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| 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 12/09/2013 |
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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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| K010000 | <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: 12/09/13</p> <p>Facility Number: 000533 Provider Number: 155419 AIM Number: 100267230</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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 hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms were equipped with 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 law.</p> <p>Hickory Creek at Crawfordsville desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective December 27, 2013.</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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| | <p>detectors. The facility has the capacity for 36 and had a census of 35 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached buildings for oxygen storage, maintenance, and miscellaneous equipment storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/16/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | |

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| K010038 SS=F | <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>1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 locked egress doors was readily accessible for for all residents, staff and visitors. LSC 7.2.1.5.1, requires doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. LSC 19.2.2.2.4 requires doors required within a means of egress shall not be equipped with a lock that requires the use of a tool or key from the egress side. Exception No. 1: Door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect all occupants.</p> <p>Findings include:</p> | K010038 | | 12/27/2013 | | | |
| | | | K038 | | | | |

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| | <p>Based on observation and interview with the maintenance director on 12/09/13 between 12:00 p.m. and 2:45 p.m., the east, west and north emergency exits from the facility were equipped with magnetic locks which unlocked automatically upon activation of the fire alarm. Otherwise, the doors required a code entered into a keypad adjacent to the exit door to override the magnetic locks securing the doors. The exit doors had no signage posted and the means to override the door locks was not obvious. The interim administrator confirmed on 12/09/13 at 3:00 p.m., many of the residents were alert and oriented without the need for specialized security measures for their safety.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 3 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. This deficient practice could affect occupants using the east and west emergency exits.</p> | | <p>It is the</p> <p>policy of this facility to have exit access arranged so that exits are readily</p> <p>accessible at all times in accordance with section 7.1.19.2.1</p> | |

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| | <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/09/13 between 12:00 p.m. and 2:45 p.m., the exit discharges for the east and west exits to the public way were covered with a layer of ice. The maintenance director acknowledged at the time of observations, the slippery surface had to be cleared.</p> <p>3.1-19(b)</p> | | <p>What corrective action will be done by the facility?</p> <p>The codes to exit the building have been added to the</p> | | |

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| | | | <p>key code box so that anyone wanting to exit can look on the box to have the</p> <p>code to get out of the building.Immediately upon exit of the Life Safety Inspection</p> <p>Surveyor, the Environmental Services Supervisor shoveled all walks and applied</p> <p>ice melt. The snow had started to melt while the</p> <p>surveyor was in the building. Ice melt</p> | |

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| | | | has been put down earlier that morning. | |

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| | | | How will the facility identify other residents having the potential to be affected by this practice? | |

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| | | | <p>& (2) All residents have the potential to</p> <p>be affected.</p> | |

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| | | | <p>What measures will be put into place to ensure the</p> <p>practice does not recur?</p> | |

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| | | | <p>The</p> <p>Environmental Services supervisor and/or designee will check to ensure the code to the magnetic lock system is in</p> <p>place daily when doing rounds. This will</p> <p>be added to the daily check list and initialed when completedIn</p> <p>an effort to maintain clear exits and walkways in inclement weather, the act of</p> | |

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| | | | <p>clearing the sidewalks has been added to the daily checklist completed by the Environmental Services Supervisor or designee. Housekeeping staff will be in-serviced on</p> <p>de-icing sidewalks, as a cross-training measure. In-services will be completed</p> <p>by December 27, 2013</p> | | |

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| | | | <p>How will corrective action be monitored to ensure the</p> <p>practice does not recur and what QA will be put into place?</p> | |

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| | | | <p>&</p> <p>(2) During QA meetings, the Maintenance Director or designee will report on the</p> <p>results of utilizing the daily checklist as an effective tool in regards to the</p> | |

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| | | | posting of the door code as well as for removal of snow and ice, monthly times 3 months and then at a frequency based upon recommendation of the QA committee. | | |

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