DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING -- B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(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: 08/30/23 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Emergency Preparedness survey, Hickory Creek at Greensburg was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 29. Quality Review completed on 09/05/23	E 0000	/p>	
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brooke Thies	Executive Director	09/23/2023

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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	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented,			

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	facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Business Manager and Maintenance Director on 08/30/23 between 10:20 a.m. and 12:45 p.m., no documentation was available to show that the Emergency Preparedness Plan was based on and included a documented facility-based and community-based risk assessment, utilizing an	E 0006	It is the intent of this facility to maintain an emergency preparedness plan (EPP) that based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. Executive Director and Maintenance Director reviewed and updated the Emergency Preparedness/Disaster plan	09/30/2023

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	all-hazards approach, included strategies for addressing emergency events identified by the risk assessment. Documents provided following a phone call to the corporate office were for "Equipment Assessments". This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present.		facility-based and community-based risk assessment documents. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents, staff, and visitors have the potential to be affected from this alleged deficient practice. All copies of the Emergency Preparedness/Disaster Plan facility-based and community-based risk assessment documents have been reviewed and updated. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director and Maintenance Director have been educated to review the Emergency Preparedness/Disaster plan facility-based and community-based risk assessment documents every 12 months. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	

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			into place: Annual review of the Emergency Preparedness/Disaster plan facility-based and community-based risk assessment documents was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and]			

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	other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Business Manager and Maintenance Director on 08/30/23 between 10:20 a.m. and 12:45 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of	E 0025	It is the intent of this facility to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient.	09/30/2023

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	operations was available for review but the agreements dated back to 2014 and 2017. Based on an interview during records review, the Business Manager agreed the agreements were outdated. This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present.		Executive Director and Maintenance Director reviewed and updated the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other providers. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents, staff, and visitors have the potential to be affected from this alleged deficient practice. All copies of the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other providers have been reviewed and updated. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director and Maintenance Director have been educated to review the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other providers every 12 months. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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			assurance program will be put into place: Annual review of the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other providers documents was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based			

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	functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or			

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	(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not			

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	limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:			

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	(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or			

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	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency			

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	scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do all of the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in	E 0039	It is the intent of this facility to conduct an annual full-scale exercise that is community-based annually. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. Executive Director and Maintenance Director/designee conducted an individual, facility-based functional exercise on 9/8/2023. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents, staff, and visitors have the potential to be affected from this alleged deficient practice. Executive Director and Maintenance Director/designee conducted an individual, facility-based functional exercise on 9/8/2023. **3. What measures will be put into place or what systemic changes will be made to**	09/30/2023

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	accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Business Manager and Maintenance Director on 08/30/23 between 10:20 a.m. and 12:45 p.m., the facility lacked documentation of an actual emergency or a required full-scale exercise. A a second exercise of choice during the past year was documented. Based on interview at the time of record review, the Business Manager and Maintenance Director stated they were not aware of any documentation which would verify an actual emergency or a required full-scale exercise during the past year and no documentation was available during the survey. This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present.		**ensure that the deficient practice does not recur:** Executive Director and Maintenance Director have been educated to ensure that the facility conducts community-based or an individual, facility-based functional exercise twice per year. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Annual review of the facility community-based or an individual, facility-based functional exercise twice per year was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.	
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 483.70(a). Survey Date: 08/30/23 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Life Safety Code survey, Hickory Creek at	K 0000	/p>	

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	Greensburg was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 29 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 09/05/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

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	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 MDS Office, with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 15 residents. Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/30/23 between 12:45 p.m. and 2:30 p.m., the MDS Office contained over 14 large boxes of supplies and was greater than 50 square feet making this a hazardous area. The MDS Office was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the MDS Office contained a large amount of combustible storage, was larger than 50 square feet, and the corridor door to the office was not self-closing.	K 0321	It is the intent of this facility to ensure 1 of 1 MDS Office, with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. On 9/11/2023 the Maintenance Director/designee removed the large boxes of combustible storage from the MDS Office. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what**	09/30/2023

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	This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present. 3.1-19(b)		**corrective actions will be taken**: 15 residents have the potential to be affected by this alleged deficient practice. The Maintenance Director/Designee inspected all hazardous areas for combustible storage with no findings. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 9/12/2023 the Executive Director in-serviced the Maintenance Director/Designee on the requirements for proper combustible storage in a hazardous area, doors must self-close and latch properly to meet set standards. The Maintenance Director/Designee will inspect all hazardous areas for proper combustible storage, with self-closing doors throughout the facility monthly to ensure that all self-closing doors latch properly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The monthly inspection results will be presented by the Maintenance Director/Designee at the monthly QA meeting. Inspection results and system components will be reviewed by the QA committee	

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			with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room.	K 0324	It is the intent of this facility to ensure staff were instructed in the use of the UL 300 hood system and K-Class fire extinguisher in kitchen. 1. **What corrective action will be accomplished for those residents found to have been**	09/30/2023

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	Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/30/23 between 12:45 p.m. and 2:30 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the night cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied, "put the flame out on the stove and grab the silver extinguisher". When asked what the nozzles were for under the hood the employee stated, "some kind of extinguisher". The employee failed to indicate activating the UL 300 hood extinguishing system and then using the correct fire extinguisher for a hood grease fire. The Maintenance Director acknowledged the response and stated all kitchen staff will be retrained and informed on proper response. This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present. 3.1-19(b)		**affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. Maintenance Director/Designee confirmed that the UL 300 hood system instructions for manually operating the fire extinguishing system were posted conspicuously in the kitchen. On 9/5/2023, kitchen staff was re-educated on instructions for proper use of the UL 300 hood system and K-Class fire extinguisher in kitchen. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Maintenance Director/Designee in-serviced kitchen staff on 9/5/2023. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 9/5/2023 The Executive Director in-serviced the Maintenance Director/Designee on the requirements for educating the kitchen staff on instructions for proper use of the UL 300 hood	

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			system and K-Class fire extinguisher in kitchen. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Maintenance Director/Designee will monitor that all kitchen staff are educated on instructions for proper use of the UL 300 hood system and K-Class fire extinguisher in kitchen upon hiring and monthly. This will be discussed in the monthly QA meeting.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered			

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	doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 staff. Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/30/23 between 12:45 p.m. and 2:30 p.m., the (1) corridor door to the boiler room, equipped with a self-closing device, failed to self-close and latch positively into the door frame, and (2) the Med room at the nurse's station, equipped with a self-closing device, failed to self-close and latch into the door frame due to a magnet being placed	K 0363	It is the intent of this facility to ensure the corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. On 8/31/23 the Maintenance Director/designee adjusted the closure of the (1) corridor door to	09/30/2023

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(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
	over the latching hardware. The Maintenance Director stated that the magnet was likely done so the nurses wouldn't have to keep using a key to enter the med supply room. This finding was acknowledged by the Business Manager and Maintenance Director at the time of discovery and again at the exit conference with the Business Manager and Maintenance Director present. 3.1-19(b)		the boiler room, equipped with a self-closing device. The door does in fact now self-close and latch into the door frame. The Administrator verified the work on 9/1/23. On 8/30/23 the Maintenance Director/designee removed the magnet placed of the latching hardware of (2) the Med room at the nurse's station, equipped with a self-closing device. The door does in fact now self-close and latch into the door frame. The Administrator verified the work on 9/1/23. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: 4 staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/Designee inspected all hazardous area doors to verify that the self-closing doors function properly and found no other negative findings. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 9/1/23 the Administrator in-serviced the Maintenance Director/Designee that corridor doors had no impediment to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 01 B. WING	08/30/2023

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			closing and latching into the door frame to meet set standards. The Maintenance Director/Designee will inspect that all corridor door have no impediment to closing or latching monthly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The monthly inspection results will be presented by the Maintenance Director/Designee at the monthly QA meeting. Inspection results and system components will be reviewed by the QA committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	