STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155417	A. BUILDING -- B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(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: 08/10/23 Facility Number: 000421 Provider Number: 155417 AIM Number: 100288340 At this Emergency Preparedness survey, Hickory Creek of Scottsburg was found in 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 34. Quality Review completed on 08/15/23	E 0000		
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: 08/10/23 Facility Number: 000421 Provider Number: 155417 AIM Number: 100288340 At this Life Safety Code survey, Hickory Creek of Scottsburg was found not in compliance with	K 0000	This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of the Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Hickory Creek of Scottsburg would like to request a desk review. Please feel free to contact Rachel Colwell, if you need any additional information to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Colwell	Administrator	09/01/2023

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	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 34 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage and oxygen storage. Quality Review completed on 08/15/23		support the desk review at 812-595-6125. Thank you for your consideration.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 4 hazardous areas such as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Laundry. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 2:05 p.m. on 08/10/23, the corridor door to the clean side of the Laundry was equipped with latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. Based	K 0321	**K321-** It is the intent of this facility to ensure the corridor to hazardous doors, such as laundry 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/designee adjusted the closure of the corridor door to the clean side of the laundry room. The door does in fact now self-close and latch into the door frame. The Administrator verified the work on 08/11/23. 2. 2.**How other residents**	09/09/2023

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	on interview at the time of the observations, the Maintenance Director agreed the corridor door to the clean side of the Laundry was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents, staff, and visitors have the potential to be affected by this alleged deficient practice. On 08/23/23 the Maintenance Director/Designee inspected all hazardous area doors to verify that they latch properly and found no other negative findings. 3. 3.**What measures will be put into place or what systemic 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 staff on the requirement that all hazardous area doors must close and latch properly to meet set standards. The Maintenance Director/Designee will inspect all hazardous area doors throughout the facility monthly to ensure that all self-closing doors latch properly. 4. 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 put into place:** The monthly inspection results will be presented by the Maintenance	

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			Director/Designee at the monthly QA meeting. Inspection results 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.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means	K 0341	**K341-** It is the intent of this facility to ensure that fire alarm systems are maintained in accordance with NFPA 72. **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 08/11/23 the Maintenance Director/Designee	09/09/2023

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	shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 2:05 p.m. on 08/10/23, the fire alarm system circuit breaker in the wall mounted electrical panel located outside the building on the west side of the property was not locked. Based on interview at the time of the observations, the Maintenance Director agreed the fire alarm system circuit breaker was not locked. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		put a lock on the fire alarm system circuit breaker in the wall mounted electrical panel located outside the building on the west side of the property. The Administrator verified the work on 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, and visitors have the potential to be affected by this alleged deficient practice. All fire alarms systems that require locks were inspected by the Maintenance Director/Designee with no other negative findings. 3. **What measures will be put into place or what systemic 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 Circuits must be properly locked. The Maintenance Director/Designee will inspect the Fire Alarm Circuits monthly to ensure that they are properly locked. 4. **How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e. what quality assurance program will be put into place: The monthly inspection results will be presented by the Maintenance Director/Designee at the monthly QA meeting. Inspection results 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.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility	K 0351	**K351**– It is the intent of the facility	09/09/2023

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	failed to ensure the spray pattern for sprinklers were not obstructed in 1 of 1 Med Rooms at the nurse's station in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states 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 deficient practice could affect over 20 residents, staff and visitors in the vicinity of the nurse's station. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 2:05 p.m. on 08/10/23, shelf storage was noted in the Med Room at the nurse's station. The height of the shelf storage was nearly to the ceiling in the room and was above and higher than the deflector for the ceiling mounted sprinkler in the room. Based on interview at the time of the observations, the Maintenance Director agreed shelf storage in the room would obstruct the sprinkler spray pattern for the ceiling mounted sprinkler in the room. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		to ensure that spray patterns for sprinklers are not obstructed in accordance with NFPA 13 to meet set standards. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: a. On 08/23/2023 the Maintenance Supervisor/designee adjusted the height of the shelving storage in the med room to ensure that the spray pattern for sprinklers were not obstructed and follow the 18 inch guideline. 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, and visitors had the potential to be affected by this alleged deficient practice. On 08/23/23 all other storage areas in the building were inspected by the Maintenance Director/designee to ensure sprinkler requirements have been met. 3. **What measures will be put into place or what systemic 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 staff on the 18- inch rule of sprinkler	

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			requirements. The Maintenance Director/designee will complete monthly inspections of storage areas in the building to ensure items are stored in a manner that 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 put into place:** The Maintenance Director/designee will bring the monthly storage inspections to the monthly QA meeting for review and discussion. Inspection results 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.	
K 0353 SS=E Bldg. 01	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. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source 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 observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 employee restrooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the employee restroom. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 2:05 p.m. on 08/10/23, a six inch in diameter hole for a former ceiling vent was noted in the suspended ceiling tile above the toilet in the employee restroom. No HVAC ductwork was hooked up to the former ceiling vent. Based on interview at the time of the observations, the Maintenance Director agreed the hole in the ceiling tile would delay activation of the sprinkler located in the restroom. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0353	**K353** – It is the intent of the facility to maintain sprinkler systems in accordance with LSC 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 an exhaust fan to replace the ceiling vent in the employee restroom. 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, and visitors have the potential to be affected from this alleged deficient practice. On 08/23/23 the Maintenance Director/Designee inspected all ceiling exhaust/fans throughout the facility with no other negative findings. The Administrator verified the work on 08/24/23. 3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	09/09/2023

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	3.1-19(b)		**practice does not recur**: On 08/23/23 the Administrator inserviced the Maintenance Supervisor/designee regarding the requirements of the facility sprinkler system per life safety code. On 08/30/23 the Maintenance Director/Desginee will install the new exhaust to replace the ceiling vent in the employee restroom. 4.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur**: The Maintenance Director/designee will bring the monthly storage inspections to the monthly QA meeting for review and discussion. Inspection results 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.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded			

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	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 failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters and on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook "Fire Drills" documentation with the Maintenance Director during record review from 10:10 a.m. to 1:05 p.m. on 08/10/23, first shift fire drills conducted within the most recent twelve month 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 8:10 a.m. In addition, second shift fire drills conducted within the most recent twelve month period on 08/01/22, 11/07/22, 02/24/23 and on 05/25/23 were conducted at, respectively, 3:27 p.m., 3:15 p.m., 3:59 p.m. and 2:59 p.m. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned first and second shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0712	**K 712** It is the standard to this facility to meet all fire drill requirements including assurance that drills occur at varied times. 1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The fire drill schedule has been reviewed and scheduled drills are in fact scheduled at varied times over all three shifts. 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, and visitors have the potential to be affected by this alleged deficient practice. The fire drill schedule has been reviewed and scheduled drills are in fact scheduled at varied times over all three shifts. 3**. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 08/23/23 the Administrator inserviced the Maintenance 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**	09/09/2023

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			assurance program will be put into place? The Maintenance Director will review and discuss fire drill completion records monthly at the monthly QA meeting. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 09/09/23.	