

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

PRINTED: 06/20/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/30/2023	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975			
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/30/23</p> <p>Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770</p> <p>At this Emergency Preparedness survey, Hickory Creek at Rochester was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 36 and had a census of 31 at the time of this survey.</p> <p>Quality Review completed on 05/31/23</p>			E 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey.</p>		
E 0004 SS=F Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]</p>						

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

TITLE

(X6) DATE

Tommi Pruitt

Executive Director

06/15/2023

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

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	<p>must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient</p>			E 0004	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set		06/08/2023

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	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Executive Director (ED) and the Maintenance Director (MD) on 05/30/23 at 11:50 a.m., the EPP had an annual review date of 5/1/22, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the ED and MD agreed the EPP has not been reviewed or updated within the last year. The ED reviewed and updated the EPP during the survey on this date.</p> <p>This finding was reviewed with the ED and MD during the exit conference.</p> <p>3.1-19(b)</p>		<p>forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey. EOO4</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Administrator and Maintenance Director have reviewed and updated Emergency Preparedness program. Documentation has been updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All copies of the Emergency Preparedness plan have been review/updated and documented.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Executive Director/Maintenance Director have been educated to review Emergency Preparedness Program every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to</p>		

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E 0013 SS=F Bldg. --	<p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the</p>		<p>review the Emergency Preparedness Program at least annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.</p> <p>By what date the systemic changes will be completed: 6/8/2023</p>		

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	<p>communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency</p>						

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	<p>preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Executive Director (ED) and the Maintenance Director (MD) on 05/30/23 at 11:50 a.m., the EPP had an annual review date of 5/1/22, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the ED agreed the EPP's Policies and Procedures has not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the ED and MD during the exit conference.</p> <p>3.1-19(b)</p>			E 0013	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey E013</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Administrator and Maintenance Director have reviewed and updated Emergency Preparedness plans policies and procedures.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>		06/08/2023

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E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6),		action(s) will be taken: The updates to the plan to include apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance Director have been educated to review Emergency Preparedness Policies and Procedures every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Policies and Procedures at least annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Policies and Procedures was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually. By what date the systemic changes will be completed: 6/8/2023		

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	<p>485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5)</p> <p>Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the</p>						

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	<p>process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) includes the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b) (6). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Executive Director (ED) and the Maintenance Director (MD) on 05/30/23 at 1:15 p.m., the provided EPP did not address the use of volunteers in an emergency. Based on interview at the time of records review, the ED provided a policy on the use of volunteers but it did not include information on allowing volunteers to be utilized in the event of an emergency..</p> <p>This finding was reviewed with the ED and MD during the exit conference.</p> <p>3.1-19(b)</p>			E 0024	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey.</p> <p>E024</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Executive Director updated building Emergency Preparedness Plan to include the uses of volunteers in an emergency.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Executive Director/Maintenance Director were educated to review the Communication Plan in the Emergency Preparedness Plan annually. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the</p>		06/08/2023

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E 0029 SS=F Bldg. --	<p>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)</p> <p>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).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and</p>				<p>Communication Plan at least annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program Communications Plan was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.</p> <p>By what date the systemic changes will be completed: 6/8/2023</p>		

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	<p>local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Executive Director (ED) and the Maintenance Director (MD) on 05/30/23 at 11:50 a.m., the EPP had an annual review date of 5/1/22 and no other date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the ED agreed the EPP's Communication Plan had not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the ED and MD during the exit conference.</p> <p>3.1-19(b)</p>			E 0029	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey. E029</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Executive Director updated building Emergency Preparedness Plan Communication Plan. 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: The updates to the Communication Plan apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance</p>		06/08/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/30/2023
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2),		<p>Director were educated to review the Communication Plan in the Emergency Preparedness Plan annually. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Communication Plan at least annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Annual review of the Emergency Preparedness Program Communications Plan was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.</p> <p>By what date the systemic changes will be completed: 6/8/2023</p>		

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	<p>§485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed</p>						

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

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	<p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must</p>						

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

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

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

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

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

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	<p>OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based</p>			E 0039	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey E039</p> <p>What corrective action(s) will be accomplished for those</p>		06/08/2023

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	<p>full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Executive Director (ED) and the Maintenance Director (MD) on 05/30/23 at 1:15 p.m., documentation for the tabletop exercise conducted on 02/15/23 was incomplete. The documentation did not show if the facility's response was analyzed to ensure the EPP policies were effective. Based on interview at the time of records review, the ED and the MD agreed no documentation for analyzing the LTC facility's response was completed.</p> <p>This finding was reviewed with the ED and MD at the exit conference.</p> <p>3.1-19(b)</p>				<p>residents found to have been affected by the deficient practice:</p> <p>Documentation for the tabletop exercise conducted on 2/15/2023 was completed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The analyzed data review could affect all residents.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Executive Director/Maintenance Director educated that the tabletop exercise will be completed with full documentation every 12 months. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the tabletop exercise at least annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Annual review of the tabletop exercise was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the</p>		

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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 05/30/23</p> <p>Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770</p> <p>At this Life Safety Code survey, Hickory Creek at Rochester was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined and verified to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The building is partially protected by a propane fueled 60 kW emergency generator. The facility has a capacity of 36 and had a census of 31 at the time of this survey.</p>	K 0000	<p>tabletop exercise is completed annually. By what date the systemic changes will be completed: 6/8/2023</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity involved with this survey.</p>		

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

PRINTED: 06/20/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2023	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH STREET ROCHESTER, IN 46975			
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K 0223 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility services which were not sprinklered. One building was used as the Maintenance Office, one for miscellaneous storage and the other was used for oxygen storage and transfilling.</p> <p>Quality Review completed on 05/31/23</p> <p>NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen corridor doors to a hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 10 residents in the corridor and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director (ED) and the</p>			K 0223	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. We respectfully request consideration for a desk review or paper compliance, due to the low number of deficiencies and or the low scope and severity</p>		06/08/2023

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	<p>Maintenance Director (MD) on 05/30/23 at 1:35 p.m., the kitchen contained over 62 gallons of trash and a storage room with a door held open; making the kitchen a hazardous area. The door to the kitchen from the corridor was self-closing, but there was a trash container stored in the path of closure of the door not allowing the door to close. Based on interview at the time of observation, the ED agreed the door was held open with a device that would release with the fire alarm but was unable to close due to the trash container being stored in the path of closure. The ED did move the trash container after observing that the door would not close. After moving the trash container the door did close and latch properly.</p> <p>This finding was reviewed with the ED and MD at the exit conference.</p> <p>3.1-19(b)</p>				<p>involved with this survey.</p> <p>K223</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Trash can has been removed allowing the door to latch in the frame.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All other doors have been reviewed to ensure the path of closer is clear to allow door to latch into frame. No other issues were found.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All staff educated on ensuring all doors have a clear path of closer. Review of doors for proper closure will be added to the monthly preventative maintenance schedule.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Executive Director will round with the maintenance director prior</p>		

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			to the compliance date to ensure all doors have a clear path and functioning properly. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks have been completed. By what date the systemic changes will be completed: 6/8/2023 is survey		