Ľ	EPARTMENT OF HEALTH AND HUMAN SERVICES							
C	CENTERS FOR MEDICARE & MEDIC	CAID SERVICES						
Γ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3)				
ı	AND BLAN OF CORRECTION	IDENTIFICATION NUMBER	A DUILDING					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155427	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2023		
NAME OF PROVIDER OR SUPPLIE HICKORY CREEK AT MAD		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
` '	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	ON BE	(X5) COMPLETION
TAG REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-NATE	DATE
E 0000						
conducted by the I accordance with 4. Survey Date: 10/1 Facility Number: Provider Number: AIM Number: 10/1 At this Emergency Creek at Madison with Emergency P Medicare and Med and Suppliers, 42 of the survey, the cert Quality Review conductive The requirement at MET as evidenced as 403.748(d)(2), 4841.184(d)(2), 4	0/23 000348 155427 0288390 Preparedness survey, Hickory was found not in compliance reparedness Requirements for licaid Participating Providers CFR 483.73. certified beds. At the time of sus was 34. mpleted on 10/12/23 t 42 CFR, Subpart 483.73 is NOT by: 16.54(d)(2), 418.113(d)(2), 32.15(d)(2), 483.475(d)(2), 482.15(d)(2), 485.920(d)(2), 57.27(d)(2), 485.920(d)(2), 57.27(d)(2), 494.62(d)(2) irements 18.113(d)(2), §441.184(d)(2), 482.15(d)(2), §483.73(d)(2), 3484.102(d)(2), §485.68(d)(2), 3485.727(d)(2), §485.920(d)	E 00	000	The creation and submiss this plan of correction doe constitute an admission be provider of any conclusion forth in the statement of deficiencies, or of any violof regulation. Due to the relative low sociand severity of this survey facility respectfully request desk review in lieu of a post-survey revisit.	es not y this n set lation ope y, the	

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

TITLE (X6) DATE

Markietta Burns Executive Director 10/23/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155427	B. W	ING		10/10	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			RAGMONT ST		
HICKOR'	Y CREEK AT MADI	SON			ON, IN 47250		
(X4) ID	SUMMARY	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 APPROPRIAT		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ons" under §485.727,					
	_	020, RHCs/FQHCs at					
	§491.12, and ESF 	RD Facilities at §494.62]:					
	(2) Testing The [f	facility] must conduct					
		he emergency plan					
		ility] must do all of the					
	following:						
	l .eeg.						
	(i) Participate in a	full-scale exercise that is					
	community-based	every 2 years; or					
	(A) When a comr	nunity-based exercise is					
not accessible, conduct a facility-based							
	functional exercise every 2 years; or						
	, , _	ility] 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 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 exercis (B) A mock disast						
	` '	er drill, or ercise or workshop that is					
	, ,	and includes a group					
		• .					
	discussion using a	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an e						
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	I everoises, and en	iorgonoy evente, and revise	1				I

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/10/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION rgency plan, as needed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION		
	*[For Hospices at (2) Testing for ho the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disassi (C) A tabletop exiled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an eriode.	spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or aunity 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 ational exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					
	care directly. The	hospice must conduct he emergency plan twice					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COMPLETE	(X3) DATE SURVEY COMPLETED 10/10/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE CO	(X5) MPLETION	
TAG	per year. The ho	R LSC IDENTIFYING INFORMATION spice must do the following:	TAG	DEFICIENCY)		DATE	
	that is community						
	1 ' '	nunity-based exercise is not uct an annual individual					
	facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is						
	exempt from enga	aging in its next required					
	full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise						
	that may include, following:	but is not limited to the					
	(A) A second full	-scale exercise that is					
	functional exercis						
	(B) A mock disas (C) A tabletop ex	ster drill; or rercise or workshop led by a					
		ludes a group discussion clinically-relevant					
	emergency scena	ario, and a set of problem					
	questions designe	ted messages, or prepared ed to challenge an					
	1 ' '	nospice's response to and					
		ntation of all drills, tabletop nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	-	441.184(d), Hospitals at					
	§482.15(d), CAHs (2) Testing. The [s at §485.625(d):] PRTF, Hospital, CAH] must					
		s to test the emergency ar. The [PRTF, Hospital,					
	CAH] must do the						

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ ′		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155427	A. BUILDING B. WING			COMPLETED 10/10/2023	
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
HICKORY CREEK AT MADISON		ISON			RAGMONT ST ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	17	AG	DEFICIENC!)		DATE
	that is community	nunity-based exercise is not					
	1 ' '	ict an annual individual,					
		ctional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
		vation of the emergency					
		is exempt from engaging in					
		ull-scale community based					
	1	ity-based functional exercise					
		et of the emergency event.					
	1	an [additional] annual					
	` '	nat may include, but is not					
	limited to the follo						
		-scale exercise that is					
	community-based						
	-	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tableto	p exercise or workshop that					
	is led by a facilitat	tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	atements, directed					
		pared questions designed					
	to challenge an e	mergency plan.					
		he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	_ =	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60 84(d)·1					
	1 -	PACE organization must					1
	1 ' '	s to test the emergency					
	plan at least annu	9 ,					
	organization must	-					1
	_	an annual full-scale exercise					
	that is community						
	(4) 14/1		1				

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(A) When a community-based exercise is not accessible, conduct an annual individual,

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155427	B. WING		10/10/2023	
NAME OF F	PROVIDER OR SUPPLIER	. }		ADDRESS, CITY, STATE, ZIP COD		
				CRAGMONT ST		
HICKOR	Y CREEK AT MADI	SON	MADIS	SON, IN 47250		
(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 APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	•	ctional exercise; or				
	` '	xperiences an actual natural				
		ergency that requires				
		mergency plan, the PACE				
	-	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)				
	of this section is conducted that may include, but is not limited to the following:					
	(A) A second full-scale exercise that is					
	, ,	or individual, a facility				
	based functional e					
	(B) A mock disas					
	' '	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.				
	*[Eor TO Foo; :4:-	on at \$492.72/d\.1				
	*[For LTC Facilitie	- , , -				
		ity] must conduct exercises ency plan at least twice per				
	_	announced staff drills using				
		ocedures. The [LTC facility,				
	ICF/IID] must do t					
	_	an annual full-scale exercise				
	that is community					
	-	nunity-based exercise is not				
	' '	ct an annual individual,				
	facility-based fund					

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

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	AN OF CORRECTION	IDENTIFICATION NUMBER 155427		JILDING	NSTRUCTION	COMPL 10/10/	ETED
	OF PROVIDER OR SUPPLIEF DRY CREEK AT MADI		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	actual natural or requires activation LTC facility is exerequired a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an er (iii) Analyze the [iii) Analyze the [iiii) Analyze the [iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the					

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427			ľ	JILDING		COMPL 10/10/	ETED
	DF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
(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 APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
	is exempt from en full-scale community-based function of the emerical following: (A) A second full-scommunity-based facility-based function (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the IC maintain documer exercises, and enter the ICF/IID's emerical following: (i) Participate in a community-based (A) When a cois not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-matactivation of the exempt from engaging full-scale community-scale community-sc	ngaging in its next required nity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise that is for an individual, ctional exercise; or ter drill; or excise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise rgency plan, as needed. 84.102] e HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is it; or community-based exercise conduct an annual thased functional exercise					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2023		
		PROVIDER OR SUPPLIEF		1945	ET ADDRESS, CITY, STATE, Z 5 CRAGMONT ST DISON, IN 47250	IP COD	
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE FHE APPROPRIATE	(X5) COMPLETION
	TAG	onset of the emerication of the emerication of this section is conclude, but is not (A) A second community-based facility-based functional exercise of this section is community-based facility-based function (B) A mock of (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or presto challenge an error (iii) Analyze the H maintain documer exercises, and emitted HHA's emerged (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan. I actual natural or more exercise is exempt for requires activation open in the emergency of the emerge	ditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is lor an individual, ctional exercise; or lisaster drill; or lo exercise or workshop that for and includes a group la narrated, lemergency scenario, and a litements, directed lipared questions designed limergency plan. HA's response to and lintation of all drills, tabletop linergency events, and revise lency plan, as needed. 86.360] le OPO must conduct lihe emergency plan. The lifollowing: ler-based, tabletop exercise last annually. A tabletop la facilitator and includes a lusing a narrated, clinically locy scenario, and a set of lits, directed messages, or lits designed to challenge an lif the OPO experiences an lift the OPO experiences an lift the opological in the lower engaging in its next lixercise following the onset	TAG			DATE

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155427	B. WING		10/10/2023	
NAME OF I	PROVIDER OR SUPPLIER)	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	ROVIDER OR SULLEL			RAGMONT ST		
HICKORY CREEK AT MADISON		ISON	MADIS	ON, IN 47250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ntation of all tabletop				
		nergency events, and revise				
	_	OPO's] emergency plan, as				
	needed.					
	*CDNOLU+ 0404	0.7401				
	*[RNCHIs at §403	૩./4ઠ]: e RNHCl must conduct				
	` ' ' '	he emergency plan. The				
	RNHCI must do th					
		er-based, tabletop exercise				
		A tabletop exercise is a				
		led by a facilitator, using a				
		/-relevant emergency				
		et of problem statements,				
		es, or prepared questions				
		enge an emergency plan.				
	_	NHCI's response to and				
		ntation of all tabletop				
	exercises, and en	nergency events, and revise				
	the RNHCI's eme	rgency plan, as needed.				
		view and interview, the facility	E 0039	E039		10/26/2023
		tercises to test the emergency		It is the practice of this facility t	ю.	
	plan at least twice p			conduct exercises to test the		
		drills using the emergency		emergency plan annually. The		
	^	CC facility must do the		facility did document an actual		
	following:	ammuel full goals service that		event that is a community base	ea	
		annual full-scale exercise that		and facility based functional	,	
	is community-based			exercise within the most recent	Į.	
		ity-based exercise is not an annual individual,		two year period. The corrective action taken for	<u> </u>	
	facility-based funct			those residents found to be	,	
	1 *	ty experiences an actual natural		affected by the deficient		
		gency that requires activation		practice include:		
		lan, the LTC facility is exempt		An actual event and tabletop		
		ext required full-scale		exercise was completed with a	_n	
		or individual, facility-based		after action report.		
		l exercise for 1 year following		Other residents that have the		
	the onset of the actu			potential to be affected have		

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(ii) Conduct an additional exercise that may

include, but is not limited to the following:

Event ID:

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been identified by: All

residents, staff, and visitors have

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	a. A second full-scal community-based of functional exercise. b. A mock disaster c. A tabletop exercifacilitator that incluan anarrated, clinically and a set of problem messages, or preparchallenge an emerginal (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergacordance with 42 deficient practice construction of the district of the facility and the district of the facility and a set of problem messages, or preparchallenge an emerginal community and the secondary of the facility and the facility and the facility and the facility also did not or man-made emerginal of the emergency player period. The facility also did not or man-made emerginal construction of the facility also did not or man-made emerginal exercise for Ice Sto "Severe Weather Poon 05/02/23. Based record review, the Maintenance of the emergency player period. The facility also did not or man-made emerginal exercise for Ice Sto "Severe Weather Poon 05/02/23. Based record review, the Maintenance of the problem of the p	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION le exercise that is r an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, n statements, directed ded questions designed to ency plan. C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This buld affect all occupants. "Emergency Preparedness"		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	DATE ut dithe e e ogram n ludes he to ure eeview ent, or		
		aired activation of the					

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Event ID:

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

PRINTED: 10/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155427		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2023	
	PROVIDER OR SUPPLIER Y CREEK AT MADI		1945 C	ADDRESS, CITY, STATE, ZIP COD CRAGMONT ST SON, IN 47250	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LL SC IDENTIFYING DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTENTION
TAG		hin the most recent two year lable for review.	TAG	Distribution,	DATE
	These findings were Maintenance Direct	e reviewed with the or during the exit conference.			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/10 Facility Number: 0 Provider Number: 1000 At this Life Safety 0 Madison was found Requirements for P Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code, (I) Health Care Occupa This one story facility one story facility of the corridor sprinklered. The facility open to the corridor smoke detectors in a	288390 Code survey, Hickory Creek at not in compliance with articipation in 42 CFR Subpart 483.90(a), re, and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. The was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, spaces and has battery powered all resident sleeping rooms. The property of 36 and had a census	K 0000	The creation and submission this plan of correction does constitute an admission by provider of any conclusion forth in the statement of deficiencies, or of any violator of regulation. Due to the relative low scopand severity of this survey, facility respectfully request desk review in lieu of a post-survey revisit.	s not this set ution pe the
		idents have customary access			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155427		B. WING 10/			10/10/	/2023	
	PROVIDER OR SUPPLIER		1	945 CF	DDRESS, CITY, STATE, ZIP COD RAGMONT ST DN, IN 47250		
(X4) ID			I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T	ΆG	DEFICIENCY)		DATE
	storage were sprink buildings which we	lered except for two detached re not sprinklered.					
	Quality Review completed on 10/12/23					ļ	
K 0232 SS=F Bldg. 01	NFPA 101 S=F Aisle, Corridor, or Ramp Width		K 0232	2	K 232 It is the practice of this facility meet the clear width requirement in the corridors. The corrective action taken for those residents found to be affected by the deficient practice include: The furniture in the corridors an now fixed to the floor or wall wheavy duty adhesive. Inspecticall halls has been conducted to the surrence no furniture was in the which was not affixed to the floor wall. Other residents that have the potential to be affected have been identified by: All	ent ior ire vith on of o hall poor	10/26/2023
	distance of at least 1 (f) the fixed furniture	re is located so as to not uilding service and fire			residents, staff, and visitors hat the potential to be affected but none were identified. The measures or systematic changes that have been put	t	
	(g) corridors throughout the smoke compartment				into place to ensure that the		

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l í í		X1) PROVIDER/SUPPLIER/CLIA	` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155427		B. WIN	G	_	10/10/	2023	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
					RAGMONT ST		
HICKORY CREEK AT MADISON				MADIS(ON, IN 47250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		electrically supervised			deficient practice does not		
		etection system in accordance ixed furniture spaces are			recur: Executive Director and	tha	
		d to allow direct supervision			Maint. Director have reviewed policy and will continue mainta		
	-	from a nurse's station or similar			the emergency preparedness	alli	
	space.	from a naise 3 station of similar			program by reviewing annually		
	*	partment is protected			after an event, or as needed.	y ,	
		oproved, supervised automatic			Executive Director/Maint Director	ctor	
		accordance with 19.3.5.8.			have been in-serviced.		
		ice could affect all residents,			Maintenance will round weekly	v to	
	-	needing to exit the facility.			ensure there is no furniture wh	,	
		· ·			is not affixed to the wall or floo		
	Findings include:				the hallway.		
					The corrective action taken t	0	
	Based on observation	ons with the Maintenance			monitor performance to assu	ıre	
	Director and the Ac	tivities Director during a tour			compliance through quality		
	of the facility from	12:50 p.m. to 1:40 p.m. on			assurance is: Executive		
	10/10/23, two upho	lstered chairs were stored in			Director/Maint. Director shall		
		Room 4 and were not affixed			ensure that all furniture in the		
	to the floor or to the wall. Each of the two chairs				corridors are fixed to the floor	or	
	were stored up against the corridor wall and				wall. Maint. Director/Designee		
	projected 32 inches into the 113 inch wide				complete audit tool weekly X4		
	corridor. A couch was stored up against the wall				weeks and monthly X 6 month		
	in the corridor outside Room 15 and projected 33				The IDT committee will detern		
	inches into the 113 inch wide corridor. In				need for further review. If 100		
	addition, a table was stored up against the				not achieved, an action plan w	/ill	
		side entrance to the facility			be developed.		
	_	rojected 16 inches into the 8					
		All measurements were made			Data of Committee 40/00/00	,	
	Based on interview	nce Director's measuring tape.			Date of Completion: 10/26/23	•	
		ai the time of the aintenance Director and the					
		greed the aforementioned					
		cations were not affixed to the					
	floor or to the wall.						
	noor or to the wall.						
	These findings were	e reviewed with the					
		for during the exit conference.					
		-					
	3.1-19(b)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT MADISON				STREET ADDRESS, CITY, STATE, ZIP COD 1945 CRAGMONT ST MADISON, IN 47250			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH C		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE

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