PRINTED: 09/27/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	JMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIEF			1620 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST NSBURG, IN 47240		
	T		1		T		T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
E 0000							
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000	/p>		
	Creek at Greensbur with Emergency Pr Medicare and Medi and Suppliers, 42 C The facility has 36 the survey, the cens	200244 155353 288790 Preparedness survey, Hickory g was found not in compliance eparedness Requirements for caid Participating Providers FFR 483.73 certified beds. At the time of					
E 0006 SS=C Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2 §418.113(a)(1)-(2 §460.84(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2)	416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a))(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment), §416.54(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),					

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

§485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)

TITLE (X6) DATE

Brooke Thies Executive Director 09/23/2023

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1ETE21 Facility ID: 000244 If continuation sheet Page 1 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	NSTRUCTION	(X3) DATE COMPL	ETED
		155353	B. W	ING		08/30/	2023
	PROVIDER OR SUPPLIER			1620 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST ISBURG, IN 47240		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	develop and main preparedness plan and updated at lea must do the follow (1) Be based on a facility-based and assessment, utiliz 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, utiliz approach. (2) Include strategemergency events assessment, incluing the consequences disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following:	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 is plan must do the nd include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk ding the management of its of power failures, natural iter emergencies that would its ability to provide care.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 2 of 27

	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155353	B. WING		08/30/2023
	PROVIDER OR SUPPLIER		1620 N	ADDRESS, CITY, STATE, ZIP COD I LINCOLN ST NSBURG, IN 47240	
(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 APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. Based on record revialed to maintain a plan (EPP) that was documented, facilit risk assessment, utilized including missing of addressing emerisk assessment in a 483.475(a) (1) and deficient practice constitution of the strategy of the strate	community-based risk ing an all-hazards ag missing residents. gies for addressing identified by the risk satisfied by the risk satisfied by the risk satisfied by the risk satisfied at least every 2 must develop and maintain aparedness plan that must updated at least every 2 must do the following: and include a documented, community-based risk ing an all-hazards ag missing clients. gies for addressing identified by the risk view and interview, the facility in emergency preparedness is based on and includes a sy-based and community-based lizing an all-hazards approach, dients and included strategies agency events identified by the accordance with 42 CFR 42 CFR 483.475(a) (2). This bould affect all occupants. Eview and interview with the land Maintenance Director on 0:20 a.m. and 12:45 p.m., no available to show that the edness Plan was based on and inted facility-based and isk 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	ent.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 3 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023
	PROVIDER OR SUPPLIEI		1620 N	ADDRESS, CITY, STATE, ZIP COD I LINCOLN ST NSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION th, included strategies for	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY) facility-based and	TION (X5) LD BE ROPRIATE COMPLETION DATE
	addressing emerger risk assessment. D phone call to the co	ncy events identified by the ocuments provided following a orporate office were for		community-based risk assessment documents.	naving
	Manager and Main discovery and again	eknowledged by the Business tenance Director at the time of at the exit conference with ger and Maintenance Director		2. How other residents in the potential to be affect the same deficient practice identified and what corrective actions will be taken: All residents, staff, and vinave the potential to be a from this alleged deficient practice. All copies of the Emergency Preparedness/Disaster Pracility-based and community-based risk assessment documents in been reviewed and updated. 3. What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur: Executive Director and Maintenance Director have educated to review the En Preparedness/Disaster place facility-based and community-based risk assessment documents of months. 4. How the corrective act will be monitored to ensure the quality assurance program will assurance program	ice will e sitors ifected t lan ave eed. e put mic ve been mergency an every 12 tion(s) ure the ot

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 4 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155353	A. BUILDING B. WING	G <u></u>	COMPLETED 08/30/2023
	ROVIDER OR SUPPLIER		162	EET ADDRESS, CITY, STATE, ZIP COD O N LINCOLN ST EENSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
E 0025 SS=C Bldg	403.748(b)(7), 418 482.15(b)(7), 483. 485.625(b)(7), 485. Arrangement with §403.748(b)(7), §460.84(b)(8) (7), §460.84(b)(6), §4 [(b) Policies and p must develop and preparedness polic on the emergency (a) of this section, paragraph (a)(1) o communication pla section. The polic be reviewed and u years [annually for minimum, the polic address the follow *[For Hospices at 1)	8.113(b)(5), 441.184(b)(7), 475(b)(7), 483.73(b)(7), 5.920(b)(6), 494.62(b)(6) Other Facilities H8.113(b)(5), §441.184(b), §482.15(b)(7), §483.73(b)), §485.625(b)(7), 194.62(b)(6). rocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at f this section, and the an at paragraph (c) of this ies and procedures must pdated at least every 2 LTC facilities]. At a cies and procedures must	TAG		ncy DATE and e
	procedures. (7) [or	483.73(b):] Policies and · (5)] The development of · other [facilities] [and]			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet Page 5 of 27

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMPL	
		155353	B. W	ING		08/30/	/2023
NAME OF I	PROVIDER OR SUPPLIEF	2	•	1	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST		
HICKOR	Y CREEK AT GREE	ENSBURG		GREENSBURG, IN 47240			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	•	receive patients in the event					
		essation of operations to					
	maintain the continuity of services to facility patients.						
	pationio.						
	*[For PACE at §46	60.84(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.						
		oo to tasmiy paneme.					
	*[For RNHCIs at §	3403.748(b):] Policies and					
	procedures. (7) TI	ne development of					
	_	n other RNHCIs and other					
	1 '	ve patients in the event of					
		ation of operations to					
		nuity of non-medical					
	services to RNHC	view and interview, the facility	E 0	025	It is the intent of this facility to		09/30/2023
		ergency preparedness policies		023	ensure emergency preparedne	ess	07/30/2023
		ude the development of			policies and procedures includ		
		other LTC facilities and other			the development of arrangeme		
	^	e residents in the event of			with other LTC facilities and ot	her	
		tion of operations to maintain			providers to receive residents	in	
	•	rvices to LTC residents in			the event of limitations or		
		CFR 483.73(b)(7). This			cessation of operations to		
	deficient practice co	ould affect all occupants.			maintain the continuity of servi	ices	
	Findings include:				IO LI O IESIUEIIIS.		
	_ mamgs morauc.				1. What corrective action will	Ì	
	Based on records re	eview and interview with the			be accomplished for those		
	Business Manager	and Maintenance Director on			residents found to have beer	1	
		0:20 a.m. and 12:45 p.m.,			affected by the deficient		
		angements with other LTC			practice:		
		providers to receive residents			No residents suffered any ill		
	in the event of limit	tations or cessation of			affects from the alleged deficie	ent.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet Page 6 of 27

PRINTED: 09/27/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMI	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE S COMPLI 08/30/2	SURVEY ETED
	PROVIDER OR SUPPLIEI Y CREEK AT GREI SUMMARY		1620 N	ADDRESS, CITY, STATE, ZIP COD N LINCOLN ST NSBURG, IN 47240		(X5)
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	operations was ava agreements dated b on an interview dur Business Manager outdated. This finding was ac Manager and Main discovery and again	ilable for review but the ack to 2014 and 2017. Based ring records review, the agreed the agreements were eknowledged by the Business tenance Director at the time of at the exit conference with ger and Maintenance Director		Executive Director and Maintenance Director reviewed and updated the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other provide 2. How other residents having the potential to be affected by the same deficient practice w 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 Healt Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and oth providers have been reviewed 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 bee educated to review the Health Care Facility Mutual Aid Response Letter of Agreement with other LTC facilities and oth providers every 12 months.	ers. g y iill ed th t her and	
				4. How the corrective action(s	s) l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

will be monitored to ensure the deficient practice will not recur, i.e. what quality

If continuation sheet

Page 7 of 27

PRINTED: 09/27/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155353	B. W	ING	<u> </u>	08/30/	/2023
				CTREET	DDDEGG CITY CTATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
HICKOR'	Y CREEK AT GREE	ENSBURG			LINCOLN ST ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
E 0039 SS=C Bldg	403.748(d)(2), 410 441.184(d)(2), 481 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), \$4 §416.54(d)(2), \$4 §460.84(d)(2), \$4 §483.475(d)(2), \$4 §485.625(d)(2), \$6 (2), \$491.12(d)(2) *[For ASCs at \$41 OPO, "Organization CMHCs at \$485.9 §491.12, and ESF (2) Testing. The [for exercises to test to annually. The [fact following:	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)			assurance program will be p into place: Annual review of the Health C Facility Mutual Aid Response Letter of Agreement with other LTC facilities and other provid documents was added to the TELS checklist and QAPI calendar. The Executive Direct will review the TELS documentation and QAPI cale monthly to ensure the annual review is completed annually.	are r lers	

FORM CMS-2567(02-99) Previous Versions Obsolete

community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 8 of 27

PRINTED: 09/27/2023 FORM APPROVED

CENTERS F	OR MEDICARE & MEDIC	CAID SERVICES			O!	MB NO. 0938-039
	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED D/2023
	F PROVIDER OR SUPPLIE		1620 N	ADDRESS, CITY, STATE, ZIP COD I LINCOLN ST NSBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	(B) If the [fact natural or man-mactivation of the exist exempt from exempt from exempt from exempt from exempt from exempt functional exercise actual event. (ii) Conduct an activate every 2 years, operation of this section include, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exist exempt from the following of the patient's home conduct exercises and e	ter drill; or ercise or workshop that is r and includes a group a narrated, emergency scenario, and a atements, directed epared questions designed mergency plan. facility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed.				

FORM CMS-2567(02-99) Previous Versions Obsolete

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 9 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155353	 UILDING	INSTRUCTION	COMPI 08/30	LETED
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD LINCOLN ST		
HICKOR	Y CREEK AT GREE	ENSBURG	 GREEN	ISBURG, IN 47240		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	(B) If the hospice	experiences a natural or				
	I -	ency that requires activation				
	1	plan, the hospital is				
		iging in its next required full				
	I	based exercise or individual				
	onset of the emerg	tional exercise following the				
	I .	dditional exercise every 2				
	1 ' '	e year the full-scale or				
		e under paragraph (d)(2)(i)				
		onducted, that may				
		limited to the following:				
	(A) A second full-	scale exercise that is				
	community-based	or a facility based				
	functional exercise	e; or				
	(B) A mock disast					
	1 ' '	ercise or workshop that is				
	· -	and includes a group				
	discussion using a					
	I -	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er	nergency plan.				
	_ ` '	spices that provide inpatient				
		hospice must conduct				
		he emergency plan twice				
	1 ' '	spice must do the following:				
		n annual full-scale exercise				
	that is community	-based; or nunity-based exercise is not				
	· '	ct an annual individual				
	facility-based fund					
		experiences a natural or				
		ency that requires activation				
	_	plan, the hospice is				
	1	iging in its next required				
		nity based or facility-based				
		e following the onset of the				
	emergency event.	-				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet Page 10 of 27

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIEI Y CREEK AT GREI			1620 N	DDRESS, CITY, STATE, ZIP COD LINCOLN ST SBURG, IN 47240	-		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	PRIATE	DATE	
IAU	(ii) Conduct an act that may include, following: (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain document exercises, and en	dditional annual exercise but is not limited to the -scale exercise that is I or a facility based e; or ster drill; or ercise or workshop led by a udes a group discussion		IAU			DATE	
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based fund (B) If the [PRTF, I an actual natural that requires activ plan, the [facility] its next required f or individual, facili following the onse (ii) Conduct	PRTF, Hospital, CAH] must s to test the emergency ar. The [PRTF, Hospital, e following:						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21 Facility ID: 000244

If continuation sheet Page 11 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155353	A. BUILDING B. WING		COM	PLETED 30/2023
	PROVIDER OR SUPPLIER Y CREEK AT GREE		1620 N	ADDRESS, CITY, STATE, ZII LINCOLN ST ISBURG, IN 47240	P COD	
(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 C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	community-based facility-based functional exercises function (B) A mo (C) A tabletop is led by a facilitate discussion, using a clinically-relevant is set of problem star messages, or prepto challenge an en (iii) Analyze the and maintain docutabletop exercises and revise the [factor exercises and revise the [factor exercises plan at least annual organization mustically (i) Participate in a that is community-(A) When a community-(A) When a community-(B) If the PACE exercises or man-made emergactivation of the entiles exempt from enfull-scale communifacility-based functionset of the emergactive functional exercises functional exercis	scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed energency plan. The [facility's] response to amentation of all drills, and emergency events collity's] emergency plan, as as as as as a solution of all drills, and emergency plan, as as as as as a solution of all drills, and emergency plan, as as as as as a solution of all drills, and emergency plan, as as as as a solution of all drills, and emergency plan, as as as as a solution of all drills, and emergency plan, as as as a solution of all drills, and emergency exercise is not exercise and annual full-scale exercise experiences an actual natural ergency that requires energency plan, the PACE gaging in its next required ity based or individual, tional exercise following the gency event. In additional exercise every the year the full-scale or ender paragraph (d)(2)(i) conducted that may include,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 12 of 27

PRINTED: 09/27/2023

	T OF HEALTH AND HU R MEDICARE & MEDIO						ORM APPROVED MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIE			1620 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST		
HICKOR	Y CREEK AT GRE	ENSBURG		GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an e (iii) Analyze the famintain docume exercises, and er the PACE's emer *[For LTC Facilitie (2) The [LTC facilito test the emergy year, including ur the emergency properties of the packet of the packet of the packet of the packet of the emergency properties of the packet of the emergency properties of the packet of	ster drill; or sercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed spared questions designed mergency plan. PACE's response to and nation of all drills, tabletop mergency events and revise gency plan, as needed. Les at §483.73(d):] Lity] must conduct exercises ency plan at least twice per nannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise rounity-based exercise is not fuct an annual individual, ctional exercise. Lility] facility experiences an man-made emergency plan, the empt from engaging its next ale community-based or based functional exercise et of the emergency event.					
		dditional annual exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

following:

that may include, but is not limited to the

(A) A second full-scale exercise that is community-based or an individual, facility

based functional exercise; or

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 13 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G	CON	TE SURVEY MPLETED 30/2023			
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE	RRECTION GHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an e (iii) Analyze the [response to and rall drills, tabletop events, and revisemergency plan, *[For ICF/IIDs at (2) Testing. The I exercises to test twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID natural or man-mactivation of the exercise to the endingence of the emer (ii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the emer (iii) Conduct an activation of the endingence of the endingenc	dercise or workshop that is a rincludes a group a narrated, a emergency scenario, and a stements, directed apared questions designed amergency plan. [LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. [S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the en annual full-scale exercise or munity-based exercise is not fuct an annual individual, actional exercise; or. experiences an actual ade emergency plan, the ICF/IID magaging in its next requires emergency plan, the ICF/IID magaging in its next required inity-based or individual, actional exercise following the regency event. Idditional annual exercise but is not limited to the escale exercise; or						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21 Facility ID: 000244

If continuation sheet Page 14 of 27

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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/IIID's response to and maintain documentation of all drills, tabletop exercises, and 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 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 plan, the HHA is exempt from engaging in its next required				1620 N LINCOLN ST GREENSBURG, IN 47240				
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 plan, the HHA is exempt from engaging in its next required	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION	
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,	TAG	discussion, using clinically-relevant set of problem star messages, or prepto challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a construction of the exercise of the emergian full-scale community-based functional exercises of the emergian conset of the emerg	a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. E/IID's response to and parentation of all drills, tabletop mergency events, and revise regency plan, as needed. 44.102] E HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is the conduct an annual based functional exercise. A experiences an actual adde emergency plan, the HHA is aging in its next required wity-based or individual, tional exercise following the gency event. ditional exercise every 2 to ever the full-scale every 2 to ever the full-scale every 2 to even the full-sca	TAG			DATE	

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353			ILDING	NSTRUCTION	COMP	E SURVEY LETED 0/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE	
	set of problem star messages, or preto challenge an erection of the hard services and enthe HHA's emergenth (ii) Analyze the Hamintain documerexercises, and enthe HHA's emergenth (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency plandactual natural or requires activation OPO is exempt for required testing ending of the emergency (ii) Analyze the Olymaintain documerexercises, and enthe [RNHCI's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test the RNHCI must do the conduct a paper of the conduct a paper of the conduct and the paper of the emergency (iii) Analyze the Olymaintain documerexercises, and enthe [RNHCI's and needed.	pared questions designed mergency plan. HA's response to and nation of all drills, tabletop nergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of hits, directed messages, or as designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next event. PO's response to and nation of all tabletop nergency events, and revise OPO's] emergency plan, as						
	group discussion	led by a facilitator, using a /-relevant emergency						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21 Facility ID: 000244

If continuation sheet Page 16 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record rever failed to conduct explan at least twice promust do all of the force (i) Participate in an is community-based a. When a community-based function of the ICF/IID factor of the ICF/IID factor of the ICF/IID factor of the employed facility-based function of the employed facility-based full-sear following the community-based full-sear following the community-based of functional exercise. In the ICF/IID factor of the employed full-scale community facility-based full-sear following the community-based of functional exercise. In the ICF/IID factor of the employed full-scale community facility-based full-scale community facility-based of functional exercise. In the ICF/IID factor of the employed full-scale community facility-based full-scale community-based of functional exercise. In the ICF/IID factor of the employed full-scale community-based of functional exercise. In the ICF/IID factor of the employed full-scale community-based of functional exercises. In the ICF/IID factor of the employed full-scale community-based of functional exercises. In the ICF/IID factor of the employed full-scale community-based of functional exercises. In the ICF/IID factor of the employed full-scale community facility-based full-scale community facility-based full-scale community-based full-scal	annual full-scale exercise that d; or ity-based exercise is not an annual individual, itonal exercise. Etility experiences an actual e emergency that requires ergency plan, the ICF/IID om engaging its next required ty-based or individual, cale functional exercise for 1 onset of the actual event. Itional exercise that may mited to the following: le exercise that is r an individual, facility-based	E 0039	It is the intent of this facility to conduct an annual full-scale exercise that is community-be annually. 1. What corrective action with be accomplished for those residents found to have been affected by the deficient practice: No residents suffered any illustreative Director and Maintenance Director/design conducted an individual, facility-based functional exercion 9/8/2023. 2. How other residents having the potential to be affected the same deficient practice be identified and what corrective actions will be taken: All residents, staff, and visitor have the potential to be affected from this alleged deficient practice. Executive Director and Maintenance Director/design conducted an individual, facility-based functional exercion 9/8/2023. 3. What measures will be purinto place or what systemic changes will be made to	ased ill en ient. ee cise ng by will rs cted and ee cise ut		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1ETE21

Facility ID: 000244

If continuation sheet

Page 17 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(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)	(X5) COMPLETION DATE		
	accordance with 42 deficient practice of Findings include: Based on records re Business Manager a 08/30/23 between 1 facility lacked docu emergency or a requisecond exercise of cowas documented. En of record review, the Maintenance Direct of any documentation actual emergency or during the past year available during the This finding was ac Manager and Maint discovery and again	CFR 483.475(d)(2). This build affect all occupants. Eview and interview with the and Maintenance Director on 0:20 a.m. and 12:45 p.m., the mentation of an actual uired full-scale exercise. A a choice during the past year Based on interview at the time e Business Manager and for stated they were not aware on which would verify an ra required full-scale exercise and no documentation was		ensure that the deficient practice does not recur: Executive Director and Maintenance Director have be educated to ensure that the faconducts community-based or individual, facility-based functive exercise twice per year. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place: Annual review of the facility community-based or an individual facility-based functional exercity twice per year was added to the TELS checklist and QAPI calendar. The Executive Directivity will review the TELS documentation and QAPI cale monthly to ensure the annual review is completed annually.	cen cility an onal (s) the ut dual, ise ne		
K 0000							
Bldg. 01	Licensure Survey w	00244 155353	K 0000	/p>			
	At this Life Safety (Code survey, Hickory Creek at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21 Facility ID: 000244

If continuation sheet Page 18 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353			JILDING	nstruction 01	(X3) DATE COMPL 08/30/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(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
K 0321	Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facility Type II (222) construction The facility has a find detection in the correction of th	the tendence of the extra Association (NFPA) 101, and the 2012 edition of the extra Association (NFPA) 101, and as					
SS=E Bldg. 01	Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-he (with 3/4 hour fire automatic fire extiraccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet Page 19 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		155353	B. WING		08/30/2023
	PROVIDER OR SUPPLIEI		1620 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN ST NSBURG, IN 47240	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		and zone locations of that are deficient in 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 Sto	orage Rooms/Spaces			
	(over 50 square fe	eet)			
		classified as Severe			
	Hazard - see K32	•	17.0221		00/20/2022
		on and interview, the facility	K 0321	It is the intent of this facility to	
		f 1 MDS Office, with large		ensure 1 of 1 MDS Office, with	
		stible storage and greater than protected as a hazardous area.		large amounts of combustible	
	_	rice could affect 15 residents.		storage and greater than 50	
	This deficient pract	dee could affect 13 fesidents.		square feet was protected as hazardous area.	a
	Findings include:			1. What corrective action wil	.
	Based on observation	on and interview with the		be accomplished for those	"
		tor during a tour of the facility		residents found to have been	n
		en 12:45 p.m. and 2:30 p.m., the		affected by the deficient	11
		ned over 14 large boxes of		practice:	
		reater than 50 square feet		No residents suffered any ill	
		dous area. The MDS Office		affects from the alleged deficie	ent.
		s a hazardous area because		On 9/11/2023 the Maintenance	
	•	the room was not self-closing		Director/designee removed th	
	or automatic closing. Based on interview at the time of observation, the Maintenance Director			large boxes of combustible	
				storage from the MDS Office.	
		ffice contained a large amount		2. How other residents having	
	_	age, was larger than 50 square		the potential to be affected b	-
		or door to the office was not		the same deficient practice v	-

FORM CMS-2567(02-99) Previous Versions Obsolete

self-closing.

Event ID:

1ETE21

Facility ID: 000244

be identified and what

If continuation sheet Page 20 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/30/2023			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE			
	This finding was ac Manager and Main discovery and again	eknowledged by the Business tenance Director at the time of at the exit conference with ger and Maintenance Director		corrective actions will be taken: 15 residents have the pote be affected by this alleged deficient practice. The Maintenance Director/Desinspected all hazardous a combustible storage with findings. 3. What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur: On 9/12/2023 the Execution Director in-serviced the Maintenance Director/Desithe requirements for propositive storage in a hazardous area, doors muself-close and latch proper meet set standards. The Maintenance Director/Desivill inspect all hazardous proper combustible storage self-closing doors through facility monthly to ensure self-closing doors latch proper self-closing doors latch proper self-closing doors latch proper to the monitored to ensure self-closing doors latch proper self-closing doo	ential to d signee reas for no e put mic ve signee on er ust rly to signee areas for ge, with out the that all operly. tion(s) ure the t sults will tenance monthly esults will be			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 21 of 27

PRINTED: 09/27/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF	PROVIDER OR SUPPLIEF	t		ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT GREE	ENSBURG		NSBURG, IN 47240		
(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)	(X5) COMPLETION DATE	
				with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.	ce	
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under Cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the cooking facilities be open to the cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the cooking facilities be open to the cooking facilities open to the cooking faci	ont is protected in NFPA 96, Standard for oll and Fire Protection of sing Operations, unless: ang equipment (i.e., small is microwaves, hot plates, if for food warming or limited ance with 18.3.2.5.2, as open to the corridor in tents with 30 or fewer with the conditions under 15.3, or as in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not pricior.	K 0324	It is the intent of this facility to ensure staff were instructed in use of the UL 300 hood system and K-Class fire extinguisher in kitchen.	n	09/30/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

reviewed with employees by management. This

deficient practice could affect staff in the kitchen

and 25 residents in the dining room.

Event ID:

1ETE21

Facility ID: 000244

1. What corrective action will

residents found to have been

be accomplished for those

If continuation sheet

Page 22 of 27

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155353			JILDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/30/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(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)	(X5) COMPLETION DATE	
	Findings include:				affected by the deficient practice: No residents suffered any ill		
	Maintenance Direct on 08/30/23 betweek kitchen contained a K-class fire extingual Based on interview what is the correct of fire underneath the "put the flame out of extinguisher". Who for under the hood kind of extinguishe indicate activating the system and then using extinguisher for a hamality of the maintenance Direct and stated all kitches informed on proper. This finding was act Manager and Maintenance Manager and Maintenance discovery and again	ood grease fire. The tor acknowledged the response en staff will be retrained and			No residents suffered any ill affects from the alleged deficied Maintenance Director/Designed confirmed that the UL 300 hood system instructions for manual operating the fire extinguishing system were posted conspicuously in the kitchen. Of 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 where identified and what corrective actions will be taken: This deficient practice could at staff in the kitchen and 25 residents in the dining room. Maintenance Director/Designed in-serviced kitchen staff on 9/5/2023. 3. What measures will be purinto 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/Designed the requirements for educating the requirements for educ	g y vill ffect t ee on	
					kitchen staff on instructions for proper use of the UL 300 hood		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 23 of 27

PRINTED: 09/27/2023

	T OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC		(V2) 14	III TIDI E CO	ONETRICTION		B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		01	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155353	B. W		01	08/30/2023	
		10000	2	_	<u> </u>	00/00/	2020
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT GREE	ENSBURG			I LINCOLN ST NSBURG, IN 47240		
(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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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 purinto place: Maintenance Director/Designe 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 hi and monthly. This will be discussed in the monthly QA meeting.	he ut e ff or	
K 0363 SS=E Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material ing fire for at least 20 fully sprinklered smoke conly required to resist the expectation of the corridor doors and doors ing flammable or					

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered

flammable or combustible material.

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 24 of 27

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMP		COMPL	ETED	
		155353	B. WING		08/30	08/30/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LINCOLN ST		
HICKORY CREEK AT GREENSBURG			GREENSBURG, IN 47240				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		with 7.2.1.9 are permissible					
		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						
		door is pushed or pulled are					
	l •	ed protective plates of					
	_	re permitted. Dutch doors					
	_	6 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	•					
	l .	I fire window assemblies are					
	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire						
	assemblies.	s or frames in window					
	assembles.						
	19.3.6.3, 42 CFR Parts 403, 418, 460, 482,						
	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485						
	· ·	(S details of doors such as					
		ngs, automatics closing					
	devices, etc.	3 ,					
		on and interview, the facility	K 0	363	It is the intent of this facility to		09/30/2023
		f over 30 corridor doors had no	"		ensure the corridor doors had	no	
	impediment to clos	ing and latching into the door			impediment to closing and		
	_	sist the passage of smoke.			latching into the door frame ar	nd	
		cice could affect 4 staff.			would resist the passage of		
					smoke.		
	Findings include:						
					1. What corrective action wi	II	
		on and interview with the			be accomplished for those		
		tor during a tour of the facility			residents found to have beer	1	
		en 12:45 p.m. and 2:30 p.m., the			affected by the deficient		
	` '	the boiler room, equipped with			practice:		
		e, failed to self-close and latch			No residents suffered any ill		
		door frame, and (2) the Med			affects from the alleged deficie	ent.	
		station, equipped with a			On 8/31/23 the Maintenance		
	_	failed to self-close and latch			Director/designee adjusted the		
	into the door frame	due to a magnet being placed			closure of the (1) corridor door	r to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 25 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155353	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/30/2023			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP COD 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				
1AG	over the latching had Director stated that the nurses wouldn't enter the med supply. This finding was act Manager and Maint discovery and again	rdware. The Maintenance the magnet was likely done so have to keep using a key to	1AG	the boiler room, equipped wi self-closing device. The door in fact now self-close and lat into the door frame. The Administrator verified the wo 9/1/23. On 8/30/23 the Maintenance Director/design removed the magnet placed latching hardware of (2) the I room at the nurse's station, equipped with a self-closing device. The door does in fact self-close and latch into the offrame. The Administrator ver the work on 9/1/23. 2. How other residents have the potential to be affected the same deficient practice be identified and what corrective actions will be taken: 4 staff have the potential to be affected by this alleged deficipractice. The Maintenance Director/Designee inspected hazardous area doors to verithe self-closing doors function properly and found no other negative findings. 3. What measures will be pure 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 corridations had no impediment to doors had no impediment to	th a does ch rk on neee of the Med t now door rified ing by will be ient all lify that in			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1ETE21

Facility ID: 000244

If continuation sheet

Page 26 of 27

PRINTED: 09/27/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICALD SERVICES UMB NO. 0936-039							
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155353			B. WING			08/30/2023	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP COD 1620 N LINCOLN ST GREENSBURG, IN 47240				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				1E	DATE
					closing and latching into the de	oor	
					frame to meet set standards.		
					Maintenance Director/Designe	e	
					will inspect that all corridor do		
					have no impediment to closing	or	
					latching monthly.		
					4. How the corrective action(will be monitored to ensure t deficient practice will not recur, i.e. what quality assurance program will be pr into place: The monthly inspection results be presented by the Maintenan Director/Designee at the mont QA meeting. Inspection result and system components will b reviewed by the QA committee with subsequent plans of correction developed and implemented as deemed necessary to ensure complian is maintained.	ut s will nce hly ss e	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1ETE21 Facility ID: 000244 If continuation sheet Page 27 of 27