STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED
		155417	B. W	NG		08/10/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				GARDNER AVE		
HICKODA	Y CREEK AT SCOT	TSRUPG			SBURG, IN 47170		
HICKOR	I CREEK AT SCUT	TODONG		30011	350NG, IN 47 170		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 0	000			
	conducted by the In-	diana Department of Health in					
	accordance with 42	CFR 483.73.					
	Survey Date: 08/10	0/23					
	Facility Number: 0	00421					
	Provider Number:	155417					
	AIM Number: 1002	288340					
	At this Emergency I	Preparedness survey, Hickory					
	Creek of Scottsburg	was found in compliance with					
	Emergency Prepare	dness Requirements for					
	Medicare and Medic	caid Participating Providers					
	and Suppliers, 42 C	FR 483.73.					
	The facility has 36 of	certified beds. At the time of					
	the survey, the cens	us was 34.					
	Quality Review con	npleted on 08/15/23					
K 0000							
Bldg. 01							
		Recertification and State	K 0	000	This plan of correction constitu		
	_	as conducted by the Indiana			the facility's written allegation	of	
	Department of Heal	th in accordance with 42 CFR			compliance for the deficiencie	s	
	483.90(a).				cited. The submission of the F	lan	
					of Correction is not an admiss	ion	
	Survey Date: 08/10)/23			of or agreement with the		
					deficiencies or conclusions		
	Facility Number: 0	00421			contained in the Department's		
	Provider Number:	155417			inspection report. Hickory Cre		
	AIM Number: 1002	288340			Scottsburg would like to reque		
					desk review. Please feel free		
	At this Life Safety (Code survey, Hickory Creek of			contact Rachel Colwell, if you		
		nd not in compliance with			need any additional information	n to	
		-			_		

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

TITLE (X6) DATE

Rachel Colwell Administrator 09/01/2023

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155417	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/10/2023
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE ISBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of This one story facility Type II (000) constraints prinklered. The fawith hard wired smeand spaces open to battery operated small sleeping rooms. The and had a census of All areas where resilies were sprinklered an services were sprinklered an services were sprinklered.	articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors the corridors. The facility has oke detectors in all resident e facility has a capacity of 36 34 at the time of this survey. dents have customary access d all areas providing facility dered, except two detached try storage and oxygen		support the desk review at 812-595-6125. Thank you for consideration.	r your
	storage. Quality Review con	npleted on 08/15/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-he (with 3/4 hour fire automatic fire extiraccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		ONIB NO. 0936-039		
		X1) PROVIDER/SUPPLIER/CLIA	i '		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155417	B. WING		08/10/2023	
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIPTING BY AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
	`			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	the door. Describe the floor hazardous areas of REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Stot (over 50 square for g. Laboratories (if Hazard - see K32)	and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) hance, and Paint Shops boms (exceeding 64 In Rooms lons) brage Rooms/Spaces eet) classified as Severe	TAG	DEFICIENCY)	DATE	
	failed to ensure 1 of as Laundries (larger separated from othe partitions and doors or automatic closing This deficient pract residents, staff and Laundry. Findings include: Based on observation Director during a toto 2:05 p.m. on 08/1 clean side of the La latching hardware at the door failed to sef frame when tested the latching mechanism	of and interview, the facility of over 4 hazardous areas such than 100 square feet) were are spaces by smoke resistant and Doors shall be self closing ag in accordance with 7.2.1.8. it is could affect over 20 evisitors in the vicinity of the country of the facility from 1:05 p.m. 10/23, the corridor door to the undry was equipped with a self closing device but elf close and latch into the door to close multiple times. The in on the door failed to protrude the on the door frame. Based	K 0321	k321- It is the intent of this facto ensure the corridor to hazardous doors, such as laur room door, is provided with a self-closing device to meet set standards. 1. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/10/23 the Maintenance Director/designed adjusted the closure of the cordoor to the clean side of the laundry room. The door does fact now self-close and latch in the door frame. The Administrative rified the work on 08/11/23.	ndry nee ridor in into	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLE	
		155417	B. W	ING		08/10/2	023
	PROVIDER OR SUPPLIER		•	1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170	•	
HICKOR	Y CREEK AT SCOT	ITSBURG		30011	560RG, IN 47 170		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		time of the observations, the			having the potential to be	-4	
		or agreed the corridor door to E Laundry was not separated			affected by the same deficient practice will be identified and		
		vith smoke resistant partitions			what corrective actions will I		
	and doors.	vitir smoke resistant partitions			taken: All residents, staff, and		
	and doors.				visitors have the potential to b		
	These findings were	e reviewed with the			affected by this alleged deficie		
	_	he Maintenance Director			practice. On 08/23/23 the		
	during the exit conf	erence.			Maintenance Director/Designe	ee	
					inspected all hazardous area		
	3.1-19(b)				doors to verify that they latch		
					properly and found no other		
					negative findings.		
					3. 3. What measures will b	I	
					put into place or what syster	nic	
					changes will be made to ensure that the deficient		
					practice does not recur: On		
					08/23/23 the Administrator		
					inserviced the Maintenance		
					Director/Designee and all staf	f on	
					the requirement that all hazard		
					area doors must close and late		
					properly to meet set standards	s.	
					The Maintenance		
					Director/Designee will inspect	all	
					hazardous area doors through		
					the facility monthly to ensure t	hat	
					all self-closing doors latch		
					properly.		
					4 4 How the earnesting		
					4. 4. How the corrective action(s) will be monitored to		
					ensure the deficient practice		
					will not recur, i.e. what qualit		
					assurance program will be p	-	
					into place: The monthly		
					inspection results will be		
					presented by the Maintenance	_	

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB	NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	onstruction <u>01</u>	(X3) DATE SU COMPLET	
		155417	B. WING		08/10/20)23
	PROVIDER OR SUPPLIE		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE ISBURG, IN 47170		
				135010, 111 47 170		
(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
				Director/Designee at the monto QA meeting. Inspection resultand system components will be reviewed by the QA committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliant is maintained.	ts pe e	
K 0341 SS=F Bldg. 01	and components accordance with N Code, and NFPA Code to provide a part of the building occupied, detection alarm control unit detection is also in appliance circuit properties alarm system transmission path integrity. 18.3.4.1, 19.3.4.1 Based on observation failed to maintain 1 accordance with NI Code, 2010 Edition location of the dedi	m - Installation m is installed with systems approved for the purpose in NFPA 70, National Electric 72, National Fire Alarm effective warning of fire in any g. In areas not continuously on is installed at each fire . In new occupancy, installed at notification bower extenders, and in transmitting equipment. In wiring or other is are monitored for	K 0341	K341- It is the intent of this factor to ensure that fire alarm syster are maintained in accordance NFPA 72.	ms	09/09/2023
	states, for fire alarn	ntrol unit. Section 10.5.5.2.2 n systems the circuit ns shall be identified as "FIRE		will be accomplished for tho residents found to have been affected by the deficient		

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ALARM CIRCUIT." Section 10.5.5.2.3 states for

fire alarm systems the circuit disconnecting means

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practice: On 08/11/23 the

Maintenance Director/Designee

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155417	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2023
	ROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170	
(X4) ID PREFIX TAG	shall have a red man the circuit disconne accessible only to a 10.5.5.3 states the disconnections shall be damage. This deficience to the connection of the disconnection of the	ons with the Maintenance our of the facility from 1:05 p.m. 10/23, the fire alarm system e wall mounted electrical panel building on the west side of at locked. Based on interview observations, the Maintenance fire alarm system circuit ked. The reviewed with the he Maintenance Director	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) put a lock on the fire alarm system circuit breaker in the work mounted electrical panel locate outside the building on the westide of the property. The Administrator verified the work 08/11/23. 2. 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 residents, staff, a visitors have the potential to be affected by this alleged deficie practice. All fire alarms system that require locks were inspectible to the Maintenance Director/Designee with no other negative findings. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: On 08/23/23 the Administrator inserviced the Maintenance Director/Designee on the requirement of Fire Alarm Circ must be properly locked. The Maintenance Director/Designee will inspect the Fire Alarm Circ monthly to ensure that they are properly locked. 4. How the corrective	rall ed st st son st
				action(s) will be monitored to	,

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ensure the deficient practice

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PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155417		ILDING	01	COMPL 08/10/	ETED
	PROVIDER OR SUPPLIER Y CREEK AT SCOT			1100 N	ddress, city, state, zip cod GARDNER AVE SBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, are by construction type throughout by an assprinkler system in 13, Standard for the Systems. In Type I and II concept II and II concept II and II concept II concept II are as where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and the closet footprint Standard for Install Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1	Installation Installation Installation Ind hospitals where required Dee, are protected Deeproved automatic Definition accordance with NFPA Definition of Sprinkler Definition alternative Desire are permitted to be Desire are permitted to be Desire are permitted to be Desire are permitted in patient sleeping rooms Desire are not required in Desire are not exceed Desire are	K 03		will not recur, i.e. what quality assurance program where put into place: The month inspection results will be presented by the Maintenance Director/Designee at the month QA meeting. Inspection result and system components will be reviewed by the QA committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K351– It is the intent of the face	ly nly s e c	09/09/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155417	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/10/2023
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE TSBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	were not obstructed nurse's station in ac NFPA 13, 2010 edit	spray pattern for sprinklers in 1 of 1 Med Rooms at the cordance with LSC 19.3.5.1. tion, Section 8.5.5.1 states pocated so as to minimize		to ensure that spray patterns sprinklers are not obstructed accordance with NFPA 13 to set standards. 1. What corrective action	in meet
	sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This			will be accomplished for the residents found to have bee affected by the deficient practice: a. On 08/23/2023 the	ose n
				Maintenance Supervisor/desi adjusted the height of the she storage in the med room to e that the spray pattern for	elving nsure
	deficient practice co	ould affect over 20 residents, the vicinity of the nurse's		sprinklers were not obstructe follow the 18 inch guideline. 2. How other residents	a and
	Findings include:			having the potential to be affected by the same deficie practice will be identified an	
	Director during a to to 2:05 p.m. on 08/1 in the Med Room at height of the shelf's ceiling in the room the deflector for the the room. Based on observations, the M shelf storage in the sprinkler spray patterns.	ons with the Maintenance our of the facility from 1:05 p.m. 0/23, shelf storage was noted the nurse's station. The torage was nearly to the and was above and higher than ceiling mounted sprinkler in interview at the time of the aintenance Director agreed room would obstruct the tern for the ceiling mounted		what corrective action(s) wi be taken: All residents, staff visitors had the potential to be affected by this alleged defici practice. On 08/23/23 all oth storage areas in the building inspected by the Maintenance Director/designee to ensure sprinkler requirements have to met.	II , and e ent er were e
	These findings were Administrator and t during the exit conf 3.1-19(b)	e reviewed with the he Maintenance Director		3. What measures will be put into place or what syste changes will be made to ensure that the deficient practice does not recur: On 08/23/23 the Administrator inserviced the Maintenance Director/designee and all stat the 18- inch rule of sprinkler	mic

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155417	A. BUILDING B. WING	01	COMPLETED 08/10/2023
	ROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				requirements. The Maintenar Director/designee will complet monthly inspections of storage areas in the building to ensure items are stored in a manner to meets sprinkler coverage. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place: The Maintenance Director/designee will bring the monthly storage inspections to monthly QA meeting for review and discussion. Inspection results and system component will be reviewed by the QA committee with subsequent plof correction developed and implemented as deemed necessary to ensure compliant is maintained.	te e e e e e e e that
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing r and standpipe systems red, and maintained in IFPA 25, Standard for the rg, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a readily available. system last checked system test			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155417	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/10/2023
	PROVIDER OR SUPPLIEF		1100 N	ADDRESS, CITY, STATE, ZIP COD I GARDNER AVE ISBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to maintain the employee restroom. Section 3.3.5.4 deficentiations of the continuous ceiling the cause the sprinkler and gas cause the sprinkler temperature. Section between the sprinkler and the tyndeficient practice continuous ceiling the cause the sprinkler and the tyndeficient practice continuous cause the sprinkler and the tyndeficient practice cause the sprinkler and	RKS information on non-required or partial or system. In and NFPA 25 In and interview, the facility no ceiling construction in 1 of 1 is. NFPA 13, 2010 edition, not a smooth ceiling as a free from significant is, or indentations. The ceiling is sea around the sprinkler and it to operate at a specified on 8.5.4.1.1 states the distance for deflector and the ceiling is set of the distance for deflector and the type of the office of construction. This is build affect over 10 residents, if the vicinity of the employee for the facility from 1:05 p.m. 10/23, a six inch in diameter hole is vent was noted in the lead how the toilet in the lead how the toilet in the lead on the office of the observations, the for agreed the hole in the leady activation of the sprinkler form.	K 0353	K353 – It is the intent of the facility to maintain sprinkler systems in accordance with L 9.7.5 to meet set standards. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 08/25/23 the Maintenance Director ordered exhaust fan to replace the cei vent in the employee restroom 2. How other residents having the patential to be affected by the deficient practice where the cein vent in the employee restroom 2. How other residents having the patential to be affected by the deficient practice where the potential to be affected by the deficient practice where the potential to be affected by the potential to be affected from this alleged definition of the practice. On 08/23/23 the maintenance Director/Designal inspected all ceiling exhaust/fathroughout the facility with no other negative findings. The Administrator verified the world 08/24/23. 3. What measures will be purint place or what systemic changes will be made to ensure that the deficient	I an ling n

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	OF CORRECTION	IDENTIFICATION NUMBER 155417	A. BUILDING B. WING	01	COMPLETED 08/10/2023
	PROVIDER OR SUPPLIER Y CREEK AT SCOT		1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			practice does not recur: On 08/23/23 the Administrator inserviced the Maintenance Supervisor/designee regardin requirements of the facility sprinkler system per life safet code. On 08/30/23 the Maintenance Director/Desgine will install the new exhaust to replace the ceiling vent in the employee restroom. 4. How the corrective action(will be monitored to ensure deficient practice will not recur: The Maintenance Director/designee will bring the monthly storage inspections to monthly QA meeting for revier and discussion. Inspection results and system componer will be reviewed by the QA committee with subsequent plof correction developed and implemented as deemed necessary to ensure compliar is maintained.	s) the e o the w ats ans
K 0712 SS=C Bldg. 01	alarm signal and s conditions. Fire dri and unexpected til conditions, at leas The staff is familia aware that drills ar	t quarterly on each shift. r with procedures and is re part of established ills are conducted between			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/10/2023 155417 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1100 N GARDNER AVE HICKORY CREEK AT SCOTTSBURG SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility K 0712 **K 712** It is the standard to this 09/09/2023 failed to conduct quarterly fire drills at unexpected facility to meet all fire drill times under varying conditions on the first shift requirements including assurance for 3 of 4 quarters and on the second shift for 4 of that drills occur at varied times. 4 quarters. This deficient practice could affect all 1. What corrective action will residents, staff and visitors. be accomplished for those residents found to have been Findings include: affected by the deficient **practice?** The fire drill schedule Based on review of Direct Supply TELS Logbook has been reviewed and scheduled "Fire Drills" documentation with the Maintenance drills are in fact scheduled at Director during record review from 10:10 a.m. to varied times over all three shifts. 1:05 p.m. on 08/10/23, first shift fire drills 2. How other residents having conducted within the most recent twelve month the potential to be affected by the same deficient practice will period on 10/07/22, 04/28/23 and 07/19/23 were conducted at, respectively, 8:09 a.m., 8:47 a.m. and be identified and what 8:10 a.m. In addition, second shift fire drills corrective action(s) will be conducted within the most recent twelve month taken: All residents, staff, and period on 08/01/22, 11/07/22, 02/24/23 and on visitors have the potential to be 05/25/23 were conducted at, respectively, 3:27 affected by this alleged deficient p.m., 3:15 p.m., 3:59 p.m. and 2:59 p.m. Based on practice. The fire drill schedule interview at the time of record review, the has been reviewed and scheduled Maintenance Director agreed the aforementioned drills are in fact scheduled at first and second shift fire drills were not varied times over all three shifts. conducted at unexpected times under varying 3. What measures will be put conditions. into place or what systemic changes will be made to These findings were reviewed with the ensure that the deficient Administrator and the Maintenance Director practice does not recur? On during the exit conference. 08/23/23 the Administrator inserviced the Maintenance 3.1-19(b)Director/designee regarding fire drill regulation. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2023
FORM APPROVED
OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC.	AID SERVICES			OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	ETED
		155417	B. WING		08/10/	2023
	PROVIDER OR SUPPLIER		1100 N	ADDRESS, CITY, STATE, ZIP COD GARDNER AVE SBURG, IN 47170		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG			DATE
				assurance program will be pi into place? The Maintenance Director will review and discus fire drill completion records monthly at the monthly QA meeting. This plan of correction constitutiour credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/09/23.	utes	

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