a "Monthly Facility Door Inspection" form (Attachment #1) that will be completed monthly after checking all doors to ensure doors latch</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 openings in	K010025	<i>appropriately. The Maintenance Director will report immediately to the Administrator any doors that are not latching and repairs completed to correct each one.</i> 1. Describe how the 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. <i>The Maintenance Director will report the results of his door inspections to the QAA committee at the monthly meeting for three (3) months - the committee may decide to stop the reporting of the Monthly Door inspection once 100% compliance has been achieved at the end of that time. The monthly door inspections and use of the Monthly Facility Door Inspection Form will continue on an ongoing basis.</i>	09/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON				STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052			
(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			
	<p>a smoke partition, such as a wall, was sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke . This deficient practice could affect visitors, staff and 10 or more residents accessing the dining room via the 200 hall corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/16/14 at 12:35 p.m., a two inch diameter hole was cut out of the wall in the 200 hall emergency exit corridor to allow the passage of wiring. The hole was unsealed. The maintenance director said at the time of observation, the contractors had failed to seal the opening during remodeling of the area.</p> <p>3.1-19(b)</p>		<p>to correct the deficient practice for each client cited in the deficiency.</p> <p><i>It is the policy of this facility to have smoke barriers to provide at least a onehalf hour fire resistance rating. This particular area of the hallway was undergoing renovations. Once the contractors had finished sanding and painting in that area, the light that attached to the wiring was reattached.</i></p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p><i>All residents had the potential to be affected. The light was reattached to the wall on 9/16/2014 thereby sealing the hole.</i></p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p><i>The Maintenance Director will work with contractor and follow up to ensure any holes are taken care of ASAP. Residents are kept safe during the remodeling process. The Maintenance Director will also do daily inspections with the contractors to ensure the remodeling area is</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
K010046 SS=D	<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 fixture in the laundry would operate during a power outage. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects 3 or more visitors and staff in the laundry.</p> <p>Findings include:</p>	K010046	<p><i>safe and secure.</i></p> <p>1. Describe how the 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.</p> <p><i>The Maintenance Director will report any findings of daily inspections with the contractors to the QAA committee at the monthly meeting for three (3) months -the committee may decide to stop the reporting of the daily inspections with the contractors once 100% compliance has been achieved at the end of that time. The daily inspections with the contractors will continue until renovations are completed.</i></p> <p>K046</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p><i>It is the policy of this facility to provide Emergency lighting of at least 1 ½ hour duration. The Emergency light in the laundry room was replaced on 10/02/2014.</i></p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and</p>	10/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
	<p>Based on observation with the maintenance director on 09/16/14 at 12:45 p.m., the emergency lighting provided for the laundry was plugged into a receptacle and had a rechargeable battery pack designed to power the lighting in the event of a power failure. The fixture was tested for operation using the test button and illuminated the area. However, when the plug was pulled out of the receptacle powering the device to simulate a power failure, the emergency lighting failed to operate. The maintenance director said at the time of observation, he did not know the light was not working when the fixture relied on the battery to operate.</p> <p>3.1-19 (b)</p>		<p>state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. <i>All residents had the potential to be affected. A new emergency light was purchased and installed on 10/02/2014.</i></p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. <i>The Maintenance Director had tested the light on 8/21/14 and it was working properly when the test button was pushed. During this inspection, the light worked when the button was pushed, but when unplugged the light would not work. The Maintenance Director will complete the "Monthly Emergency Light Inspection" (Attachment 2) form and test the Emergency lights both plugged in and unplugged to ensure working properly. The Maintenance Director will bring the completed emergency light inspection form to the Administrator for review and discussion as needed for identified issues. All identified issues will be corrected at that time.</i></p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON	STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052
--	---

(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
K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in</p>	K010051	<p>into place. <i>The Maintenance Director will report any findings of the monthly inspections of the emergency light to the QAA committee at the monthly meeting for three (3) months - the committee may decide to stop the reporting of the monthly inspections once 100% compliance has been achieved at the end of that time. The Monthly Emergency Light Inspections will continue on an ongoing basis.</i></p> <p>K051 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. <i>It is the policy of this facility to</i></p>	09/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON				STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052			
(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			
	<p>an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/16/14 at 2:10 p.m., the fire alarm control panel (FACP) was located behind the 200 hall nurses' station which was not in use. The FACP served as the only annunciator for any visual or audible trouble alarm. The closest occupied nurses' station was behind two smoke barrier door sets at the 100 hall nurses' station. The maintenance director said at the time of observation, he thought staff would hear and respond to a FACP trouble alarm annunciated from the 200 hall nurses' station. The FACP was arranged to activate a trouble alarm. The trouble alarm could not be heard at the 100 hall nurses' station which is monitored 24 hours per day. The maintenance director agreed at the time of observation, there was no reaction by 100 hall staff after the trouble alarm was activated for five minutes.</p> <p>3.1-19(b)</p>		<p><i>have a fire alarm system with approved components, devices or equipment installed. Due to renovations, the location of the fire alarm panel was closed. An annunciator was installed on 9/29/14 (Attachment #3) at the 100 hall nurses station to ensure proper response if fire panel were to alarm.</i></p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. <i>All residents had the potential to be affected. An annunciator wired to the fire panel was installed on the 100 hall nurses station to ensure proper response if fire panel were to alarm.</i></p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. <i>The Maintenance Director will ensure the fire alarm system and annunciator work properly during monthly inspections.</i></p> <p>1. Describe how the 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. <i>The Maintenance Director will</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
K010062 SS=F	<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, the facility failed to ensure 1 of 1 sprinkler head providing protection for the fire alarm control panel was maintained. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/16/14 at 12:40 p.m., the sprinkler head protecting the fire alarm control panel had no escutcheon, leaving a 1/4 inch gap into the attic above. The maintenance director acknowledged at the time of observation, the escutcheon had not be replaced after the 200 hall nurses' station</p>	K010062	<p><i>report any findings of the monthly inspections of the fire alarm system and annunciator to the QAA committee at the monthly meeting for three (3) months - the committee may decide to stop the reporting of the monthly inspections once 100% compliance has been achieved at the end of that time. The Monthly Fire Alarm System inspections will continue on an ongoing basis.</i></p> <p>K062 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. <i>It is the policy of this facility to have an automatic sprinkler system that is continuously maintained in reliable operating condition and are inspected and tested periodically. The missing escutcheon was replaced on 09/16/2014.</i> 1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. <i>All residents had the potential to</i></p>	09/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155211	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT LEBANON			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 PERRY WORTH RD LEBANON, IN 46052		
(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	
	was remodeled. 3.1-19(b)		<p><i>be affected. The escutcheon was replaced on 9/16/2014.</i></p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. <i>The Maintenance Director will work with contractor and follow up to ensure anyholes are taken care of ASAP. Residents are kept safe during the remodeling process. The Maintenance Director will also do daily inspections with the contractors to ensure the remodeling area is safe and secure.</i></p> <p>1. Describe how the 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. <i>The Maintenance Director will report any findings of daily inspections with the contractors to the QAA committee at the monthly meeting for three (3) months -the committee may decide to stop the reporting of the daily inspections with the contractors once 100% compliance has been achieved at the end of that time. The daily inspections with the contractors will continue until renovations are completed.</i></p>		