PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155406	B. W	ING		09/13	/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
E 0000							
	An Emergency Preponducted by the Inin accordance with a Survey Date: 09/13 Facility Number: 0 Provider Number: 1000 At this Emergency Prepare Medicare and Mediand Suppliers, 42 Comparison of the survey, the censurvey, the censurv	paredness Survey was diana Department of Health 42 CFR 483.73. 6/22 00475 155406 290540 Preparedness survey, Hickory found in not compliance with dness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of us was 32. Impleted on 09/15/22 4(a), 418.113(a), 5(a), 483.475(a), 483.475(a), 485.68(a), 20(a), 486.360(a), (a) Review and Update 6.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a),	E 04		The creation and submission this plan of correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violation of regulation. We are asking for a desk review with the completion date of 10.12.2022	not his et	DATE
	§485.920(a), §486 §494.62(a). The [facility] must	625(a), §485.727(a), 5.360(a), §491.12(a), comply with all applicable d local emergency					

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

TITLE (X6) DATE

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 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/05/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED 09/13/2022	
		155406	B. W	NG			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	ECTION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			DATE
1/40	preparedness recomust develop esta comprehensive e program that mee section. The eme program must incomprehensive en program must incomprehensive en program must incomprehensive en program established and updated at lemust do all of the section and updated at lemust do all of the section en preparedness recomprehensive en program that mee section, utilizing and updated at lemust develop and main preparedness pland updated at lemust develop and main preparedness pland evelop expensive expensi	puirements. The [facility] ablish and maintain a mergency preparedness ets the requirements of this regency preparedness elude, but not be limited to, ments: Ian. The [facility] must entain an emergency en that must be [reviewed], east every 2 years. The plan following: It §482.15 and CAHs at ergency Plan. The [hospital entail applicable end local emergency equirements. The [hospital or op and maintain a emergency preparedness ets the requirements of this en all-hazards approach. It §483.73(a):] The LTC facility must entain an emergency in that must be reviewed,		IAU			DATE
	Based on record re	view and interview, the facility	E 00	004	E004		10/12/2022

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failed to review and update the Emergency

Preparedness Plan (EPP) at least annually in

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What corrective action(s) will

be accomplished for those

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/13/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970					
(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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) JLD BE COMPLETION ROPRIATE DATE			
PREFIX	(EACH DEFICIENT REGULATORY OF accordance with 42 practice could affect Findings include: Based on records reduction Director on 09/13/2 cover page, the last other documentation EPP was reviewed by year. Based on an interview, the Mainter was last reviewed in the finding was reviewed.	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION CFR 483.73(a). This deficient et all occupants. Eview with the Maintenance 22 at 10:41 a.m., on the EEP review date was 07/30/21, no n could be found to show the and updated within the last interview during records nance Director stated the plan	PREFIX	residents found to have affected by the deficien practice: Administrator and Maint Director have reviewed a updated Emergency Preprogram. Documentation updated. How other residents ha potential to be affected same deficient practice identified and what corraction(s) will be taken: All copies of the Emerge Preparedness plan have review/updated and documentation updated. All copies of the Emerge Preparedness plan have review/updated and documentation updated. All copies of the Emerge Preparedness plan have review/updated and documentation updated and documentation updated. How the corrective action updated and documentation updated and documentation updated and documentation updated and what corrective Updated and documentation updated and what corrective updated and documentation updated and documentation updated and documentation updated and what corrective updated and documentation updated and documentation updated and documentation updated and what corrective updated and documentation updated and documentation updated and what corrective updated and documentation updated and what corrective updated and documentation updated and what corrective updated and updated and what corrective updated and updated an	e been t enance and paredness has been ving the by the will be rective ncy been umented. put into t : enance ated to aredness is in I calendar cutive rector to at on(s) sure the ot			
				assurance program will into place: Annual review of the Em Preparedness Program vito the TELS checklist and calendar. The Executive	ergency was added d QAPI			

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PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	(X3) DATE SURVEY COMPLETED 00/13/2023	
		100400	B. WING		09/13/2022
	PROVIDER OR SUPPLIE		390 W	FADDRESS, CITY, STATE, ZIP COD BOULEVARD , IN 46970	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAU	REGULATORY	K ESC IDENTIF TING INFORMATION	TAU	will review the TELS documentation and QAPI cale monthly to ensure the annual review is completed annually. By what date the systemic changes will be completed: 10.12.2022	endar
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485	15(b), 483.475(b), 483.73(b), 625(b), 485.68(b), 920(b), 486.360(b),			
	develop and imples preparedness pole on the emergency (a) of this section paragraph (a)(1) communication perception. The poli	errocedures. [Facilities] must ement emergency licies and procedures, based by plan set forth in paragraph and the lan at paragraph (c) of this cies and procedures must updated at least every 2			
	and procedures. develop and impl preparedness pol on the emergenc (a) of this section	s at §483.73(b):] Policies The LTC facility must ement emergency licies and procedures, based by plan set forth in paragraph c, risk assessment at of this section, and the			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD , IN 46970	
(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
	section. The polic	an at paragraph (c) of this ies and procedures must pdated at least annually.			
	*Additional Requir ESRD Facilities:	ements for PACE and			
	procedures. The I develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policiaddress managem nonmedical emergimited to: Fire; eq failure; care-relate disasters likely to safety of the partic The policies and p	PACE organization must ment 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 ment of medical and pencies, including, but not uipment, power, or water d emergencies; and natural threaten the health or cipants, staff, or the public.			
	and procedures. develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) o communication pla section. The polic be reviewed and u years. These eme not limited to, fire, failures, care-relat supply interruption	ies at §494.62(b):] Policies The dialysis facility must ment 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 ipdated at least every 2 rgencies include, but are equipment or power ed emergencies, water in, and natural disasters ine facility's geographic			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING COMPL			
		155406	B. W	ING		09/13/20	022
NAME OF D	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					BOULEVARD		
HICKOR'	Y CREEK AT PERU	J		PERU,	IN 46970		
(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 APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	area.			0.4.0			
		view and interview, the facility	E 0	013	EO13		10/12/2022
		l update the Emergency			What corrective action(s) will		
	-	EPP) Policies and Procedures			be accomplished for those		
		accordance with 42 CFR			residents found to have bee	n	
		icient practice could affect all			affected by the deficient		
	occupants.				practice:		
	Findings in -11-				Administrator and Maintenan	ce	
	Findings include:				Director have reviewed and	dnaaa	
	Rosed on records	wiew with the Maintanana			updated Emergency Prepared		
	Based on records review with the Maintenance Director on 09/13/22 at 10:41 a.m., on the EEP				program. Policies and Proced Manual have been reviewed a		
cover page, the last review date was 07/30/21, no				updated.	aliu		
other documentation could be found to show the				How other residents having	tho		
		rocedures were reviewed and			potential to be affected by th		
		last year. Based on an			same deficient practice will		
	-	cords review, the Maintenance			identified and what corrective		
		Policies and Procedures was		action(s) will be taken:			
	last reviewed in Jul				All copies of the Emergency		
					Preparedness plan including		
	The finding was rev	viewed with the Maintenance			Policies and Procedure Manu	al	
	-	lministrator during the exit			have been review/updated an	ıd	
	conference.				documented.		
			What measures will be put into			nto	
			place or what systemic				
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Executive Director/Maintenan		
					Director have been educated		
					review Emergency Preparedn	ess	
					Program every 12 months in		
					QAPI. The QAPI and PM cale		
					was updated for the Executive		
					Director/Maintenance Director	r to	
					review the Emergency	_4	
					Preparedness Program at lea		
					annually. The facility reviewed		
					Policy and Procedure Manual		
			1		all staff during an in-service of	n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLE		ETED		
		155406	B. WI	NG		09/13/	/2022
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					BOULEVARD		
HICKOR	Y CREEK AT PER	U		PERU,	IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					9.28.2022		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					Annual review of the Emerger	су	
					Preparedness Program was a	•	
					to the TELS checklist and QA		
					calendar. The Executive Dire	ctor	
					will review the TELS		
					documentation and QAPI cale	ndar	
					monthly to ensure the annual		
					review is completed annually.	On	
					going monthly all staff in-servi		
					will review sections of the		
					Emergency Preparedness and	Ł	
					Policy Manual review and all r		
					hire employees will be instruct		
					at time of hire of our Emergen		
					Preparedness program.	-,	
					By what date the systemic		
					changes will be completed:		
					10.12.2022		
E 0029	403.748(c), 416.5	54(c), 418.113(c),					
SS=F		15(c), 483.475(c), 483.73(c),					
Bldg		625(c), 485.68(c),					
	` '	920(c), 486.360(c),					
	491.12(c), 494.62						
	, ,	Communication Plan					
		6.54(c), §418.113(c),					
	- , , -	0.84(c), §482.15(c),					
	` ' ' '	3.475(c), §484.102(c),					
	` ' '	6.625(c), §485.727(c),					
	- , , -	6.360(c), §491.12(c),					
	§494.62(c).	0.000(0), 3701.12(0),					
	3-002(0).						

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(c) The [facility] must develop and maintain

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155406		(X2) MULTIPLE A. BUILDING B. WING	DATE SURVEY OMPLETED 9/13/2022					
	PROVIDER OR SUPPLIER Y CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	plan that complies local laws and must least every 2 ye facilities]. Based on record refailed to review and Preparedness Plan (least annually in ac 483.73(a). This defoccupants. Findings include: Based on records reprinciple of the last of the documentation of the last of the review during reprinced in July of the finding was reviewed in July of the finding was reviewed.	eparedness communication is with Federal, State and lest be reviewed and updated ears [annually for LTC]. The wiew and interview, the facility of update the Emergency (EPP) Communication Plan at cordance with 42 CFR icient practice could affect all eview with the Maintenance (22 at 10:41 a.m., on the EEP review date was 07/30/21, no in could be found to show the in Plan was reviewed and last year. Based on an cords review, the Maintenance Communication Plan was last (2021). Wiewed with the Maintenance diministrator during the exit	E 0029	E029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Executive Director updated building Emergency Preparedness Plan Communication Plan. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The updates to the Communication Plan apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance Director were educated to review the Communication Plan in the Emergency Preparedness Plan annually. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Communication Plan at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not	10/12/2022			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	A. BUILDING COM			(X3) DATE COMPL 09/13/	LETED
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0036 SS=F Bldg	484.102(d), 485.6 485.727(d), 485.6 491.12(d), 494.62 EP Training and §403.748(d), §41 §441.184(d), §46 §483.73(d), §483 §485.68(d), §485 §485.920(d), §48 §494.62(d). *[For RNCHIs at Hospice at §418. PACE at §460.84 HHAs at §484.10 CAHs at §486.62 485.727, CMHCs §486.360, and RI Training and testi	5(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 620(d), 486.360(d), 62(d)			recur, i.e., what quality assurance program will be p into place: Annual review of the Emerger Preparedness Program Communication Plan was add to the TELS checklist and QA calendar. The Executive Dire will review the TELS documentation and QAPI cale monthly to ensure the annual review of the Communication is completed annually. By what date the systemic changes will be completed: 10.12.2022	ncy ded PI ector endar	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		A. BUILDING B. WING		COMI	COMPLETED 09/13/2022		
	PROVIDER OR SUPPLIER Y CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	that is based on the in paragraph (a) or assessment at paragraph (b) of this section, plan at paragraph training and testing reviewed and updates and testing. The Land maintain an etraining and testing the emergency plates of this section, risk (a)(1) of this section at paragraph (b) of communication plates to the enviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plan setting. The ICF/II maintain an emergency plan setting programer emergency plan setting section, risk at (a)(1) of this section at paragraph (b) of communication plates the programment of the paragraph (b) of communication plates the paragraph (c) of this section. The train must be reviewed a years. The ICF/II requirements for eat §483.470(i).	ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The grogram must be ated at least every 2 years. The grogram must be ated at least every 2 years. The grogram must develop and grogram that is based on an set forth in paragraph (a) assessment at paragraph (b) as assessment at paragraph (c) of this ing and testing program and updated at least The grogram that is based on an set forth in paragraph (a) assessment at paragraph (b) assessment at paragraph (c) of this ing and testing program and updated at least The grogram that is based on an set forth in paragraph (c) of this ing and testing program and updated at least ear at paragraph (c) of this ing and testing program and updated at least every					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		A. BUILDING B. WING		COMPLETED 09/13/2022			
	PROVIDER OR SUPPLIER Y CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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		
	emergency prepar and patient orientation the emergency (a) of this section, paragraph (a)(1) or procedures at para and the communic of this section. The orientation program updated at every 2 Based on record reversited to review and Preparedness Plan (annually in accordant This deficient practic Findings include: Based on records reprinciple by the last other documentation EPP Training Program within the last year. The records review, the the Training Program 2021. The finding was reviews and patients or program and program an	est develop and maintain an redness training, testing ation program that is based plan set forth in paragraph risk assessment at if this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and must be evaluated and 2 years. Friew and interview, the facility update the Emergency EPP) Training Program at least nee with 42 CFR 483.73(a). The could affect all occupants. In the work with the Maintenance 2 at 10:41 a.m., on the EEP review date was 07/30/21, no in could be found to show the sam was reviewed and updated. Based on an interview during Maintenance Director stated in was last reviewed in July of the work with the Maintenance ministrator during the exit.	E 0036	E036 What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice: Administrator and Maintenant Director have reviewed and updated Emergency Prepared Training Program. Documents has been updated. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All copies of the Emergency Preparedness plan have been review/updated and document What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenant Director have been educated review Emergency Preparedr Program every 12 months in	n ice dness ation the ne be ve n ited. into		

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			ONIB NO. 0936-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		155406	B. WING		09/13/2022	
			CTD FFT	ADDRESS CITY STATE TIP COP		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD BOULEVARD		
HICKUD	Y CREEK AT PERU	ı		IN 46970		
HICKOR	I ONEEN AT FERU	,	FERU,	114 40970	<u> </u>	
(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	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				QAPI. The QAPI and PM cale	ndar	
				was updated for the Executive		
				Director/Maintenance Director	to	
				review the Emergency		
				Preparedness Program at leas	st	
				annually.		
				How the corrective action(s)		
				will be monitored to ensure t	he	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will be p	ut	
				into place:		
				Annual review of the Emergen	-	
				Preparedness Program was a	dded	
				to the TELS checklist and QAF		
				calendar. The Executive Direct	ctor	
				will review the TELS		
				documentation and QAPI cale	ndar	
				monthly to ensure the annual		
				review is completed annually.		
				By what date the systemic		
				changes will be completed:		
				10.12.2022		
L 0022	400 740(1)(4) 444	2.54(-1)(4), 440, 442(-1)(4)				
E 0037	. , , ,	6.54(d)(1), 418.113(d)(1),				
SS=F	` , ` , '	2.15(d)(1), 483.475(d)(1),				
Bldg	, , , ,	.102(d)(1), 485.625(d)(1),				
	, , , ,	.727(d)(1), 485.920(d)(1),				
	486.360(d)(1), 49°	. , . ,				
	EP Training Progr					
	- ,,,,	416.54(d)(1), §418.113(d)(1),				
	- ,,,,	460.84(d)(1), §482.15(d)(1),				
	- , , , -	83.475(d)(1), §484.102(d)(1),				
	. , , , .	.85.625(d)(1), §485.727(d)				
	(1), §485.920(d)(1), 9480.30U(a)(T),				
	§491.12(d)(1).					
	*[For DNO!!!= -+ 0	2402 740 ASC = + \$446 54				
		403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475,				

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Event ID:

1UUE21

Facility ID: 000475

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155406	B. W	ING		09/13/	/2022
MANGOR	DROLHDER OF CURRY TO		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .		390 W E	BOULEVARD		
HICKOR	Y CREEK AT PERU	J		PERU,	IN 46970		
(X4) ID		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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCI		DATE
	_	2, "Organizations" under					
		at §486.360, RHC/FQHCs					
	at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness						
		edures to all new and					
		viduals providing services					
	under arrangemer	-					
	consistent with the						
		ency preparedness training					
	at least every 2 ye	ears.					
	(iii) Maintain docu	mentation of all emergency					
	preparedness train	ning.					
	(iv) Demonstrate s	staff knowledge of					
	emergency proced						
	· ·	cy preparedness policies					
		re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
	The hospice must	do all of the following:					
	``	n emergency preparedness					
		edures to all new and					
		mployees, and individuals					
	I .	under arrangement,					
	consistent with the	· · · · · · · · · · · · · · · · · · ·					
	(ii) Demonstrate s	G					
	emergency proced						
		gency preparedness training					
	at least every 2 ye						
	` <i>'</i>	view and rehearse its					
		redness plan with hospice					
		ling nonemployee staff),					
	with special emphasis placed on carrying out the procedures necessary to protect patients						
	and others.	coessary to protect patients					
		mentation of all emergency					
	preparedness train						

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Event ID:

1UUE21 Facility ID: 000475

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	r í	UILDING	NSTRUCTION		SURVEY LETED 5/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE	
	and procedures a	ncy preparedness policies are significantly updated, the aduct training on the and						
	program. The PR following: (i) Initial training in policies and proceeding staff, indice under arrangeme consistent with the preparedness trait (iii) After initial trait preparedness trait (iii) Demonstrate emergency proceeding (iv) Maintain docupreparedness trait (v) If the emerger and procedures are	umentation of all emergency ining. ncy preparedness policies ure significantly updated, the uct training on the updated						
	organization mus (i) Initial training in policies and proce existing staff, indi services under ar participants, and their expected rol (ii) Provide emergat least every 2 y (iii) Demonstrate emergency proce participants of wh whom to contact	gency preparedness training						

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		JILDING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 09/13/2022	
	PROVIDER OR SUPPLIER Y CREEK AT PERU		390 W E	DDRESS, CITY, STATE, ZIP COD 8OULEVARD N 46970	<u> </u>	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL)) BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	/ NATE	DATE
	(v) If the emerger and procedures a PACE must condupolicies and procedures and pr	R LSC IDENTIFYING INFORMATION Incy preparedness policies re significantly updated, the fuct training on the updated reduces. Res at §483.73(d):] (1) Inc. The LTC facility must do all Inc. emergency preparedness reduces to all new and reducible providing services reduces to all new and reducible providing services reduces to all new and reducible providing services reduces to all emergency reduces training Inc. Ref (a): Ref (b): Ref (c): Re		CROSS-REFERENCED TO THE APPRO	PRIATE	
	emergency proce	staff knowledge of dures. All new personnel and assigned specific				
	responsibilities re	garding the CORF's				
		vithin 2 weeks of their first ning program must include				
		ocation and use of alarm				
	systems and sign	als and firefighting				
	equipment. (v) If the emerge	ency preparedness policies				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 09/13/2022	
	PROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970	•	_
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	CORF must condu policies and proce					
	program. The CAlfollowing:	35.625(d):] (1) Training I must do all of the n emergency preparedness				
	reporting and exti					
protection, and where necessary, evacuation of patients, personnel, and guests, fire						
	I	poperation with firefighting				
		orities, to all new and				
	· -	viduals providing services nt, and volunteers,				
	consistent with the					
		ency preparedness training				
	at least every 2 ye					
		mentation of the training.				
	(iv) Demonstrate s	_				
	emergency proced	_				
	(v) If the emerge	ncy preparedness policies				
	and procedures a	re significantly updated, the				
		t training on the updated				
	policies and proce	edures.				
		485.920(d):] (1) Training. provide initial training in				
	· ·	redness policies and				
		new and existing staff,				
	individuals providi					
		volunteers, consistent with				
	their expected role					
	1	the training. The CMHC				
		staff knowledge of				
		dures. Thereafter, the				
	CMHC must provi					
		ning at least every 2 years.				
		view and interview, the facility	E 0037	037		10/12/2022

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 3/2022
	PROVIDER OR SUPPLIEF		390 W	ADDRESS, CITY, STATE, ZIP C BOULEVARD , IN 46970	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Emergency Prepare facility must do all training in emergen procedures to all ne individuals providing and volunteers, con roles; (ii) Provide estraining at least and documentation of a training; (iv) Demo emergency procedures 483.73(d) (1). This all residents in the factorial	anual training for the edness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and ew and existing staff, ag services under arrangement, sistent with their expected mergency preparedness anally; (iii) Maintain all emergency preparedness anstrate staff knowledge of ares in accordance with 42 CFR deficient practice could affect facility. Eview with the Maintenance at 10:11 a.m., the annual EEP tion had a date of July 2020, ation was provided to show if an the EPP within the last 12 an interview at the time of Maintenance Director stated g was completed in July of the viewed with the Maintenance diministrator during the exit		What corrective action be accomplished for it residents found to hat affected by the deficite practice: Administrator and Main Director have reviewed updated Emergency Perogram. Policies and Manual have been revupdated. Training has provided to current state continue to be provided current staff on an ong Documentation of the part of the Emergency Preparedness Program included demonstration knowledge. How other residents is potential to be affected same deficient practice identified and what continue action(s) will be taken All copies of the Emergency Preparedness plan has review/updated and down that measures will be place or what system changes will be made ensure that the deficite practice does not recontinue to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI. The Center of PM calendar was updated and prector to provide training on Emergency Preparedness Program months in QAPI.	those ave been ent Intenance d and Preparedness Procedure viewed and been aff, will d to all going basis. training is m which n of staff having the ed by the ce will be orrective n: gency ve been ocumented. be put into lic e to lent cur: intenance lucated to mergency m every 12 QAPI and lated for the intenance	

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/13/2022	
	ROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requires \$416.54(d)(2), \$4484.485.68(d)(2), \$4483.475(d)(2), \$485.625(d)(2), \$	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)		Emergency Preparedness Program at least annually. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be positive into place: Annual training of the Emerge Preparedness Program included staff drills was added to the TI checklist and QAPI calendar. Executive Director will review TELS documentation and QAI calendar monthly to ensure the annual review is completed annually. By what date the systemic changes will be completed: 10.12.2022	the out ency ling ELS The the	

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Event ID:

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		X1) PROVIDER/SUPPLIER/CLIA					3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER						
		155406	B. Wl	ING		09/13/	/2022	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					BOULEVARD			
HICKOR	Y CREEK AT PERU	J		PERU,	IN 46970			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DETICIENC!)		DATE	
	. ,	acility] must conduct he emergency plan						
		.						
	annually. The [facility] must do all of the following:							
	ioliowing.							
	(i) Participate in a full-scale exercise that is							
	community-based							
	(A) When a comn	nunity-based exercise is						
		nduct a facility-based						
		e every 2 years; or						
	, , _	lity] experiences an actual						
		ade emergency that requires						
		mergency plan, the [facility]						
		gaging in its next required						
	•	or individual, facility-based						
		e following the onset of the						
	actual event.	ditional evereine at least						
	, ,	ditional exercise at least posite the year the full-scale						
		cise under paragraph (d)(2)						
		s conducted, that may						
		limited to the following:						
		scale exercise that is						
	, ,	or individual, facility-based						
	functional exercise							
	(B) A mock disast							
	(C) A tabletop exe	ercise or workshop that is						
	led by a facilitator	and includes a group						
	discussion using a	a narrated,						
	clinically-relevant	emergency scenario, and a						
	set of problem sta	tements, directed						
		pared questions designed						
	to challenge an er							
		acility's] response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
	the [facility's] eme	rgency plan, as needed.						
	*[For Hospices at	418 113(d)·1						
	· ·	spices that provide care in						

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	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 155406	 UILDING	NSTRUCTION	COMPL 09/13/	ETED
	F PROVIDER OR SUPPLIEF		390 W E	.ddress, city, state, zip cod BOULEVARD IN 46970		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, conduct based functional exercises of the emergency exempt from engascale community-facility-based functional exercises of this section is conclude, but is not (A) A second full-community-based functional exercises (B) A mock disas (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem states of problem states of the care directly. The exercises to test the per year. The hos (i) Participate in a that is community.	nunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Iditional exercise every 2 ee year the full-scale or ee under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based ee; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. Spices that provide inpatient thospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise				

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406		UILDING	NSTRUCTION	COM	e survey pleted 3/2022		
	F PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970						
(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 CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	accessible, condu- facility-based fund (B) If the hospice man-made emerge of the emergency exempt from enga- full-scale community-based emergency event (ii) Conduct an and that may include, following: (A) A second full- community-based functional exercis (B) A mock disas (C) A tabletop ext facilitator that including a narrated, emergency scena- statements, direct questions designe emergency plan. (iii) Analyze the himaintain docume exercises, and en the hospice's emergency	act an annual individual ctional exercise; or experiences a natural or gency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is dor a facility based e; or ster drill; or tercise or workshop led by a udes a group discussion clinically-relevant ario, and a set of problem ted messages, or prepared ed to challenge an enospice's response to and intation of all drills, tabletop mergency events and revise ergency plan, as needed.							
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community (A) When a communicaccessible, condu	PRTF, Hospital, CAH] must s to test the emergency ar. The [PRTF, Hospital, e following:							

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	AN OF CORRECTION	IDENTIFICATION NUMBER 155406		UILDING	nstruction 	COMPL 09/13/	ETED	
	OF PROVIDER OR SUPPLIEF DRY CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	an actual natural of that requires active plan, the [facility] its next required from individual, facility following the onse (ii) Conduct a exercise or and the limited to the following the onse facility-based function (B) A money (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preper to challenge an ereceit (iii) Analyze the and maintain doct tabletop exercises and revise the [fact needed. *[For PACE at §44 (2) Testing. The Fronduct exercises plan at least annuorganization mustiful (i) Participate in a that is community (A) When a community (A) When a community (B) If the PACE experience or man-made emergers and the control of the pace of the pace or man-made emergers and the control of the pace of the	scale exercise that is or individual, a stional exercise; or ock disaster drill; or ock disaster drill; or ock exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. In the [facility's] response to umentation of all drills, and emergency events cility's] emergency plan, as a stotest the emergency plan, as a to test the emergency plan, as a to test the emergency exercise do the following: an annual full-scale exercise exercise is not ct an annual individual,						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155406	B. W	ING		09/13/	/2022
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	C .		390 W E	BOULEVARD		
HICKOR	HICKORY CREEK AT PERU			PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	-	gaging in its next required					
		nity based or individual,					
		ctional exercise following the					
	onset of the emer	-					
	, ,	n additional exercise every					
		he year the full-scale or					
		e under paragraph (d)(2)(i)					
	but is not limited to	onducted that may include,					
		scale exercise that is					
	` '	or individual, a facility					
	based functional e						
	(B) A mock disast						
		ercise or workshop that is					
	. ,	and includes a group					
	discussion, using	— ·					
		emergency scenario, and a					
	set of problem sta						
	· ·	pared questions designed					
	to challenge an er	·					
	_	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	#F 1 TO F 1111	10400 70403					
	*[For LTC Facilitie	. , -					
	· · ·	ity] must conduct exercises					
	_	ency plan at least twice per					
	1 '	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	•					
		nn annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	•	ct an annual individual,					
	facility-based fund						
	· , , -	ility] facility experiences an					
		nan-made emergency that					
	-	of the emergency plan, the					
	LIC facility is exe	mpt from engaging its next					1

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	EMENT OF DEFICIENCIES LAN OF CORRECTION	IDENTIFICATION NUMBER 155406	l í	UILDING	NSTRUCTION	COMPL 09/13/	ETED
NAMI	E OF PROVIDER OR SUPPLIER			390 W E	NDDRESS, CITY, STATE, ZIP COD BOULEVARD		
HIC	ORY CREEK AT PERU	J		PERU, I	IN 46970		
(X4) I PREFI TAC	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	required a full-scal individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional et (B) A mock disas (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem stal messages, or preto challenge an er (iii) Analyze the [I response to and neall drills, tabletop events, and revise emergency plan, and that is community. (A) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community. (A) When a community. (A) When a community. (B) If the ICF/IID exercises for the exercises of the exercises for the exercises for the exercises for the exercise in an activation of the exercise is exempt from enfull-scale community.	ble community-based or based functional exercise of the emergency event. Idditional annual exercise but is not limited to the escale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a exements, directed pared questions designed emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et he [LTC facility] facility's as needed. 2483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the emergency plan at least the ICF/IID must do the emergency plan, at least the ICF/IID must do the emergency plan, the ICF/IID againg in its next requires emergency plan, the ICF/IID againg in its next required entry-based or individual, extional exercise following the					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		A. BUILDING COMPL			
		155406	B. W	ING	09/13/2022		/2022
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	· ·		390 W E	BOULEVARD		
HICKOR	Y CREEK AT PERU	J	•	PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!)		DATE
	, , ,	Iditional annual exercise					
	_	but is not limited to the					
	following:	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
	, ,	and includes a group					
	discussion, using	~ ·					
		emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the IC	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	' '	community-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.	A experiences an actual					
	' '	ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		ctional exercise following the					
	onset of the emer	<u> </u>					
		Iditional exercise every 2					
		ie year the full-scale or					
		e under paragraph (d)(2)(i)					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY MPLETED 13/2022
	PROVIDER OR SUPPLIEF		390 W	ADDRESS, CITY, STATE, ZIP CO BOULEVARD IN 46970	DD	
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(A) A second community-based facility-based function (B) A mock d (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem states messages, or preto challenge an er (iii) Analyze the H maintain documer exercises, and enter the HHA's emergent to CPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency problem statement prepared question emergency plan. If actual natural or not require activation opposes exempt for required testing exercises, and emergency (ii) Analyze the Olimaintain documer exercises, and emergency and emergency (iii) Analyze the Olimaintain documer exercises, and emergency exercises, and emergency exercises.	limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the 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 tis, directed messages, or as designed to challenge an if the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPL	ETED	
		155406	B. WI	NG		09/13/	2022
HICKOR	ROVIDER OR SUPPLIER			390 W E PERU,	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970		
(X4) ID	SUMMARY S	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	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually. A group discussion I narrated, clinically scenario, and a sed directed messaged designed to challe (ii) Analyze the RN maintain document exercises, and em the RNHCI's emer Based on record reversal failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community or man-made emerging of the emergency ple from engaging its necommunity-based of the emergency ple from engaging its necommunity-based of the onset of the actual (ii) Conduct an additinclude, but is not lia. A second full-scale	e RNHCI must conduct the emergency plan. The set following: er-based, tabletop exercise is a sed by a facilitator, using a serelevant emergency et of problem statements, so, or prepared questions enge an emergency plan. NHCI's response to and station of all tabletop ergency events, and revise engency plan, as needed. Friew and interview, the facility ercises to test the emergency er year, including drills using the emergency experiences an actual natural gency that requires activation an, the LTC facility is exempt ext required full-scale in a reindividual, facility-based exercise for 1 year following tall event. Second of the following: the exercise that is rean individual, facility-based	E 00	039	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator and Maintenance Director have reviewed and updated Emergency Prepared program. Policies and Procedu Manual have been reviewed a updated. Training has been provided to current staff. A full-scale exercise has been performed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All copies of the Emergency Preparedness plan have been review/updated and document.	ness ure nd	10/12/2022

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE C A. BUILDING B. WING	**************************************	X3) DATE SURVEY COMPLETED 09/13/2022
	PROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD , IN 46970	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION se or workshop that is led by a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) All in-services and drills will be	5.112
	facilitator that inclu a narrated, clinicall and a set of probler	des a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to		documented and maintained in secured environment.	а
	challenge an emerg (iii) Analyze the L7 maintain document exercises, and emer LTC facility's emer	ency plan. CC facility's response to and ation of all drills, tabletop receive events, and revise the gency plan, as needed in		What measures will be put int place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance	e
	deficient practice co	CFR 483.73(d)(2). This bull affect all occupants.		Director have been educated to conduct exercises to test the emergency plan at least twice pyear. The QAPI and PM calend was updated for the Executive	per dar
	Director on 09/13/2 documentation of a exercise, actual nat nor an annual indiv exercise if a common available for review	view with the Maintenance (2 at 10:09 a.m., no community based annual ural or man-made emergency, idual facility-based functional unity drill is not available was v. Based on interview at the lew, the Maintenance Director		Director/Maintenance Director conduct exercises to test the emergency plan at least twice pyear. Documentation of all in-services including drills will be maintained in a secured environment.	oer
	stated the facility dexercise that is comemergency within the finding was rev	id not participate in a full-scale imunity-based or had an		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: Conducting exercises to test the emergency plan at least twice pyear was added to the TELS checklist and QAPI calendar. Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually. Contact including invitation with community emergency responded.	e per The he I

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/13/2022
	PROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP CO BOULEVARD IN 46970	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE
				will be documented and maintained. By what date the syste changes will be completed.	
K 0000				10.12.2022	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/13 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Peru was found not Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code, (I Health Care Occupa This one story facility Type II (222) constructs sprinklered. The fa with smoke detection open to the corridor detectors in resident has a capacity of 36 time of this survey.	00475 155406 290540 Code survey, Hickory Creek at in compliance with	K 0000	The creation and submathis plan of correction constitute an admission provider of any conclust forth in the statement of deficiencies, or of any of regulation. We are asking for a deserview with the completed date of 10.12.2022	does not n by this sion set of violation

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ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPLETED		
		155406	B. W	ING		09/13/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER			BOULEVARD		
HICKOR	Y CREEK AT PER	U			IN 46970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were sprinklered a	nd all areas providing facility					
	services were sprii	nklered except for the detached					
	oxygen storage bu	ilding and detached					
	maintenance shed	which were not sprinklered.					
	Quality Review co	ompleted on 09/15/22					
K 0324	NEDA 404						
SS=E	NFPA 101	_					
	Cooking Facilities						
Bldg. 01	Cooking Facilities						
	Cooking equipment is protected in						
	accordance with NFPA 96, Standard for						
	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:						
		king equipment (i.e., small					
		as microwaves, hot plates,					
		d for food warming or limited					
	_	dance with 18.3.2.5.2,					
	19.3.2.5.2	4- 4bidi-					
		s open to the corridor in					
		nents with 30 or fewer					
		with the conditions under					
	18.3.2.5.3, 19.3.2						
	_	s in smoke compartments					
		patients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
		s protected according to					
	-	.3 are not required to be					
		ardous areas, but shall not					
	be open to the co						
	_	jh 18.3.2.5.4, 19.3.2.5.1					
		.5, 9.2.3, TIA 12-2					10/10/2022
		ion and interview, the facility	K 0	324	K324		10/12/2022
		aff were instructed in the use of			What corrective action(s) w	ill	
		system in 1 of 1 Kitchen. NFPA			be accomplished for those		
		nstructions for manually			residents found to have bee	n	
	1	extinguishing system shall be			affected by the deficient		
	posted conspicuou	sly in the kitchen and shall be			practice:		

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reviewed with employees by management. This

deficient practice could affect staff in the kitchen

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Administrator and Maintenance

Director held all staff in-service

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
155406		B. WING 09/13/2022			/2022		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BOULEVARD		
HICKUB,	Y CREEK AT PERU	ı			IN 46970		
THORON	- ONLLINATION			I LINU,			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and 15 residents in	one smoke compartment.			regarding the types of fire		
					extinguishers, uses for a K		
	Findings include:				extinguisher versus the ABC		
					extinguishers we have through	n-out	
		on with the Maintenance			the facility. Staff education on	the	
		2 at 11:50 a.m., the kitchen			location of the K type		
		hood system and a K-class			extinguisher, and the location	of	
	1	th posted instructions. Based			the pull station for the 300 UL		
		ook was asked; what is the			Hood System.		
		there was a grease fire					
		d. The employee replied; put a			How other residents having	the	
		yee failed to indicate activating			potential to be affected by th	е	
	the UL 300 hood ex	tinguishing system and using			same deficient practice will be	ре	
	the correct fire extin	nguisher for a hood grease fire.			identified and what correctiv	е	
	The Maintenance D	Director and Administrator			action(s) will be taken:		
	acknowledged the (Cook's response and stated all			Administrator and Maintenanc	e	
	kitchen staff will be	e informed on proper response.			Director will continue to provid	le	
					and review on-going education	n with	
	The findings were r	reviewed with the Maintenance			current staff and newly hired s	taff	
	Director and the Ad	lministrator during the exit			What measures will be put in	ito	
	conference.				place or what systemic		
					changes will be made to		
	3.1-19(b)				ensure that the deficient		
					practice does not recur:		
					Executive Director/Maintenand	ce	
					Director have been educated	to	
					ensure staff has knowledge of	fire	
					extinguishers and the location	of	
					the 300 UL Hood System. The)	
					QAPI and PM calendar was		
					updated for the Executive		
					Director/Maintenance Director	to	
					conduct education monthly for	· all	
					new hires and annually for all	staff.	
					How the corrective action(s)		
					will be monitored to ensure t	:he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/13/2022
	PROVIDER OR SUPPLIER		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970	
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) PRIATE COMPLETION DATE
K 0353	NFPA 101			into place: Staff knowledge of fire extinguishers and the locat the 300 UL Hood System wadded to the TELS checklis QAPI calendar. The Execu Director will review the TEL documentation and QAPI comonthly to ensure the mon review is completed. By what date the systemic changes will be completed 10.12.2022	vas st and utive _S calendar thly
SS=F Bldg. 01	Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR	supply source RKS information on non-required or partial or system.			
	failed to maintain 16 on the automatic sp	riew and interview, the facility of 1 Post Indicator Valve (PIV) rinkler system in accordance C 9.7.5 requires all sprinkler	K 0353	K353 What corrective action(s) be accomplished for thos residents found to have b	e

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		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406				JILDING	<u>01</u>	COMPLETED	
		B. WING 09/13/2022					
NAME OF P	DOMNED OF CLIDE TER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIER			390 W	BOULEVARD		
HICKOR'	Y CREEK AT PERU	J		PERU,	IN 46970		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
	systems shall be ins	-			affected by the deficient		
		dance with NFPA 25, Standard			practice:		
		Testing, and Maintenance of			The PIV value was repaired to)	
		rotection Systems. NFPA 25,			close completely.		
		on 4.1.4.1 states the property			How other residents having	I	
	_	d representative shall correct			potential to be affected by the	•	
		es or impairments that are			same deficient practice will I		
	_	spection, test and maintenance ndard. Corrections and repairs			identified and what corrective	re	
		by qualified maintenance			action(s) will be taken:		
	_	fied contractor. NFPA 25,			No other repairs were		
		ds shall be made for all			recommended during the last sprinkler inspection.		
	•	nd maintenance of the system			What measures will be put in	10	
		all be made available to the			place or what systemic	110	
	1 -	risdiction upon request. This			changes will be made to		
		ould affect all residents, staff,			ensure that the deficient		
	and visitors in the fa				practice does not recur:		
	and visitors in the i	actificy.			Maintenance Director was		
	Findings include:				educated to review and follow	un	
	i mamgs merade.				on all sprinkler inspection repo	•	
	Based on records re	view of the "Testing and			The maintenance	J113.	
		ipe Fire Sprinkler Systems"			director/designee will review	,	
		d 03/03/22 with Maintenance			all sprinkler inspection repo	I	
		2 at 10:18 a.m., under the			monthly during his PM round	•	
		on page one of the report			to ensure they are addressed		
		ould not close completely."				-	
		at the time of record review,			How the corrective action(s)		
		rector acknowledged the			will be monitored to ensure		
		ed the PIV has not been			deficient practice will not		
	repaired.				recur, i.e., what quality		
					assurance program will be p	ut	
	The finding was rev	viewed with the Maintenance			into place:		
	Director and the Ad	lministrator during the exit			The Administrator/designee w	rill	
	conference.				review sprinkler inspection rep		
					with the Maintenance Director		
	3.1-19(b)				prior to the compliance date to		
					ensure all deficiencies noted		
					during sprinkler inspection ha	ve	
					been completed.		
					1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD (X3) DATE SURVEY COMPLETED 09/13/2022				
HICKORY CREEK AT PERI		390 W BOULEVARD PERU, IN 46970				
PREFIX (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) The Executive Director will review the preventative maintenance checks perform by the maintenance director monthly and sign off that the reports were followed up on. By what date the systemic changes will be completed: 10.12.2022	COMPL DAT		

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