STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING -- B. WING	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/04/24 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 At this Emergency Preparedness survey, McCormick's Creek Rehabilitation and Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 87 certified beds. At the time of the survey, the census was 74. Quality Review completed on 03/06/24	E 0000	**The facility requests paper compliance for this survey.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/04/24 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 At this Life Safety Code survey, McCormick's	K 0000	**The facility requests paper compliance for this survey.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or***	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sara hatfield	Executive Director	03/18/2024

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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	Creek Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and has smoke detectors hardwired to fire alarm system in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 74 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/06/24		***conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	
K 0222 SS=B Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect at least 6 residents and staff in Therapy. Findings include: Based on observation with the Director of Maintenance on 03/04/24 at 1:00 p.m., the exit door in therapy was marked as a facility exit, magnetically locked, and could be opened by entering a four-digit code on the access control pad; but the code was not posted at the exit. Based on interview at the time of observation, the Director of Maintenance agreed the code to open the exit door was not posted by the access control pad and used a label maker to print out and post the code at the time of observation. The finding was reviewed with the Executive Director and Director of Maintenance during the exit conference.	K 0222	K222 Egress Doors **The facility requests paper compliance for this citation.** This plan of corrections is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law. **1 Immediate actions taken for those residents identified:** a No resident was found to be affected by the finding. The exit door near therapy the code was immediately posted under the key pad. All other exit doors had code posted by the exit doors. **2 How the facility identified other residents:** a Visitors, staff, and residents that reside at the community had the potential to be affected	03/18/2024

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	3.1-19(b)		however no one was identified. **3 Measures put into place/system changes.** a The maintenance director/designee, placed the code under the key pad immediately. Mtc Director or designee will audit codes weekly to ensure they are in place by the exit doors. **4 How the corrective actions will be monitored:** a The maintenance director/designee will present these audits to the QAPI committee during QAPI meetings to ensure completion and compliance. The results of these audits will be reviewed in quality assurance meeting monthly for 6 months or until 100% compliance is achieved for90 days. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5 Date of compliance: 3/18/24**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance			

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	and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 03/04/24 at 12:15 p.m. with the Director of Maintenance, documentation could not be provided regarding a visual semi-annual fire alarm system inspection. The last recorded inspection of the Fire alarm system was completed on 03/03/23 and was documented as an annual system inspection, but no documentation could be located as far as a semi-annual visual inspection. Based on interview at the time of record review, the Director of Maintenance agreed that a semi-annual visual inspections of the fire-alarm system was not available for review as of the time of this survey and stated he wasn't aware of the requirement. This finding was discussed with the Executive	K 0345	K345 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice 2. Fire Alarm semi visual was completed 3/15/24. A semi visual will be performed again in September 2024. 3. The corrective action for those residents having the potential to be affected by the same deficient practice: No residents effected 4. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: A Reminder System was put in place in Tels and an in-service was given to the maintenance director regarding semi annual visual test.	03/18/2024

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	Director and Director of Maintenance at the exit conference. 3.1-19(b)		5. To ensure the deficient practice does not reoccur, the monitoring system established is to: Administrator/ Designee will monitor Annual/Semi Fire Alarm visual testing. Any issues will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for three consecutive months. This plan to be amended when indicated. 6. Completion date systemic changes will be completed: 3/18/24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility	K 0712	K712	03/18/2024

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	failed to conduct quarterly fire drills at unexpected times under varying conditions on the first and second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Tels Fire Drill Reports documentation with the Director of Maintenance during record review at 10:20 a.m. on 03/04/24, first shift (7:00 a.m. to 3:00 p.m.) fire drills conducted on 01/21/24, 07/28/23 and 10/31/23 were conducted at, respectively, 11:30 a.m., 11:30 a.m. and 11:40 a.m. Second shift (3:00 p.m. to 11:00 p.m.) fire drills conducted on 02/29/23, 05/31/23, 08/24/23 and 11/30/23 were conducted at, respectively, 3:00 p.m., 4:30 p.m., 2:40 p.m. and 4:50 p.m. Based on interview at the time of record review, the Director of Maintenance agreed the aforementioned first and second shift fire drills were not conducted at unexpected times under varying conditions. This finding was reviewed with the Exective Director and Director of Maintenance at the exit conference. 3.1-19(b) 3.1-51(c)		(K 712) The facility failed to provide fire drill records reflecting drills being conducted at unexpected times. To ensure that NFPA 101 Fire Drills standard is met the following corrections will be made: • Mtc Director and Executive Director in-serviced on unexpected fire drill times on unexpected shifts to be done. • The fire drill form will be audited to ensure it is accurate and timeframes are two hours apart **when conducting fire drills.** Procedure/process for Implementing the Plan Ensure the fire drill must be unannounced and conducted within unexpected appropriate timeframes. Inserviced the Mtc Director Director and Executive Director. Monthly audit to conduct fire drills were done at unexpected times. Monitoring and tracking procedures to ensure the plan of correction is effective: • Audits will be performed quarterly to monitor and track the fire drill	

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			process to ensure fire drills are not pre announced, drills occur within the appropriate timeframes and staff adequately respond to the fire alarms. • The Mtc Director will randomly audit the timing of fire drill testing for compliance on a quarterly basis. Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program: • The Maintenance Director will report the audit results and actions taken during the time frames of fire drills to ensure random timing of drills. Patient Care Quality Council and the Governing Body on a quarterly basis until 100% compliance has been achieved for two consecutive quarters. Individual Responsible: **Maintenance Director** Date completed: • March 18, 2024	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric			

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	System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure the transfer time to the alternate power source on the monthly load tests for 2 of the past 12 months was capable of supplying service within 10 seconds. This deficient practice	K 0918	**K 918 F Electrical Systems-Essential Electric System** **The Facility respectively requests desk review for this**	03/18/2024

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	could affect all residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance on 03/04/24 between 9:45 a.m. and 12:40 p.m., the Test Generator Under Load log sheets documented the generator transfer time from normal power to emergency power took more than 10 seconds in February 2024 and August 2023. The under load testing on 02/15/24 at 10:15 a.m. showed transfer time to emergency power was 30 seconds. The under load testing on 08/30/23 at 12:30 p.m. showed transfer time to emergency power was 20 seconds. Based on interview at the time of record review, the Director of Maintenance agreed the transfer time was documented as taking more than 10 seconds in February and August. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)		**citation.**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1. Immediate actions taken for those residents identified: Executive Director/Maintenance Director initiated an inspection to ensure loading timing was correct on generator. 2. How the facility identified other residents: Current residents in the facility have the potential to be affected, no negative outcomes identified. 3. Measures put into place/ System changes:Maintenance Director and ED in serviced on citation. An audit will be conducted weekly to ensure proper loading time on Generator. Written records of maintenance and testing are maintained and readily available. 4. How the corrective actions will be monitored: Maintenance director/ Executive Director will audit weekly to ensure that the load time test was performed for the facility diesel powered generator. The Maintenance Director will ensure the loading time inspections are	

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			up to date in Tells. Reviews of audits will be taken to QA for review and analysis monthly for 6 months to ensure 100% compliance has been achieved. 5.) DOC 3/18/24	