

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/13/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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K0000	<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: 02/13/12</p> <p>Facility Number: 000418 Provider Number: 155565 AIM Number: 100274870</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Sunset 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 (111) construction and was fully</p>	K0000	<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. Hickor Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 3/14/2012.</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>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors are provided in resident rooms. The facility has the capacity for 68 and had a census of 46 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/17/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			
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K0018 SS=E	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 68 corridor doors were equipped with positive latches. This deficient practice affects staff, visitors and 16 or more residents in the northeast smoke compartment where the resident activities lounge is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/13/12, at 2:25 p.m., a double french door set protected the corridor opening to the resident activities lounge. The doors did not close into the door frame securely. One door was equipped</p>	K0018	<p>It is the policy of this facility to have doors equipped with positive latches in smoke compartments.</p> <p>1. What corrective action will be done? The double french doors in the resident lounge will be removed. A smoke detector that is wired into the fire alarm system will be installed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be done? There are no other doors in the facility that do not have positive latches. 3. What measures will be put into place to ensure this practice does not recur? No doors will be installed in facility that do not have positive latching. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? Any new construction or additions will be reviewed by maintenance supervisor and</p>	03/14/2012
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	with an unapproved roller latch at the top of the door. The second door had an inactive latch which required a manual operation to engage the latch into the door frame. The maintenance director acknowledged at the time of observation, the doors did not have proper positive latching devices.  3.1-19(b)		Administrator to assure no doors are installed without positive latches.		

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K0025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure an opening in a smoke partition such as a wall in 1 of 5 smoke compartments was sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient could affect visitors, staff and 19 residents in the southeast smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/13/12 at 2:35 p.m., a two inch hole was observed in the medical records office wall. The maintenance director said at the time of observation, a pipe had been removed and the hole left behind was not sealed afterward.</p>	K0025	<p>It is the policy of this facility ensure smoke compartments are sealed to limit the transfer of smoke. 1. What corrective action will be done: The two inch hole in the medical records office wall was caulked using fire rated caulk (3MFire Block FB136). 2. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The maintenance supervisor and maintenance consultant completed an inspection of all smoke compartments on 2/20/12 and no other holes in smoke compartments were identified. 3. What measures will be put into place to ensure this practice does not recur? Maintenance Supervisor was rein-serviced on need to ensure any holes in walls located in smoke compartments are sealed to limit transfer of smoke. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? Maintenance</p>	03/09/2012			

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	3.1-19(b)		Supervisor or Administrator will do random audits of smoke compartments on a monthly basis to ensure there are no holes in walls in smoke compartments that are not sealed. The results of these audits will be reviewed at the monthly QA&A Committee meeting for any further recommendations for the next quarter.	

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K0046 SS=E	<p>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 the exterior exit discharge path for 2 of 8 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 19 residents southeast smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 02/13/12 at 3:00 p.m., the exit discharge path from the southeast resident sleeping room smoke compartment consisted of a 60 foot sidewalk to the parking lot evacuation point. Emergency lighting provided by a two bulb fixture above the exit doorway could not illuminate the entire pathway. In addition, one bulb in the two bulb fixture was pointed in the opposite direction of discharge leaving a single bulb</p>	K0046	<p>It is the policy of this facility to ensure the exterior exit discharge paths is provided with emergency powered egress lighting. 1. What corrective action will be done? a) The fixture was replaced on exit discharge path from the southeast resident sleeping room smoke compartment and another motion sensor fixture was installed on southwest corner of discharge path to illuminate sidewalk. b) Motion sensor fixture was moved to corner of building outside kitchen supply room door and another motion sensor fixture was installed on southwest corner of building at the kitchen supply room door. 2. How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a) &amp; b) Maintenance Supervisor has been at facility after dark to assure all emergency egress areas are properly illuminated. 3. What measure will be put into place to ensure this practice does not recur? Maintenance supervisor was rein-serviced on need to have all emergency egress areas properly illuminated. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? Maintenance Supervisor or Administrator will check lighting</p>	03/09/2012	

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	<p>pointed in the direction of exit. The maintenance director agreed at the time of observation, insufficient lighting and the failure of the properly directed bulb could leave the path in darkness.</p> <p>b. Based on observation with the maintenance director on 02/13/12 at 3:20 p.m., the exit discharge path from the kitchen supply storeroom delivery door was illuminated by a two bulb emergency light located under the exit doorway roof overhang. The lighting did not cover the discharge path to the parking lot. The maintenance director agreed at the time of observation there was no emergency lighting for the exit discharge pathway.</p> <p>3.1-19(b)</p>		<p>after dark to assure emergency egress areas are well illuminated on a monthly basis. The results of these checks will be reviewed a the monthly QA&amp;A Committee meeting for any further recommendations for the next twelve months.</p>	

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K0048 SS=B	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility Fire Policy and Procedure on 02/13/12 at 12:10 p.m. with the maintenance director, the plan did</p>	K0048	<p>It is the policy of this facility to ensure the fire safety plan includes use of kitchen fire extinguisher. 1. What corrective action will be done? The fire policy and procedure was updated to include the use of K-class fire extinguisher located in the kitchen in relationship to use of the kitchen overhead extinguishing system. 2. How will facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All disaster manuals have been updated with the revised fire policy and procedure. 3. What measures will be put into place to ensure this practice does not recur? The fire policy and procedure will be reviewed by administrator every six months to ensure K-class fire extinguisher remains part of the plan. Staff have received a copy of revised fire policy and procedure with their pay check on 2/29/12. The revised fire policy and procedure will be reviewed at the next all staff meeting to be held on 3/6/2012. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? The fire policy and procedure will be reviewed quarterly by the QA&amp;A committee to assure the K-class fire extinguisher is addressed in the</p>	03/09/2012			

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	<p>not include the use of the K class fire extinguishers located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. The maintenance supervisor acknowledged at the time of record review, the fire extinguishers had not been included as part of the written plan.</p> <p>3.1-19(b)</p>		fire plan.	
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K0147 SS=E	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords and/or unapproved multitap adapters were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 16 residents in the northeast smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 02/13/12 at 2:40 p.m., an extension cord was used to supply power to a curling iron in the beauty shop. In addition, the curling iron was left on in the unoccupied area. The maintenance director said at the time of observation, the curling iron should not have been left on when the shop was closed and the extension cord was not approved for use.</p>	K0147	<p>It is the policy of this facility not to use unapproved extension cords or multitap adapters as a substitute for fixed wiring. 1. What corrective action will be done? a) The curling iron in the beauty shop was immediately turned off by maintenance supervisor and extension cord removed. b) On 2/14/12 the multitap adapter in room 16 was removed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a) All rooms were checked by Maintenance Supervisor on 2/14/12 for any extension cords and those found were removed. b) All rooms were checked by Maintenance Supervisor on 2/14/12 for multitap adapter and those found were removed. 3. What measures will be put into place to ensure this deficient practice does not recur? a) Beautician was rein-serviced not to use extension cord and not to leave curling iron on unattended. A locked cabinet was installed in beauty shop in order for beautician to keep all equipment stored when she is not in beauty shop. b) A letter will be sent to families explaining that no extension cords or multitap adapters may be used in resident room. This same information will</p>	03/09/2012			

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	<p>b. Based on observation with the maintenance director on 02/13/12 at 2:20 p.m., a multitap adapter was used to supply power for appliances in resident room 16 east. The maintenance director said at the time of observation, he was not aware these adapters were not approved for use.</p> <p>3.1-19(b)</p>		<p>be given to residents and/or families on admission. Staff will be informed at next staff meeting to be held on 3/6/2012 that no extension cords or multi-tap adapters are to be used in resident rooms. 4. How will the corrective action be monitored to ensure the deficient practice does not recur? Maintenance Supervisor or Administrator will complete random audits of resident rooms and beauty shop on a monthly basis to ensure no extension cords or multitap adapters are in use and curling iron not left on unattended. The results of these audits will be reviewed at the monthly QA&amp;A Committee meeting for any further recommendation for the next twelve months.</p>		