

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

PRINTED: 10/05/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155406		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 09/13/2022	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 09/13/22</p> <p>Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540</p> <p>At this Emergency Preparedness survey, Hickory Creek at Peru was found in not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 36 certified beds. At the time of the survey, the census was 32.</p> <p>Quality Review completed on 09/15/22</p>			E 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>We are asking for a desk review with the completion date of 10.12.2022</p>		
E 0004 SS=F Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency</p>						

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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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	<p>preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in</p>			E 0004	<p>EO04 What corrective action(s) will be accomplished for those</p>		10/12/2022

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	<p>accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 09/13/22 at 10:41 a.m., on the EEP cover page, the last review date was 07/30/21, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the plan was last reviewed in July of 2021.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>		<p>residents found to have been affected by the deficient practice: Administrator and Maintenance Director have reviewed and updated Emergency Preparedness program. Documentation has been updated.</p> <p>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 documented.</p> <p>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/Maintenance Director have been educated to review Emergency Preparedness Program every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director</p>		

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E 0013 SS=F Bldg. --	<p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the</p>		<p>will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p>		

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	<p>communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic</p>						

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	<p>area.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 09/13/22 at 10:41 a.m., on the EEP cover page, the last review date was 07/30/21, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the Policies and Procedures was last reviewed in July of 2021.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>			E 0013	<p>EO13</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Administrator and Maintenance Director have reviewed and updated Emergency Preparedness program. Policies and Procedure Manual have been reviewed and updated.</p> <p>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:</p> <p>All copies of the Emergency Preparedness plan including Policies and Procedure Manual have been review/updated and documented.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Executive Director/Maintenance Director have been educated to review Emergency Preparedness Program every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. The facility reviewed the Policy and Procedure Manual with all staff during an in-service on</p>		10/12/2022

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E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain		9.28.2022 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually. On going monthly all staff in-services will review sections of the Emergency Preparedness and Policy Manual review and all new hire employees will be instructed at time of hire of our Emergency Preparedness program. By what date the systemic changes will be completed: 10.12.2022		

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	<p>an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 09/13/22 at 10:41 a.m., on the EEP cover page, the last review date was 07/30/21, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the Communication Plan was last reviewed in July of 2021.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>			E 0029	<p>E029</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Executive Director updated building Emergency Preparedness Plan Communication Plan.</p> <p>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:</p> <p>The updates to the Communication Plan apply to all residents.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:</p> <p>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.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not</p>		10/12/2022

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E 0036 SS=F Bldg. --	<p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)</p> <p>EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency</p>		<p>recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program Communication Plan was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p>		

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	<p>preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The</p>						

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	<p>dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training Program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 09/13/22 at 10:41 a.m., on the EEP cover page, the last review date was 07/30/21, no other documentation could be found to show the EPP Training Program was reviewed and updated within the last year. Based on an interview during records review, the Maintenance Director stated the Training Program was last reviewed in July of 2021.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>			E 0036	<p>E036</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Administrator and Maintenance Director have reviewed and updated Emergency Preparedness Training Program. Documentation has been updated.</p> <p>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:</p> <p>All copies of the Emergency Preparedness plan have been review/updated and documented.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Executive Director/Maintenance Director have been educated to review Emergency Preparedness Program every 12 months in</p>		10/12/2022

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,		QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually. By what date the systemic changes will be completed: 10.12.2022		

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	<p>HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p>						

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	<p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p>						

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies</p>						

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	<p>and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility</p>			E 0037	037		10/12/2022

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	<p>failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director on 09/13/22 at 10:11 a.m., the annual EEP training documentation had a date of July 2020. No other documentation was provided to show if staff were trained on the EPP within the last 12 months. Based on an interview at the time of records review, the Maintenance Director stated the last staff training was completed in July of 2020.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>				<p>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 Preparedness program. Policies and Procedure Manual have been reviewed and updated. Training has been provided to current staff, will continue to be provided to all current staff on an ongoing basis. Documentation of the training is part of the Emergency Preparedness Program which included demonstration of staff knowledge.</p> <p>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 documented.</p> <p>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/Maintenance Director have been educated to provide training on Emergency Preparedness Program every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to provide training on the</p>		

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E 0039 SS=F Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d) (2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p>		<p>Emergency Preparedness Program at least annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual training of the Emergency Preparedness Program including staff drills was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p>		

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

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

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

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

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

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

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

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	<p>of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p>						

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	<p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p>			E 0039	<p>039</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Administrator and Maintenance Director have reviewed and updated Emergency Preparedness program. Policies and Procedure Manual have been reviewed and updated. Training has been provided to current staff. A full-scale exercise has been performed.</p> <p>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:</p> <p>All copies of the Emergency Preparedness plan have been review/updated and documented.</p>		10/12/2022

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	<p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 09/13/22 at 10:09 a.m., no documentation of a community based annual exercise, actual natural or man-made emergency, nor an annual individual facility-based functional exercise if a community drill is not available was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility did not participate in a full-scale exercise that is community-based or had an emergency within the last 12 months.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p>				<p>All in-services and drills will be documented and maintained in a secured environment.</p> <p>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/Maintenance Director have been educated to conduct exercises to test the emergency plan at least twice per year. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to conduct exercises to test the emergency plan at least twice per year. Documentation of all in-services including drills will be maintained in a secured environment.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Conducting exercises to test the emergency plan at least twice per year was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually. Contact including invitation with community emergency responders</p>		

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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 09/13/22</p> <p>Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540</p> <p>At this Life Safety Code survey, Hickory Creek at Peru was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated detectors in resident sleeping rooms. The facility has a capacity of 36 and had a census of 32 at the time of this survey.</p> <p>All areas providing customary access to residents</p>			K 0000	<p>will be documented and maintained.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>We are asking for a desk review with the completion date of 10.12.2022</p>		

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K 0324 SS=E Bldg. 01	<p>were sprinklered and all areas providing facility services were sprinklered except for the detached oxygen storage building and detached maintenance shed which were not sprinklered.</p> <p>Quality Review completed on 09/15/22</p> <p>NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen</p>	K 0324	<p>K324 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Administrator and Maintenance Director held all staff in-service</p>		10/12/2022		

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	<p>and 15 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/13/22 at 11:50 a.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; put a lid on it. The employee failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. The Maintenance Director and Administrator acknowledged the Cook's response and stated all kitchen staff will be informed on proper response.</p> <p>The findings were reviewed with the Maintenance Director and the Administrator during the exit conference.</p> <p>3.1-19(b)</p>				<p>regarding the types of fire extinguishers, uses for a K extinguisher versus the ABC extinguishers we have through-out the facility. Staff education on the location of the K type extinguisher, and the location of the pull station for the 300 UL Hood System.</p> <p>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: Administrator and Maintenance Director will continue to provide and review on-going education with current staff and newly hired staff 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/Maintenance 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.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>		

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K 0353 SS=F Bldg. 01	<p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 Post Indicator Valve (PIV) on the automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler</p>	K 0353	<p>into place: Staff knowledge of fire extinguishers and the location of the 300 UL Hood System was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the monthly review is completed.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p> <p>K353 What corrective action(s) will be accomplished for those residents found to have been</p>	10/12/2022	

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	<p>systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on records review of the "Testing and Maintenance Wet Pipe Fire Sprinkler Systems" documentation dated 03/03/22 with Maintenance Director on 09/13/22 at 10:18 a.m., under the deficiencies section on page one of the report stated, "The PIV would not close completely." Based on interview at the time of record review, the Maintenance Director acknowledged the deficiency and stated the PIV has not been repaired.</p> <p>The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.</p> <p>3.1-19(b)</p>				<p>affected by the deficient practice: The PIV value was repaired to close completely. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other repairs were recommended during the last sprinkler inspection. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director was educated to review and follow up on all sprinkler inspection reports. The maintenance director/designee will review all sprinkler inspection reports monthly during his PM rounds to ensure they are addressed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator/designee will review sprinkler inspection reports with the Maintenance Director prior to the compliance date to ensure all deficiencies noted during sprinkler inspection have been completed.</p>		

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					<p>The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the reports were followed up on.</p> <p>By what date the systemic changes will be completed: 10.12.2022</p>		