PRINTED: 08/23/2022 FORM APPROVED

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	LETED
		155442	B. W	NG		08/04	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER			MLEY STREET		
HICKOR	Y CREEK AT FRA	NKLIN			KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg		_					
		eparedness Survey was	E 00	000	The creation and submission		
		ndiana Department of Health in			this plan of correction does no		
	accordance with 42	2 CFR 483.73.			constitute an admission by thi		
					provider of any conclusion set		
	Survey Date: 08/0	Survey Date: 08/04/22			in the statement of deficiencie	es, or	
	F '11', N 1	000353			of any violation of regulation.		
	Facility Number: Provider Number:						
	AIM Number: 10						
	AIM Number: 100	0290720					
	At this Emergency	Preparedness survey, Hickory					
	1	was found not in compliance					
		reparedness Requirements for					
		licaid Participating Providers					
	and Suppliers, 42						
	and Suppliers, 12	01103.73					
	The facility has 36	certified beds. At the time of					
	the survey, the cen						
	Quality Review co	ompleted on 08/09/22					
	The requirement a	t 42 CFR, Subpart 483.73 is NOT					
	MET as evidenced	-					
E 0004	403,748(a), 416.	54(a), 418.113(a),					
SS=F	` '	15(a), 483.475(a), 483.73(a),					
Bldg		625(a), 485.68(a),					
J		920(a), 486.360(a),					
	491.12(a), 494.6						
	` ''	, Review and Update					
	Annually	·					
	,	l6.54(a), §418.113(a),					
	- , , -	60.84(a), §482.15(a),					
		3.475(a), §484.102(a),					
	§485.68(a), §485	5.625(a), §485.727(a),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§485.920(a), §486.360(a), §491.12(a),

§494.62(a).

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	 JILDING	NSTRUCTION	(X3) DATE : COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER		580 LEN	NDDRESS, CITY, STATE, ZIP COD MLEY STREET LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive errorgam that mee section. The emer program must include the following eleminary of the following eleminary ele	uirements. The [facility] ablish and maintain a mergency preparedness as the requirements of this gency preparedness ude, but not be limited to, ents: an. The [facility] must tain an emergency at that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or ap and maintain a mergency preparedness at the requirements of this an all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency at that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must tain an emergency an that must be [evaluated], and this must be [evaluated], and this must be [evaluated],				

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	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	ľ í	JILDING	ONSTRUCTION	(X3) DATE COMPL 08/04/	ETED
	FPROVIDER OR SUPPLIEI			580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET (LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	failed to maintain a plan that was review annually in accorda This deficient pract. Findings include: Based on review of Disaster Plan" docu the Administrator a Supervisor during r 12:00 p.m. on 08/0 complete emergence reviewed by the fact twelve month period. The aforementioner reviewed on 11/06/most recent twelve second copy of emedocumentation entitively at the nurse's serview on 11/06/19 recent twelve monta the time of record agreed emergency procedures have no most recent twelve. This finding was reviewed.	wiew and interview, the facility in emergency preparedness wed and updated at least since with 42 CFR 483.73(a). ice could affect all occupants. "Hickory Creek at Franklin immentation dated 11/06/19 with and the Field Maintenance record review from 9:00 a.m. to 4/22, documentation for a sy preparedness program fility within the most recent divided was not available for review. In addition, the engency preparedness program the "Disaster Plan" which is tation also had its most recent which was not within the most high period. Based on interview direview, the Administrator preparedness policies and the been reviewed within the month period. Viewed with the Administrator tenance Supervisor during the	EO	004	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: The administrator and Maintenance Director have reviewed and updated Preparedness program. Documentation has been updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All copies of the Emergency Preparedness plan have been reviewed/updated and documented. What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not recomply the program every 12 months in QAPI. The QAPI and PM cales was updated for the Executive Director/Maintenance Director review the Emergency Preparedness Program at least annually.	ents y the e e e e c to ees e to ees e to ees e to ees e to	09/03/2022

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/04/2022
	ROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0006 SS=F Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a), 483.475(a)(1)-(2), 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2), §483.73(a)(1)-(2), §483.73(a)(1)-(2), §485.625(a)(1)-(2), §485.920(a)(1)-(2), §491.12(a)(1)-(2), [(a) Emergency Pl develop and maining preparedness plan	416.54(a)(1)-(2), 418.113(a) h(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) h(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment h, §416.54(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2), h, §485.68(a)(1)-(2), h, §485.727(a)(1)-(2), h, §486.360(a)(1)-(2), h, §486.360(a)(1)-(2), h, §494.62(a)(1)-(2) han. The [facility] must tain an emergency hath must be reviewed, hast every 2 years. The plan	TAG		DATE vill be ent at I be ncy dded PI ctor
			1		ĺ

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 ${\it Facility ID:} \quad 000352$

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	OF CORRECTION	IDENTIFICATION NUMBER 155442	 UILDING	NSTRUCTION	COMPL 08/04/	ETED
	ROVIDER OR SUPPLIER		580 LEN	DDRESS, CITY, STATE, ZIP COD MLEY STREET LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(1) Be based on a facility-based and assessment, utilizing approach.* (2) Include strategemergency events assessment. * [For Hospices at Plan. The Hospice maintain an emergency every 2 years. The following: (1) Be based on a facility-based and assessment, utilizing approach. (2) Include strategemergency events assessment, incluithe consequences disasters, and other affect the hospice. *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following: (1) Be based on a facility-based and assessment, utilizing approach and updated at lead of the following: (1) Be based on a facility-based and assessment, utilizing approach and assessment, utilizing approach and assessment, utilizing approach and assessment, utilizing approach and assessment, utilizing approach.	nd include a documented, community-based risk ing an all-hazards gies for addressing identified by the risk §418.113(a):] Emergency is must develop and gency preparedness plan wed, and updated at least ing an all-hazards and include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk ing an all-hazards gies for addressing is identified by the risk ing the management of its of power failures, natural interest in an emergency in that must be reviewed, ast annually. The plan must ind include a documented, community-based risk indicude a documented, community-based risk indicude a documented, community-based risk indicude a documented, community-based risk			TE	
	(2) Include strateg	-				

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MUL' A. BUIL B. WINC	DING	STRUCTION	(X3) DATE COMPL 08/04/	ETED
	OF PROVIDER OR SUPPLIED			580 LEM	DDRESS, CITY, STATE, ZIP COD LEY STREET IN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Plan. The ICF/IID an emergency probe reviewed, and years. The plan massessment, utilizapproach, including (2) Include strategemergency event assessment. Based on record refailed to maintain a plan that was (1) be documented, facilitarisk assessment, utilizable which was reviewed month period and (addressing emergen risk assessment in a 483.73(a) (1) and 4 Survey & Certificated dated 02/01/19, the Medicaid Services the State Operation add emerging infection add emerging infection and the survey with the state of all-hazard emerging infection. Examples of EIDs Virus and others". affect all occupants Findings include: Based on review of Disaster Plan" documents of EIDs and others affect all occupants.	additional and the secondaria and include a documented, community-based risk and includes a great and interview, the facility and emergency preparedness ased on and includes a great and community-based lizing an all-hazards approach and within the most recent twelve and included strategies for the events identified by the accordance with 42 CFR and 2 CFR 483.73(a) (2). In the accordance with 42 CFR and (CMS) updated Appendix Z of a Manual to reflect changes to the definition and stated "Planning for a sapproach should also include as disease (EID) threats. Include Influenza, Ebola, Zika This deficient practice could are the side of the secondaria and the field Maintenance and the Field Maintenance.	E 000		E006 What corrective action(s) will accomplished for those reside found to have been affected by deficient practice: A Facility Risk Assessment, including strategies for address these events, was completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The Facility Risk Assessment review included events that confect all residents. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconcept to the potential to the place of the practice does not reconcept to the place of the practice does not reconcept to the place of the pl	nts y the sing e	09/03/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	r í	UILDING	NSTRUCTION	(X3) DATE : COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER			580 LEI	ADDRESS, CITY, STATE, ZIP COD MLEY STREET LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:00 p.m. on 08/04 facility-based and c assessment reviewe most recent twelve available for review assessment was date 11/06/19 which was twelve month periodisted "Infectious D threat but did not in the second copy of program documenta which is kept at the most recent review within the most recent "Disaster Plan" cop have an emergency included in the doct interview at the tim Administrator agree preparedness programs assessment docume as being conducted month period.	ommunity-based risk d by the facility within the month period was not . The aforementioned risk ed as being reviewed on s not within the most recent d. The risk assessment also isease Outbreak" as a relative clude EID threats. In addition, emergency preparedness ation entitled "Disaster Plan" nurse's station also had its on 11/06/19 which was not ent twelve month period. The y at the nurse's station did not preparedness risk assessment umentation. Based on e of record review, the			Risk Assessment will be completed every 12 months. QAPI and PM calendar was updated for the Executive Director/Maintenance Director review the Facility Risk Assessment at least annually. How the corrective action(s) we monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place: Annual review of the Facility Research was added to the TELS checklist and QAPI calendar. The Executive Direct will review the TELS documentation and QAPI cale monthly to ensure the Facility Risk Assessment is completed annually.	ill be ent at be isk	
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §483.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155442	B. W.	ING		08/04	/2022
NAME OF I	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					MLEY STREET		
HICKOR	Y CREEK AT FRAN	NKLIN		FRANK	LIN, IN 46131		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 6.360(b), §491.12(b),		TAG	DEI TOILING 1		DATE
	§494.62(b).	5.360(b), §491.12(b),					
	3404.02(b).						
	(b) Policies and p	rocedures. [Facilities] must					
	develop and imple	ement emergency					
	preparedness policies and procedures, based						
		plan set forth in paragraph					
	1 ' '	risk assessment at					
		of this section, and the an at paragraph (c) of this					
	-	,					
	section. The policies and procedures must be reviewed and updated at least every 2 years.						
	_	s at §483.73(b):] Policies					
	1	Γhe LTC facility must					
	develop and imple	G •					
	1 ' '	icies and procedures, based					
		risk assessment at					
	1 ' '	of this section, and the					
		an at paragraph (c) of this					
	-	cies and procedures must					
	be reviewed and i	updated at least annually.					
	*Additional Requir	rements for PACE and					
	ESKD Facilities.						
	*IFor PACE at §4	60.84(b):] Policies and					
		PACE organization must					
	develop and imple	_					
		icies and procedures, based					
		plan set forth in paragraph					
	1 ' '	risk assessment at					
		of this section, and the					
	communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and						
	_	gencies, including, but not					
		uipment, power, or water					

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155442	, ,	JILDING	onstruction <u>-</u>	COMPL 08/04/	ETED
	F PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	disasters likely to safety of the partic. The policies and previewed and update and procedures. develop and imple preparedness policities on the emergency (a) of this section, paragraph (a)(1) communication placetion. The policities and preparedness policities and preparedness policities and preparedness policities and preparedness policities and procedities and p	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water in, and natural disasters ine facility's geographic view and interview, the facility is update its emergency es and procedures to include ures for emerging infectious ecordance with the CMS cion memo QSO: 19-06-ALL. occedures must be reviewed annually in accordance with This deficient practice could	E 00	013	E013 What corrective action(s) will accomplished for those reside found to have been affected by deficient practice: Executive Director updated building Emergency Prepared Plan to include emerging infectious diseases (EID). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The updates to the plan to include action is action action action action action action.	nts y the ness	09/03/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442		JILDING	ONSTRUCTION	(X3) DATE : COMPL 08/04/	ETED
HICKOR	PROVIDER OR SUPPLIER Y CREEK AT FRAN	IKLIN	STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF policies and proced facility based and c assessment reviewe twelve month perio Emergency prepare also did not include copy of emergency documentation enti- kept at the nurse's s emergency prepare reviewed within the period and also did preparedness polici This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION ures based on a documented community based risk d within the most recent d was not available for review. edness policies and procedures re EID. In addition, the second preparedness program thed "Disaster Plan" which is tation also did not have its dness policies and procedures remost recent twelve month not include emergency es and procedures for EID. viewed with the Administrator enance Supervisor during the				copies le lude Pland the loce ency sure lly. vill be lient lat ll be locy lude The the locy lude The plane	(X5) COMPLETION DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LE	ADDRESS, CITY, STATE, ZIP COD IMLEY STREET KLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
E 0029 SS=F Bldg	484.102(c), 485.6. 485.727(c), 485.9. 491.12(c), 494.62 Development of C §403.748(c), §416. §441.184(c), §460. §483.73(c), §485. §485.68(c), §485. §485.920(c), §486. §494.62(c). (c) The [facility] m an emergency preplan that complies local laws and mu at least every 2 ye facilities]. Based on record reversible facilities of the develop and preparedness common with Federal, State, reviewed and update accordance with 42 practice could affect findings include: Based on review of Disaster Plan" document the Administrator at Supervisor during recomplan reviewed by the recent twelve month review. In addition emergency prepared	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 2.85(c), §485.727(c), 2.360(c), §491.12(c), 2.360(c), §491.12(c), 2.360(c), §491.12(c), 2.360(c), 2.360	E 0029	E029 What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: Executive Director updated building Emergency Prepared Plan Communication Plan. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The updates to the Communication Plan apply to a residents. What measures will be put into	ess	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CO A. BUILDING B. WING			
		B. WING STREET 580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) place or what systemic change will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance Director were educated to revite the Communication Plan in the Emergency Preparedness Plan annually. The QAPI and PM	08/04/		
	_	tenance Supervisor during the		calendar was updated for the Executive Director/Maintenand Director to review the Communication Plan at least annually. How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place: Annual review of the Emergent Preparedness Programt Communication Plan was added to the TELS checklist and QAF calendar. The Executive Direct will review the TELS documentation and QAPI calent monthly to ensure the annual review of the Communication I is completed annually.	ill be ent at l be cy ed el ctor	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. BUILDING B. WING		COM	COMPLETED 08/04/2022		
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LEI	ADDRESS, CITY, STATE, ZIP MLEY STREET (LIN, IN 46131	COD		
HICKOR' (X4) ID PREFIX TAG E 0041 SS=F Bldg	SUMMARY S (EACH DEFICIENCE REGULATORY OR 482.15(e), 483.73(e) Hospital CAH and §482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.6(e) Emergency and The [LTC facility as implement emerge systems based on forth in paragraph §482.15(e)(1), §48(e) Emergency generations	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION (e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The			SHOULD BE	(X5) COMPLETION DATE	
	the location require Care Facilities Cool Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101 and TIA 12-4), and structure is built or structure or building 482.15(e)(2), §483 Emergency general The [hospital, CAI implement the eminspection, testing requirements foun						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442 A. BUILDING B. WING		UILDING	E CONSTRUCTION G =-		COMPLETED 08/04/2022				
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
PRI) ID EFIX AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		Emergency generand LTC facilities] source to power e have a plan for ho power systems opemergency, unless *[For hospitals at § §483.73(g), and C The standards ince this section are appreference by the E Federal Register in \$52(a) and 1 CFR the material from the You may inspect a Information Resource and Reconstruction (NARA). For information Resource and Reconstruction an	S482.15(h), LTC at AHS §485.625(g):] orporated by reference in oproved for incorporation by Director of the Office of the naccordance with 5 U.S.C. part 51. You may obtain the sources listed below. A copy at the CMS arce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of NRA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are afterence, CMS will publish a mederal Register to nages. Protection Association, 1 K, D, www.nfpa.org, th Care Facilities Code, and August 11, 2011. Im amendment (TIA) 12-2 to August 11, 2011. TPA 99, issued August 9,						
		(17 <i>)</i> 11/4 12 -4 10 NF	FPA 99, issued March 7,	1	I			I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155442	B. WI	NG		08/04/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, S Standby Power Sy including TIAs to C 2009. Based on record revinterview; the facility emergency power sy maintenance required Care Facilities Code Code in accordance This deficient practice. Findings include: Based on record reveand the Field Maint a.m. to 12:00 p.m. coperiod emergency gournentation for fully gas fired emergency gournely gas for fully gas for fully gas for fully gas fully	FPA 101, issued August FPA 101, issued October Itandard for Emergency and Itandard for Eme	E 00	041	E041 What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: The supplemental 4-hour load testing was performed and is available for review. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other generators on site to perform the supplemental load testing What measures will be put into	nts y the	09/03/2022

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	OF CORRECTION	IDENTIFICATION NUMBER 155442		JILDING	INSTRUCTION	COMPL 08/04/	ETED
	PROVIDER OR SUPPLIER Y CREEK AT FRAN			580 LEN	ADDRESS, CITY, STATE, ZIP COD MLEY STREET LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Field Maintenance Stacility from 12:00 placility has one LP glocated outside the latter property. The morated at 25 kW.	th the Administrator and the Supervisor during a tour of the p.m. to 1:10 p.m. on 08/04/22, the gas fired emergency generator building on the north side of nanufacturer's nameplate rating dicated the generator was viewed with the Administrator enance Supervisor during the			place or what systemic change will be made to ensure that the deficient practice does not recompleted. The Maintenance Director will on 4-hour load testing requirements. The maintenand director will verify the thirty-six month period emergency generator load testing is completed based on the preventative maintenance schedule. How the corrective action(s) we monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place: The Executive Director will revew the testing was completed. The thirty-sixth month period emergency generator load test was added to the preventative maintenance che performed by the maintenance che performed by the maintenance director monthly and sign off the checks completed.	be ce th ill be ent at be iew prior are ne ting	
K 0000							
Bldg. 01	A Life Safety Code	Recertification and State	K 00	000	The creation and submission o	of	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	A. B	MULTIPLE CO UILDING 'ING	onstruction 01		LETED L/2022	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TON D BE OPRIATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		vas conducted by the Indiana Ith in accordance with 42 CFR 1/22			this plan of correction doe constitute an admission by provider of any conclusior in the statement of deficie of any violation of regulati	y this n set forth ncies, or		
	Facility Number: 0 Provider Number: AIM Number: 100	155442						
	Franklin was found Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code, (Code survey, Hickory Creek at not in compliance with articipation in 1, 42 CFR Subpart 483.90(a), re, and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.						
	Type II (222) const sprinklered. The fa with smoke detection open to the corridor smoke detectors in	ity was determined to be of ruction and was fully scility has a fire alarm system on in the corridors, spaces and has battery powered all resident sleeping rooms. apacity of 36 and had a census this survey.						
	were sprinklered. A storage were sprink garage which was r	idents have customary access All areas providing facility clered except for one detached not sprinklered. mpleted on 08/09/22						
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require	ed means of egress shall not a latch or a lock that						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. Bl	A. BUILDING <u>01</u> B. WING			COMPLETED 08/04/2022				
		PROVIDER OR SUPPLIER Y CREEK AT FRAN		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131						
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
		egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security ne used, only one loc permitted on each be made for the raby: remote control locks or keys carri other such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Sec are being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected automatic sprinkle space is protected detection system (at an attended loc space); and both the systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRES ARRANGEMENTS Approved, listed dessemblies serving special locks that systems installed in 7.2.1.6.1 shall be assemblies serving special locks.	king arrangements for the eds of the patient are sking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or emeans available to the e.e. 2.2.6, 19.2.2.2.5.1, LOCKING Sking arrangements for the epatient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked of by a complete smoke (or is constantly monitored ation within the locked the sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING Selelayed-egress locking in accordance with							

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPI	LETED
		155442	B. WING	j		08/04	/2022
			1 (STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MLEY STREET		
HICKOB,	Y CREEK AT FRAN	NKI IN			LIN, IN 46131		
THOROT		W.C.I.V	L'	10000	E114, 114 10101		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
		ervised automatic fire					
	1	or an approved, supervised					
	automatic sprinkle	-					
	18.2.2.2.4, 19.2.2						
		ROLLED EGRESS					
	LOCKING ARRAN						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted. 18.2.2.2.4, 19.2.2	2.4					
	· ·	BY EXIT ACCESS					
	LOCKING ARRAI						
		it access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2	.2.4					
		on and interview, the facility	K 022	2	K222		09/03/2022
	failed to ensure the	means of egress through 1 of			What corrective action(s) will	be	
	3 exits were readily	accessible for residents			accomplished for those reside	nts	
	without a clinical d	iagnosis requiring specialized			found to have been affected b	y the	
	security measures.	Doors within a required means			deficient practice:		
	of egress shall not b	be equipped with a latch or					
	_	ne use of a tool or key from the			code to door was posted.		
	_	otherwise permitted by LSC					
		Door-locking arrangements			How other residents having th	е	
	_	n accordance with 19.2.2.2.5.2.			potential to be affected by the		
		tice could affect over 10			same deficient practice will be	!	
		visitors if needing to exit the			identified and what corrective		1
		e exit door near the nurse's			action(s) will be taken:		
	station by Room 4.						
	F' 1' ' 1 1				All exit doors were inspected t		
	Findings include:				ensure a door code was poste	ed at	
	D 1 1	24 4 A 1 2 2 4 4			each exit door.		
		ons with the Administrator			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	_	
		tenance Supervisor during a			What measures will be put into		
	tour of the facility f	from 12:00 p.m. to 1:10 p.m. on	1		place or what systemic change	es	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/04/2022
	ROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Room 4 could be op code into a keypad	oor near the nurse's station by bened by entering a four digit at the exit door but the code		will be made to ensure that the deficient practice does not re	
	interview at the tim Administrator and t Supervisor stated no have a clinical diag facility and agreed t exit door by Room This finding was re	ne exit door. Based on e of the observations, the he Field Maintenance ot all residents in the facility nosis to be in a secure wing or the code was not posted at the 4. viewed with the Administrator tenance Supervisor during the		The Maintenance Director was educated to ensure door code are posted at each exit door. Review of door codes posted be added to the monthly preventative maintenance routed to the corrective action(s) monitored to ensure the deficient practice will not recur, i.e., where quality assurance program were door code.	es will unds. will be cient nat
	3.1-19(b)			put into place. The Executive Director will we the maintenance director prior the compliance date to ensure codes are posted at exit door. The Executive Director will restricted the preventative maintenance checks performed by the maintenance director monthly sign off that the checks completed.	er to e all s. eview
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observation	ng g of at least 1-1/2-hour ed automatically in	K 0291	K291 What corrective action(s) will	09/03/2022 be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			ETED	
		155442	B. WING			08/04/	2022
			CTD	DEET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ER			ALEY STREET		
HICKOD,	Y CREEK AT FRA	NIKI INI			IN, IN 46131		
HICKOK	I CREEK AT FRA	INNLIN	FR	AINNL	_IIN, IIN 40131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAC	G	DEFICIENCY)		DATE
	lighting systems w	vas maintained in accordance			accomplished for those reside	nts	
		7.9. LSC 7.9.2.6 states battery			found to have been affected by	y the	
	-	cy lights shall use only reliable			deficient practice:		
		ble batteries provided with					
		or maintaining them in properly			Batteries in emergency lightin	g	
	-	Batteries used in such lights			have been replaced.		
	_	opproved for their intended use					
		with NFPA 70 National Electric			How other residents having the	е	
		ent practice could affect all			potential to be affected by the		
	residents, staff and	l visitors.			same deficient practice will be		
					identified and what corrective		
	Findings include:				action(s) will be taken:		
	Based on observat	ions with the Administrator			All emergency lights have bee	n	
	and the Field Mair	ntenance Supervisor during a			reviewed for proper functioning	g.	
	tour of the facility	from 12:00 p.m. to 1:10 p.m. on					
	08/04/22, three bat	ttery operated lighting systems			What measures will be put into)	
	were noted in the f	facility and each battery			place or what systemic change	es	
	operated light fund	ctioned when its respective test			will be made to ensure that the	•	
	button was pushed	except for the battery			deficient practice does not rec	ur:	
		ted on the north wall of the					
	building at the em	ergency generator location			Maintenance Director educate	d	
		g. Based on interview at the			battery powered lighting system	m	
		ations, the Field Maintenance			maintenance. of battery powe	red	
		the aforementioned battery			emergency lighting systems w	ill	
	-	ey lighting system failed to			be added to the monthly		
		s respective test button was			preventative maintenance		
	pushed multiple tin	mes.			schedule		
	This finding was r	eviewed with the Administrator			How the corrective action(s) w	ill be	
	_	ntenance Supervisor during the			monitored to ensure the deficie		
	exit conference.				practice will not recur, i.e., who		
					quality assurance program will		
	3.1-19(b)				put into place:		
					The Executive Director will rou	ınd	
					with the maintenance director	prior	
					to the compliance date to ensu	-	
					all battery powered emergency		
					lights are functioning properly.		
	I						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. BUILDING B. WING	01	COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET (LIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The Executive Director will revene the preventative maintenance checks performed by the maintenance director monthly sign off that the checks completed.	
K 0324 SS=D Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1 Cooking facilities p NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to install the laccordance with the	IFPA 96, Standard for and Fire Protection of and Fire Protection of and Operations, unless: and equipment (i.e., small smicrowaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer in the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be adous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1	K 0324	K324 What corrective action(s) will be accomplished for those reside found to have been affected be	nts
	equipment shall be	installed in accordance with for Ventilation Control and		deficient practice:	,

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	ETED		
		155442	B. WI	NG		08/04/	2022	
				STDEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			MLEY STREET			
HICKUB	Y CREEK AT FRAN	IKI IN			LIN, IN 46131			
HICKOR	I ONEEN AT FRAN	NITELIN		FINAINA				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Commercial Cooking			The facility has properly install	led		
	Operations. NFPA 96, 2011 edition, Section 6.1.1				the grease filters.			
	_	filters, listed baffles, or other						
	-	al devices for use with			How other residents having the	е		
		g equipment shall be provided.			potential to be affected by the			
		grease filters shall be arranged			same deficient practice will be			
		ir passes through the grease			identified and what corrective			
		3.5 states grease filters shall be			action(s) will be taken:			
	_	e not less than 45 degrees from						
		tion 6.2.5. states grease filters			No other kitchen hoods in facil	lity.		
		fic orientation to drain grease						
		lesignated, or the hood shall			What measures will be put into			
		nat filters cannot be installed			place or what systemic change			
	_	ation. This deficient practice			will be made to ensure that the			
	could affect over tw	vo staff in the kitchen.			deficient practice does not rec	ur:		
	TC' 1' ' 1 1				<u> </u>			
	Findings include:		The maintenance director was					
	D 1 1	51 at A 1 1 1 4 a	educated on of grease filters in the					
		ons with the Administrator			kitchen. Hood inspection to be			
		tenance Supervisor during a	placed on routine maintenance					
	-	From 12:00 p.m. to 1:10 p.m. on our grease filters in the kitchen			schedule in TELS.			
		above the range were oriented			Llow the corrective estion(s)	ما الن		
	-	and were not oriented		How the corrective action				
	-	e floor to allow grease to drain		monitored to ensure the de				
		the bottom of the grease			practice will not recur, i.e., who			
		terview at the time of the			quality assurance program wil	i be		
		dministrator and the Field			put into place:			
		visor agreed four of four			The Executive Director with th	۵		
	^	kitchen range hood system			maintenance director prior to t	_		
	-	re not oriented perpendicular			compliance date to ensure ho			
	_	grease to drain into the drip			inspection reports are available			
	tray at the bottom o	-			and recommendations followe			
	22, 22 110 0010111 0	5			on. The Executive Director wi	-		
	This finding was re	viewed with the Administrator			review the preventative			
	_	tenance Supervisor during the			maintenance checks performe	ed by		
	exit conference.	z orper risor daring me			the maintenance director mon	-		
	The Completion				and sign off that the checks	y		
	3.1-19(b)				completed.			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN SUMMARY:		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131		
PREFIX TAG	` `	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev failed to maintain an accordance with NF sprinkler systems sh maintained in accor for the Inspection, T Water-Based Fire P 2011 Edition, Section owner or designated or repair deficiencie found during the ins required by this star shall be performed to personnel or a qualit 4.3.1 requires record inspections, tests, and	supply source RKS information on non-required or partial r system.	K 0353	K353 What corrective action(s) will accomplished for those reside found to have been affected by deficient practice: Sprinkler inspection repairs for room 17, 7, and outside room were completed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other repairs were	ents by the r 4

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/04/2022				
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
	SUMMARY (EACH DEFICIENT REGULATORY OF authority having jurisdeficient practice of and visitors in the firm of the findings include: Based on review of inspection contractor Testing and Mainter Sprinkler Systems" with the Administra Supervisor during resulting 12:00 p.m. on 08/04 the facility's sprink recent annual insperior "Deficiency Summannual sprinkler systems" ("Room 17, Room 7) painted heads". Base record review, the I stated the contractor sprinkler heads but approved by the factor of the stated of the stated of the contractor sprinkler heads but approved by the factor of the stated of the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION risdiction upon request. This could affect all residents, staff, acility. The sprinkler system or's "Form for Inspection, nance of Wet Pipe Fire documentation dated 01/18/22 ator and the Field Maintenance ecord review from 9:00 a.m. to 4/22, deficiencies were noted for her system during the most ction for the facility. The hary" section of the 01/18/22 stem inspection report stated and outside Room 4 have sed on interview at the time of Field Maintenance Supervisor or sent a quote to replace the the quote has not yet been	580 LE	MLEY STREET	ato ges he ecur: as o of The view and d as will be cient hat vill be the l the o the ll ed up will ned by			
				and sign off that the checks completed.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/04/2022		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using g complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1, Based on observation failed to ensure electompartments was condition. LSC 19. with Section 9.1. L wiring and equipment National Electrical of Article 300.15 state be installed at each otherwise permitted Article 314.28 state used as pull or junct 314.28 (A) through could affect over 15 the vicinity of Roor Findings include: Based on observation and the Field Maint tour of the facility f 08/04/22, exposed of open ended conduit suspended ceiling in set by Room 5 and injunction box or con at the time of the obt Maintenance Super	Electric Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric Italiations can continue in Italiations can continue Italiations	K 0511	K511- What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: was made and are now in a junction box near room 5. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All other areas were inspected exposed wiring and repaired. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recommend the made to exposed wiring. Inspection for exposed electric wiring in building ceiling will be added to our Preventative Maintenance Plan.	oe onts y the esterior of the control of the contro	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		ľ í	JILDING	onstruction 01	(X3) DATE : COMPL 08/04/	ETED	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	_	viewed with the Administrator enance Supervisor during the			How the corrective action(s) we monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place: The Executive Director will with the maintenance director prior the compliance date to ensure exposed wiring is contained. Executive Director will review to preventative maintenance che performed by the maintenance director monthly and sign off the checks completed.	ent be to all The cks	
K 0712 SS=F Bldg. 01	alarm signal and seconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills aroutine. Where draware that drills aroutine. The staff is a signal and staff training documents on the fire training documents.	ay be used instead of	K 0	712	K712 What corrective action(s) will accomplished for those reside found to have been affected by deficient practice:	nts	09/03/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/04/2022 155442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 580 LEMLEY STREET HICKORY CREEK AT FRANKLIN FRANKLIN, IN 46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied A fire drill was completed on each conditions. This deficient practice affects all shift. residents, staff and visitors. How other residents having the Findings include: potential to be affected by the same deficient practice will be Based on review of Direct Supply TELS "Logbook identified and what corrective Documentation: Fire Drills" documentation with action(s) will be taken: the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to A fire drill was completed on each 12:00 p.m. on 08/04/22, documentation of a first shift. shift fire drill or staff training documentation on fire drill procedures in the second quarter (April, May, June) 2022 and on the third shift in the third quarter (July, August, September) 2021 was not What measures will be put into available for review. In addition, documentation place or what systemic changes of a second shift fire drill or staff training will be made to ensure that the documentation on fire drill procedures in the deficient practice does not recur: fourth quarter (October, November, December) 2021 and in the second quarter 2022 was also not The Maintenance Director was available for review. Based on interview at the educated on monthly fire drill time of record review, the Administrator stated the schedule. The fire drill schedule facility operates three shifts per day and agreed was added to the monthly documentation of a fire drill or staff training on fire preventative maintenance drill procedures for the aforementioned shifts and schedule. quarters in 2021 and 2022 was not available for review. How the corrective action(s) will be monitored to ensure the deficient This finding was reviewed with the Administrator practice will not recur, i.e., what and the Field Maintenance Supervisor during the quality assurance program will be exit conference. put into place: 3.1-19(b) The Executive Director will verify the current fire drills were held on 2. Based on record review and interview, the each shift with the maintenance facility failed to document the staff who director prior to the compliance participated in quarterly fire drills or staff training date to ensure all shifts have documentation on fire drill procedures on the first, practiced a fire drill. The

second and third shifts for 1 of 4 quarters. LSC

Executive Director will review the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		 UILDING	onstruction 01	(X3) DATE COMPL 08/04/	ETED			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	Section 19.7.1.6 rec quarterly on each sl LSC Section 19.7.1 care occupancies sh procedures and dev affects all residents Findings include:	quires drills to be conducted nift under varied conditions. 8 states employees of health nall be instructed in life safety ices. This deficient practice		preventative maintenance che performed by the maintenance director monthly and sign off t the fire drills were completed.	e			
	Documentation: Fir the Administrator a Supervisor during r 12:00 p.m. on 08/04 who participated in conducted on 02/02 shift fire drill conduand the third shift fat 1:00 a.m. was no interview at the tim Administrator state shifts per day and a staff who participat aforementioned shi not available for rev	re Drills" documentation with and the Field Maintenance record review from 9:00 a.m. to 4/22, documentation of the staff the first shift fire drill record acted on 02/25/22 at 2:15 p.m. are drill conducted on 03/28/22 at available for review. Based on record review, the d the facility operates three greed documentation of the ed in the fire drills for the fts and quarters in 2022 was view.						
		viewed with the Administrator senance Supervisor during the						
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenal The generator or source and assoc of supplying servi	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the in is not met during the						

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		IDENTIFICATION NUMBER 155442	A. BUILDING 01 B. WING		COMPLETED 08/04/2022		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	annually confirm the safety and critical and testing of the switches are performed in the switches are performed. The switches are performed in the switches are performed in the switches are personned in the switches are exercised under formed in the switches are great in 20-40 day once every 36 more scheduled test until a complete simula automatic or manuloads, and are compersonnel. Maintenenergy power sound accordance with noticity to be a switches are program for period components is est manufacturer required of maintenance are and readily available and circuits are manufactured in the posterior of the switches are greatly power consideration for reformed in the switches are greatly power consideration for reformed in the switches are greatly power consideration for reformed in the switches are greatly available and circuits are manufactured in the switches are greatly available and circuits are manufactured in the switches are greatly as a switches are greatly a	all transfer of all EES aducted by competent nance and testing of stored rces (Type 3 EES) are in IFPA 111. Main and feeder is inspected annually, and a dically exercising the ablished according to irrements. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, normal power circuits. Esibility of damage of the source is a design new installations. (NFPA 99), NFPA 110,	K 0918	K918	09/03/2022		
	interview; the facility period emergency generated 99 and NFPA 110. Code, 2012 Edition, 1 and Type 2 essent sources (EPSS) shall Class X, Level 1 generated emergency generated to the facility period of the	ty failed to document 36 month enerator testing for 1 of 1 ors in accordance with NFPA NFPA 99, Health Care Facilities Section 6.4.1.1.6.1 states Type ial electrical system power 1 be classified as Type 10, nerator sets per NFPA 110. dard for Emergency and		What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: The supplemental 4-hour load testing was performed and is available for review.	pe nts y the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155442		B. W	B. WING			08/04/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					MLEY STREET		
HICKOR	Y CREEK AT FRAN	JKI IN			(LIN, IN 46131		
THOROIT	·	VIX.LII V		11000			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION					DATE
	Standby Powers Systems, 2010 Edition, Section				How other residents having th	e	
	8.4.9 states Level 1	EPSS shall be tested at least			potential to be affected by the		
	once within every 3	36 months. Section 8.4.9.1			same deficient practice will be		
	states Level 1 EPSS	S shall be tested continuously			identified and what corrective	•	
	for the duration of i	its assigned class (See Section			action(s) will be taken:		
		2 states where the assigned					
	class is greater than	4 hours, it shall be permitted			No other generators on site to		
	to terminate the test	t after 4 continuous hours.			perform the supplemental load	ı	
	Section 8.4.9.5 state	es the minimum load for this			testing		
	_	ed in 8.4.9.5.1, 8.4.9.5.2, or					
	8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load.				What measures will be put into		
					place or what systemic change	es	
	This deficient practice could affect all residents,				will be made to ensure that the	e	
	staff and visitors.				deficient practice does not rec	ur:	
	Findings include:				The Maintenance Director will	be	
					on 4-hour load testing		
	Based on record rev	view with the Administrator			requirements. The maintenan	ce	
	and the Field Maint	tenance Supervisor from 9:00			director will verify the thirty-six	th	
	a.m. to 12:00 p.m. o	on 08/04/22, thirty-six month			month period emergency		
	period emergency g	generator testing			generator load testing is		
	documentation for	four continuous hours for the			completed based on the		
	LP gas fired emerge	ency generator for the facility			preventative maintenance		
	was not available for	or review. Based on interview			schedule.		
	at the time of record	d review, the Field					
	Maintenance Super	visor stated supplemental load			How the corrective action(s) w	ill be	
	testing documentati	ion for four hours within the			monitored to ensure the defici-	ent	
	most recent three ye	ear period was not available for			practice will not recur, i.e., who	at	
	review. Based on o	observations with the			quality assurance program wil	lbe	
		the Field Maintenance			put into place:		
	Supervisor during a tour of the facility from 12:00						
	p.m. to 1:10 p.m. or	n 08/04/22, the facility has one			The Executive Director will rev	view	
	LP gas fired emerge	ency generator located outside			with the maintenance director	prior	
	the building on the	north side of the property.			to the compliance date to ensu	ure	
	The manufacturer's	nameplate rating for the			the testing was completed. The	ne	
	generator indicated	the generator was rated at 25			thirty-sixth month period		
	kW.				emergency generator load tes	ting	
					was added to the preventative		
	This finding was re	viewed with the Administrator			maintenance schedule. The		
	and the Field Maintenance Supervisor during the				Executive Director will review	the	

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUIL		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2022		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
	exit conference. 3.1-19(b)				preventative maintenance che performed by the maintenance director monthly and sign off the the checks completed.)	

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