STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING -- B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/18/22 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Emergency Preparedness survey, Hickory Creek at Greensburg was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 24. Quality Review completed on 10/21/22	E 0000	**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. We are asking for a desk review with a compliance date of 11/18/22.**	
E 0029 SS=C 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 an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Rapp	RN HFA	11/04/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING -- B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain a complete emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Plan with the Executive Director and Maintenance Director (from another facility) on 10/18/22 between 10:10 a.m. and 12:20 p.m., the table of contents page pointed to page 10 for current staff contact information. Page 10 of the Disaster Plan contained a staff contact page but not contact numbers, the contacts were blank. Based on an interview during records review, the Executive Director agreed that contact information for the staff was incomplete. This finding was acknowledged by the Executive Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director (from another facility) present at 2:00 p.m.	E 0029	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Executive Director/Maintenance Director reviewed and updated Emergency Preparedness/Disaster plan contact page with current names and phone numbers. **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/Disaster plan have been review/updated. **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 contact list every 12 months and with changes in contact information in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually. **How the corrective action(s)**	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING -- B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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/Disaster plan contact list was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/18/22 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Life Safety Code survey, Hickory Creek at Greensburg 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. This one story facility was determined to be of Type II (222) construction and fully sprinkled. The	K 0000	**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. We are asking for a desk review with a compliance date of 11/18/22.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 01 B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 24 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/21/22			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler riser rooms was provided with a smoke resistant enclosure. This deficient practice could affect staff and at least 33 residents in the facility. This deficient practice could affect staff and at least 15 residents in the facility. Findings include:	K 0372	**It is the intent of this facility to ensure penetrations caused by the passage of wire and/or conduit through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier.** **What corrective actions will be accomplished for those residents found to be affected**	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 01 B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observations during a tour of the facility with the Executive Director and Maintenance Director (from another facility) on 10/18/22 between 12:20 p.m. and 1:45 p.m., in the Sprinkler Riser Closet, approximately 7 inches near the top is constructed with lattice material creating multiple holes through which smoke can pass. The inside of the riser room is open to space above the drop ceiling, allowing smoke from outside or inside the riser closet to flow directly above the drop ceiling and away from the smoke and fire detection systems in the dining room. This finding was acknowledged by the Maintenance Director (from another facility) at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director (from another facility) present at 2:00 p.m. 3.1-19(b)		**by the deficient practice?** The Maintenance Director has drywalled Sprinkler Riser Closet. He has also fire caulked all the seams to create a smoke barrier. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All closets were inspected. No other concerns noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director was educated to ensure the sprinkler riser room has a smoke resistant enclosure. Review of sprinkler riser room will be added to the monthly preventative maintenance rounds. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director will round with the maintenance director prior to the compliance date to ensure the sprinkler riser room has a smoke resistant enclose. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 01 B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips in the therapy area met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 12 resident who receive therapy in the therapy room.	K 0920	**It is the intent of the facility to ensure power strips in the therapy area meets UL rating of 1363A or 60601-1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The power strip in the patient care vicinity was replaced with approved UL rating, and secured	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 01 B. WING	10/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director (from another facility) on 10/18/22 between 12:20 p.m. and 1:45 p.m., the Therapy area had a power strip near the stair equipment in the patient care vicinity that lacked a UL rating of 1363A or 60601-1 label on the power strip. Additionally, the aforementioned powers strip was dangling from the wall placing stress on the cords. This finding was acknowledged by the Maintenance Director (from another facility) at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director (from another facility) present at 2:00 p.m. 3.1-19(b)		to the wall. **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 rooms were inspected for power strips. No other concerns noted. **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 ensure all power strips have a correct UL rating and are secured to the wall. Review of rooms for power strips will be added to the monthly preventative maintenance rounds. **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 Executive Director will round with the maintenance director prior to the compliance date to ensure all power strips have the correct UL rating and are secured to the wall. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed.	