DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDICA		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND DE LIVER CORRESPONDE	TD F1 1977 C - 97 C - 1 7 C -		a a s ent emen		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. Bl	A. BUILDING B. WING			COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIER		-	340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
Bldg	conducted by the In accordance with 42 Survey Date: 05/30 Facility Number: 06 Provider Number: 1 AIM Number: 1000 At this Emergency Creek at Rochester with Emergency Promote and Mediand Suppliers, 42 C	00326 55430 290770 Preparedness survey, Hickory was found not in compliance eparedness Requirements for caid Participating Providers FR 483.73. The facility has a nad a census of 31 at the time	E 0	000	The creation and submiss this plan of correction does constitute an admission by provider of any conclusion forth in the statement of deficiencies, or of any viol of regulation. We respect request consideration for desk review or paper compliance, due to the low number of deficiencies and the low scope and severity involved with this survey.	s not y this n set ation fully a		
E 0004 SS=F Bldg	403.748(a), 416.5 441.184(a), 482.1 484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §460 §483.73(a), §483. §485.68(a), §485. §485.920(a), §486 §494.62(a). The [facility] must Federal, State and	4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a), (a) Review and Update 5.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 5.360(a), §491.12(a), comply with all applicable						

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

TITLE (X6) DATE

Tommi Pruitt Executive Director 06/15/2023

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2023		
	PROVIDER OR SUPPLIER Y CREEK AT ROCI		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(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)	(X5) COMPLETION DATE		
	comprehensive en program that mee section. The emer program must incithe following elem (a) Emergency Pladevelop and main preparedness pla and updated at lemust do all of the * [For hospitals at §485.625(a):] Emor CAH] must con Federal, State, an preparedness req CAH] must develocomprehensive en program that mee section, utilizing at * [For LTC Facilitie Emergency Plan. develop and main preparedness pla and updated at lemergency Plan. develop and main preparedness pla and updated at lemergency Plan. develop and main preparedness pla and updated at lemergency Plan.	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must itain an emergency in that must be reviewed, ast annually. lities at §494.62(a):] The ESRD facility must itain an emergency in that must be [evaluated], ast every 2 years.					
	failed to review and Preparedness Plan (view and interview, the facility dupdate the Emergency (EPP) at least annually in CFR 483.73(a). This deficient	E 0004	The creation and submissio this plan of correction does constitute an admission by provider of any conclusions	not this		

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	OF CORRECTION	IDENTIFICATION NUMBER 155430	A. BUILDING B. WING		COMP	LETED 0/2023
	PROVIDER OR SUPPLIER Y CREEK AT ROCH		340 E 18	DDRESS, CITY, STATE, ZIP C BTH STREET STER, IN 46975	OD	
(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 CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
IAU	practice could affect Findings include: Based on records re Director (ED) and to on 05/30/23 at 11:50 review date of 5/1/2 found to show the E within the last year. records review, the has not been review year. The ED review during the survey or	view with the Executive the Maintenance Director (MD) 0 a.m., the EPP had an annual 2, no other date could be EPP was reviewed and updated Based on an interview during ED and MD agreed the EPP ted or updated within the last wed and updated the EPP in this date.		forth in the statement deficiencies, or of any of regulation. We resprequest consideration desk review or paper compliance, due to the number of deficiencie the low scope and sevinvolved with this surfected by the deficiency be accomplished for the residents found to have affected by the deficiency practice: Administrator and Main Director have reviewed updated Emergency Program. Documentation updated. How other residents his potential to be affected same deficient practice identified and what contact action(s) will be taken All copies of the Emergy Preparedness plan have review/updated and do What measures will be place or what systemic changes will be made ensure that the deficiency practice does not recurred to the ensure that the deficiency prector have been edure the ensure that the deficiency program every 12 mon QAPI. The QAPI and Program every 12 mon QAPI. The QAPI and Program updated for the Expoirector/Maintenance in the potential to the Expoirector/Maintenance in the program and program is updated for the Expoirector/Maintenance in the program is updated for the Expoirector/Maintenance in	violation pectfully n for a e low es and or verity vey. n(s) will chose ve been ent ntenance d and reparedness on has been naving the de by the ce will be prective ic gency ve been coumented. e put into ic to ent ur: ntenance ucated to paredness on has deen	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIE		3	340 E 18	DDRESS, CITY, STATE, ZIP COD BTH STREET STER, IN 46975	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) review the Emergency	ATE	(X5) COMPLETION DATE
E 0013 SS=F Bldg	484.102(b), 485.6	5(b), 483.475(b), 483.73(b), 625(b), 485.68(b),			Preparedness Program at lea annually. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place: Annual review of the Emerger Preparedness Program was at to the TELS checklist and QA calendar. The Executive Dire will review the TELS documentation and QAPI calemonthly to ensure the annual review is completed annually. By what date the systemic changes will be completed: 6/8/2023	the out ncy added Pl actor	
	491.12(b), 494.62 Development of E §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485 §485.920(b), §48 §494.62(b). (b) Policies and p develop and impl preparedness po on the emergenc (a) of this section	220(b), 486.360(b), 2(b) EP Policies and Procedures 6.54(b), §418.113(b), 0.84(b), §482.15(b), .475(b), §484.102(b), .625(b), §485.727(b), 6.360(b), §491.12(b), rocedures. [Facilities] must ement emergency icies and procedures, based by plan set forth in paragraph control, risk assessment at the forth of this section, and the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY TPLETED 30/2023
	PROVIDER OR SUPPLIEF		340 E	ADDRESS, CITY, STATE, ZIP (18TH STREET ESTER, IN 46975	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	section. The police	an at paragraph (c) of this sies and procedures must updated at least every 2				
	and procedures. In develop and imples preparedness policion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and use "Additional Require ESRD Facilities: *[For PACE at §46 procedures. The develop and imples preparedness policion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policia address managen nonmedical emergimited to: Fire; equilimited t	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually. Tements for PACE and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water ad emergencies; and natural threaten the health or				
	The policies and previewed and upd *[For ESRD Faciliand procedures.	cipants, staff, or the public. brocedures must be ated at least every 2 years. ties at §494.62(b):] Policies The dialysis facility must				
	develop and imple	ement emergency				

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u></u>	COMPLETED
		155430	B. W	ING		05/30/2023
NAME OF I	PROVIDER OR SUPPLIEF	₹	_		ADDRESS, CITY, STATE, ZIP COD	
HICKUD	Y CREEK AT ROCI	HESTER			I8TH STREET ESTER, IN 46975	
	T				-01ER, IN 409/0	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
IAU		icies and procedures, based		IAU		DATE
	1 ' '	plan set forth in paragraph				
		risk assessment at				
		of this section, and the				
		an at paragraph (c) of this				
		cies and procedures must				
		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					
	area.	he facility's geographic				
	Based on record review and interview, the facility		E 00	013	The creation and submissio	on of $06/08/2023$
		d update the Emergency		J 1 J	this plan of correction does	
		s (EPP) Policies and Procedures			constitute an admission by	
	_	accordance with 42 CFR			provider of any conclusion	
	483.73(a). This defi	icient practice could affect all			forth in the statement of	
	occupants.				deficiencies, or of any violat	
					of regulation. We respectful	lly
	Findings include:				request consideration for a	
	Rased on records re	eview with the Executive			desk review or paper	
		the Maintenance Director (MD)			compliance, due to the low number of deficiencies and	or
		0 a.m., the EPP had an annual			the low scope and severity	"
		22, no other date could be			involved with this survey	
		EPP's Policies and Procedures			E013	
	were reviewed and	updated within the last year.			What corrective action(s) w	rill
		ew during records review, the			be accomplished for those	
		's Policies and Procedures has			residents found to have bee	en
	not been reviewed	or updated within the last year.			affected by the deficient	
	TEL: (* 1)	. 1 .4 4 .55 . 11.55			practice:	
	_	viewed with the ED and MD			Administrator and Maintenand	ce
	during the exit conf	erence.			Director have reviewed and	dness
	3.1-19(b)				updated Emergency Prepared plans policies and procedures	
					How other residents having	
					potential to be affected by the	
					same deficient practice will	
					identified and what corrective	

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CENTERS FOI	R MEDICARE & MEDI	CAID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED		
		155430	B. W	NG		05/30	/2023	
HICKOR	PROVIDER OR SUPPLIE Y CREEK AT ROC			340 E ² ROCHI	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975		(V5)	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	+	TAG			DATE	
F 0004					action(s) will be taken: The updates to the plan to incapply to all residents. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenar Director have been educated review Emergency Preparedre Policies and Procedures ever months in QAPI. The QAPI at PM calendar was updated for Executive Director/Maintenar Director to review the Emerger Preparedness Policies and Procedures at least annually. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be preparedness Policies and Procedures was added to the Interpretation of the Emerger Preparedness Policies and Procedures was added to the Interpretation of the Emerger Preparedness Policies and Procedures was added to the Interpretation of Interpretation and QAPI calendar. The Executive Direction will review the TELS documentation and QAPI calemonthly to ensure the annual review is completed annually By what date the systemic changes will be completed: 6/8/2023	nto nce to ness ry 12 nd r the nce ency the cetor endar .		
E 0024	403.748(b)(6), 4	16.54(b)(5), 418.113(b)(4),						

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441.184(b)(6), 482.15(b)(6), 483.475(b)(6),

483.73(b)(6), 484.102(b)(5), 485.625(b)(6),

SS=F

Bldg. --

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G		COMPL	
		155430	B. WING			05/30/	/2023
	ROVIDER OR SUPPLIER		340	E 18	DDRESS, CITY, STATE, ZIP COD 3TH STREET STER, IN 46975		
(X4) ID	SHMMARV	STATEMENT OF DEFICIENCIE	ID	Т			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAC		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	485.68(b)(4), 485.491.12(b)(4), 494. Policies/Procedure \$403.748(b)(6), \$4\$441.184(b)(6), \$4\$485.68(b)(4), \$485.68(b)(4), \$485.920(b)(5), \$4\$1.184(b)(6), \$4\$1	727(b)(4), 485.920(b)(5), 62(b)(5) es-Volunteers and Staffing 416.54(b)(5), §418.113(b)(4), 460.84(b)(7), §482.15(b)(6), 33.475(b)(6), §485.727(b)(4), 491.12(b)(4), §494.62(b)(5). Procedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must ring:] 7) as noted above] The use of emergency or other g strategies, including the for integration of State and ted health care ddress surge needs during ess surge needs during and the emergency staffing ess surge needs during and 418.113(b):] Policies and					
	Simple your in all t	and build	1				I

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emergency staffing strategies, including the

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430 A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2023					
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD 18TH STREET			
HICKOR	Y CREEK AT ROCH	HESTER		ROCH	ESTER, IN 46975			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	 	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
IAU	process and role for Federally designal professionals to an an emergency. Based on record revisited to ensure Em (EPP) includes the emergency or other including the processionals to added emergency in accord (6). This deficient proceupants. Findings include: Based on records reduce Director (ED) and the on 05/30/23 at 1:15 address the use of volume ED provided a pubit it did not includivolunteers to be utility.	for integration of State and ted health care ddress surge needs during view and interview, the facility ergency Preparedness Plan use of volunteers in an emergency staffing strategies, and role for integration of esignated health care dress surge needs during an dance with 42 CFR 483.73(b) what with the Executive he Maintenance Director (MD) p.m., the provided EPP did not colunteers in an emergency, at the time of records review, policy on the use of volunteers in incompanion on allowing dized in the event of an eviewed with the ED and MD	E 00		The creation and submission this plan of correction does constitute an admission by provider of any conclusions forth in the statement of deficiencies, or of any violat of regulation. We respectful request consideration for a desk review or paper compliance, due to the low number of deficiencies and the low scope and severity involved with this survey. E024 What corrective action(s) where the second is second to have been affected by the deficient practice: Executive Director updated building Emergency Prepared Plan to include the uses of volunteers in an emergency. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: Executive Director/Maintenant Director were educated to revereighted.	not this set cion lly or ill n lness the ne be ve ce riew	06/08/2023	
					the Communication Plan in the Emergency Preparedness Pla	е		

Director to review the

annually. The QAPI and PM calendar was updated for the Executive Director/Maintenance

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	PARTMENT OF HEALTH AND HUMAN SERVICES INTERS FOR MEDICARE & MEDICAID SERVICES						
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2023		
	PROVIDER OR SUPPLIER		340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET IESTER, IN 46975			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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	(X5) COMPLETION DATE		
TAU	REGULATORT OF	CESC IDENTIFIEND INFORMATION	TAG	Communication Plan at least annually.	DAIL		
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pointo place: Annual review of the Emerger Preparedness Program Communications Plan was addo to the TELS checklist and QAI calendar. The Executive Directivity review the TELS documentation and QAPI calemonthly to ensure the annual review of the Communication is completed annually. By what date the systemic changes will be completed: 6/8/2023	ut ncy ded PI ctor		
E 0029 SS=F Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COMP			ETED
		155430	B. W	ING		05/30/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER			ESTER, IN 46975		
THOROIX	·	IEGTER		ROOFIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		st be reviewed and updated					
	1	ears [annually for LTC					
	facilities].						
		view and interview, the facility	E 00	029	The creation and submission	-	06/08/2023
		l update the Emergency			this plan of correction does i		
	_	(EPP) Communication Plan at			constitute an admission by this		
	1	cordance with 42 CFR			1 ·	provider of any conclusion set	
	` ′	icient practice could affect all			forth in the statement of		
	occupants.				deficiencies, or of any violati		
	Findings include: Based on records review with the Executive				of regulation. We respectfull	У	
					request consideration for a		
					desk review or paper		
					compliance, due to the low	_	
	Director (ED) and the Maintenance Director (MD) on 05/30/23 at 11:50 a.m., the EPP had an annual				number of deficiencies and o	or	
		22 and no other date could be			the low scope and severity		
		EPP's Communication Plan was			involved with this survey.		
		eed within the last year. Based			E029		
	_	ing records review, the ED			What corrective action(s) will	1	
		ommunication Plan had not			be accomplished for those		
	_	pdated within the last year.			residents found to have beer		
	been reviewed or up	pdated within the last year.			affected by the deficient		
	This finding was re	viewed with the ED and MD			practice:		
	during the exit conf				Executive Director updated		
	during the exit com	orenee.			building Emergency Prepared	ness	
	3.1-19(b)				Plan Communication Plan.	1000	
					How other residents having t	he	
					potential to be affected by th		
					same deficient practice will b		
					identified and what corrective		
					action(s) will be taken:		
					The updates to the		
					Communication Plan apply to	all	
					residents.		
					What measures will be put in	to	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not reoccur:		
					Executive Director/Maintenand	ce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIE Y CREEK AT ROC		340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
140	REGULATORY	LEC BENTH THY BY ORMATION		Director were educated to reviet 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. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be purinto place: Annual review of the Emergency Preparedness Program Communications Plan was added to the TELS checklist and QAPI calendar. The Executive Direct will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication First completed annually. By what date the systemic changes will be completed:	ew e he tt cy ded Pl ctor mdar
E 0039 SS=F Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2),		6/8/2023	

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Event ID:

§483.475(d)(2), §484.102(d)(2), §485.68(d)(2),

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	
		155430	B. W	ING		05/30/	/2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		340 E 1	8TH STREET		
HICKOR	Y CREEK AT ROCI	HESTER		ROCHE	STER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§485.625(d)(2), §- (2), §491.12(d)(2)	485.727(d)(2), §485.920(d) , §494.62(d)(2).					
	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,						
		20, RHCs/FQHCs at					
		RD Facilities at §494.62]:					
		acility] must conduct					
		he emergency plan					
		ility] must do all of the					
	following:						
	(i) Participate in a full-scale exercise that is						
	-	every 2 years; or					
	1 ' '	nunity-based exercise is					
		onduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
		ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
	-	or individual, facility-based e following the onset of the					
	actual event.	e following the offset of the					
		ditional exercise at least					
	, ,	posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
	` '	limited to the following:					
		scale exercise that is					
		or individual, facility-based					
	functional exercise	-					
	(B) A mock disast						
	(C) A tabletop exe	ercise or workshop that is					
		and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430		UILDING	NSTRUCTION	COMP	E SURVEY PLETED D/2023	
	PROVIDER OR SUPPLIER Y CREEK AT ROCI		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE AP	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE		
TAG	to challenge an er (iii) Analyze the [firmaintain documer exercises, and en the [facility's] eme the patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a community based functional emergency exempt from engangement from engang	regency plan. acility's] response to and intation of all drills, tabletop regency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must do retest the emergency rally. The hospice must do revery 2 years; or reverse every 2 years; or experiences a natural or repency that requires activation plan, the hospital is reging in its next required full based exercise or individual ctional exercise every 2 response of the following the gency event. diditional exercise every 2 response events are full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: rescale exercise that is a or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a		TAG	CROSS-REPERICENCY) DEFICIENCY)	OPKIAIE	DATE	
	messages, or pre to challenge an er	pared questions designed mergency plan.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIER		340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975	•
(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 CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICED TO THE APPROPR	DBE COMPLETION
	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a commaccessible, conduct facility-based functional exercise emergency exempt from engate full-scale community functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop extenditation that including a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency's emergency in the hospice's emergency.	ct an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required city based or facility-based or facility based or a facility based or a facility based or a facility based or a facility based or facility based or or a facility based or faci			
	§482.15(d), CAHs	.41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIER		<u> </u>	340 E 1	ADDRESS, CITY, STATE, ZIP COD 8TH STREET ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community-(A) When a commaccessible, condutacility-based function (B) If the [PRTF, Han actual natural of that requires active plan, the [facility] is next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A mo (C) A tabletop is led by a facilitate discussion, using clinically-relevantace set of problem state messages, or prepto challenge an error (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded.	to test the emergency r. The [PRTF, Hospital, following: n annual full-scale exercise based; or unity-based exercise is not ct an annual individual, tional exercise; or dospital, CAH] experiences or man-made emergency ation of the emergency s exempt from engaging in ull-scale community based ty-based functional exercise t of the emergency event. an [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed orared questions designed energency plan. ne [facility's] response to umentation of all drills, is, and emergency plan, as					
	conduct exercises	ACE organization must to test the emergency ally. The PACE					
	organization must	ao me ronowing:					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/30/2023			
	PROVIDER OR SUPPLIE		•	STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	SHOULD BE COMPLET			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		an annual full-scale exercise							
	that is community								
		nunity-based exercise is not							
		ıct an annual individual,							
		ctional exercise; or							
		xperiences an actual natural							
		ergency that requires							
		mergency plan, the PACE							
	The state of the s	ngaging in its next required							
		nity based or individual,							
	onset of the emer	ctional exercise following the							
		an additional exercise every							
	` '	the year the full-scale or							
	1	e under paragraph (d)(2)(i)							
		conducted that may include,							
	but is not limited t								
		-scale exercise that is							
		or individual, a facility							
	based functional								
	(B) A mock disas								
	` '	ercise or workshop that is							
		and includes a group							
	discussion, using								
	_	emergency scenario, and a							
		atements, directed							
		pared questions designed							
	to challenge an e								
	_	PACE's response to and							
	maintain docume	ntation of all drills, tabletop							
	exercises, and en	nergency events and revise							
		gency plan, as needed.							
	*[For LTC Facilitie	es at §483.73(d):]							
	(2) The [LTC facil	ity] must conduct exercises							
	to test the emerge	ency plan at least twice per							
		announced staff drills using							
	, ,	ocedures. The [LTC facility,							
	ICF/IID] must do								
	_	an annual full-scale exercise							

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	MENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	ì í	UILDING	NSTRUCTION	COM	E SURVEY PLETED 60/2023	
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
	accessible, conduction facility-based functional LTC facility is exercipled and individual, facility following the onse (ii) Conduct an athat may include, following: (A) A second full community-based based functional (B) A mock disase (C) A tabletop exist of problem start messages, or present to challenge an expense to and all drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at (2) Testing. The I exercises to test twice per year. The following: (i) Participate in a that is community (A) When a community (B) If the care is a community (A) When a community (B) If the care is a community (B) If the care is a community (C) If the care is a community (C) When a community (C) If the care is a care in the care in the care is a care in the care in the care is a care in the care in the care in the care in the care is a care in the care in t	nunity-based exercise is not uct an annual individual, ctional exercise. cility] facility experiences an man-made emergency that in of the emergency plan, the empt from engaging its next ale community-based or based functional exercise et of the emergency event. dditional annual exercise but is not limited to the exercise; or ster drill; or exercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed exercised exercise designed emergency plan. [LTC facility] facility's maintain documentation of exercises, and emergency et he [LTC facility] facility's as needed. §483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the						

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	OF CORRECTION	IDENTIFICATION NUMBER 155430	A. BUILDING B. WING		COM	PLETED 80/2023
	PROVIDER OR SUPPLIER		340 E 1	ADDRESS, CITY, STATE, ZIF 18TH STREET ESTER, IN 46975	O COD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	(B) If the ICF/IID editativation of the enis exempt from enis exempt following: (A) A second full-scommunity-based facility-based function (B) A mock disastruction (C) A tabletop exempt following exempt from e	ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed energency plan. EF/IID's response to and estation of all drills, tabletop ergency events, and revise energency plan, as needed. 14.102] HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is				

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	OF CORRECTION	IDENTIFICATION NUMBER 155430	ľ	UILDING	NSTRUCTION	COMPL 05/30	ETED	
	PROVIDER OR SUPPLIER Y CREEK AT ROCH		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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	
	exempt from engal full-scale community based functional exercises of this section is continuous facility-based functional exercises of this section is continuous facility-based functional exercises of this section is continuous facility-based functional exercises facility-based functional functional facility-based functional facility-based functional func	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED	
		155430	B. W	NG		05/30/	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			18TH STREET			
HICKOR	Y CREEK AT ROCI	HESTER			ESTER, IN 46975			
	1	1.201.211			1			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		om engaging in its next						
		xercise following the onset						
	of the emergency							
		PO's response to and ntation of all tabletop						
		nergency events, and revise						
		OPO's] emergency plan, as						
	needed.	OFO's] efficigency plan, as						
	necucu.							
	*[RNCHIs at §40	3 7481·						
	-	e RNHCI must conduct						
		he emergency plan. The						
	RNHCI must do th	- · · · · · · · · · · · · · · · · · · ·						
	(i) Conduct a pape	er-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 se	et of problem statements,						
	directed message	s, or prepared questions						
	_	enge an emergency plan.						
		NHCI's response to and						
		ntation of all tabletop						
		nergency events, and revise						
		rgency plan, as needed.						
		view and interview, the facility	E 0	J39	The creation and submission		06/08/2023	
		tercises to test the emergency			this plan of correction does i			
	plan at least twice p	-			constitute an admission by t			
		drills using the emergency			provider of any conclusion s	et		
	following:	C facility must do the			forth in the statement of deficiencies, or of any violati	on		
	_	annual full-scale exercise that			of regulation. We respectful			
	is community-based				request consideration for a	y		
	1	ity-based exercise is not			desk review or paper			
		an annual individual,			compliance, due to the low			
	facility-based funct				number of deficiencies and o	or		
	b. If the LTC facility experiences an actual natural				the low scope and severity			
	or man-made emergency that requires activation			involved with this survey				
	of the emergency plan, the LTC facility is exempt				E039			
		gaging its next required full-scale in a			What corrective action(s) wi	II		
		or individual, facility-based			be accomplished for those			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(X4) ID	CLIMMADA	STATEMENT OF DEFICIENCIE	1	ID	T		(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAU		l exercise for 1 year following	+	IAU	residents found to have been		DATE
	the onset of the acti	-			affected by the deficient	'	
		itional exercise that may			1		
		imited to the following:			practice: Documentation for the tableto	<u>_</u>	
	a. A second full-sca				exercise conducted on 2/15/2		
		or an individual, facility-based				023	
	functional exercise.	_			was completed. How other residents having	tho	
	b. A mock disaster				potential to be affected by th		
		se or workshop that is led by a			same deficient practice will I		
		ides a group discussion, using			identified and what corrective		
		y-relevant emergency scenario,			action(s) will be taken:	-	
		n statements, directed			The analyzed data review cou	ıld	
	_	red questions designed to			affect all residents.	iiu	
	challenge an emerg	-			What measures will be put in	,to	
		CC facility's response to and			place or what systemic	110	
		ation of all drills, tabletop			changes will be made to		
		gency events, and revise the			ensure that the deficient		
		gency plan, as needed in			practice does not recur:		
		CFR 483.73(d)(2). This			Executive Director/Maintenan		
		ould affect all occupants.			Director educated that the tab		
	dericient practice of	oura urreet uir occupanio.			exercise will be completed with		
	Findings include:				documentation every 12 mont		
	i mamga maraua.				The QAPI and PM calendar w		
	Based on records re	eview with the Executive			updated for the Executive	40	
		the Maintenance Director (MD)			Director/Maintenance Director	· to	
		p.m., documentation for the			review the tabletop exercise a		
		onducted on 02/15/23 was			least annually.	-	
		cumentation did not show if			is a standard,		
	_	se was analyzed to ensure the			How the corrective action(s)		
		effective. Based on interview at			will be monitored to ensure		
	the time of records	review, the ED and the MD			deficient practice will not		
		tation for analyzing the LTC			recur, i.e., what quality		
	facility's response v				assurance program will be p	ut l	
	_ ^	-			into place:		
	This finding was re	viewed with the ED and MD at			Annual review of the tabletop		
	the exit conference.				exercise was added to the TE	LS	
					checklist and QAPI calendar.		
	3.1-19(b)				Executive Director will review		
					TELS documentation and QA		
					calendar monthly to ensure th	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D.			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155430	B. W	ING	-	05/30/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			8TH STREET		
HICKORY	Y CREEK AT ROCH	JESTED			ESTER, IN 46975		
THOROIX	I CILLINAT NOCI	ILSTEIN	ROCH				
(X4) ID	SUMMARY	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
					tabletop exercise is completed	ţ	
					annually.		
					By what date the systemic		
					changes will be completed:		
					6/8/2023		
14 0000							
K 0000							
DI-I 04							
Bldg. 01	A I :f- C-f-+- C-1-	D4:64:	17.0	000	The constitution and columbia is a few		
	•	Recertification and State vas conducted by the Indiana	K 0	000	The creation and submission		
	•	th in accordance with 42 CFR			this plan of correction does		
	483.90(a).	till ill accordance with 42 CFR			constitute an admission by t provider of any conclusion s		
	403.30(a).				forth in the statement of	eı	
	Survey Date: 05/30	0/23				ion	
	Survey Date. 05/30	11 23			deficiencies, or of any violati of regulation. We respectful		
	Facility Number: 0	00326			request consideration for a	'y	
	Provider Number: 1				desk review or paper		
	AIM Number: 100				compliance, due to the low		
	Timir rumoon 100	2,0,7,0			number of deficiencies and o	or	
	At this Life Safety (Code survey, Hickory Creek at			the low scope and severity		
	-	d not in compliance with			involved with this survey.		
	Requirements for P	-			oou ao ou. voy.		
	_	, 42 CFR Subpart 483.90(a),					
		re and the 2012 Edition of the				ļ	
	•	ction Association (NFPA) 101,					
		SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one-story facil	ity was determined and					
	verified to be of Ty	pe II (222) construction and					
		The facility has a fire alarm					
	-	detection in the corridors and					
	_	the corridor. The facility has				ļ	
	• •	oke detectors in all resident				ļ	
		e building is partially				ļ	
		ane fueled 60 kW emergency				ļ	
	_	ity has a capacity of 36 and				ļ	
	had a census of 31 a	at the time of this survey.				ļ	
						ļ	

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Event ID:

8S4Z21

Facility ID: 000326

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING 01 B. WING			COMPL	x3) date survey completed 05/30/2023	
	PROVIDER OR SUPPLIER			340 E 18	ODRESS, CITY, STATE, ZIP COD STH STREET STER, IN 46975		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LD BE COMPLETION	
K 0223 SS=E Bldg. 01	All areas where resi were sprinklered. To buildings providing not sprinklered. One Maintenance Office storage and the othe storage and transfill Quality Review com NFPA 101 Doors with Self-Cl Doors with Self-Cl Doors in an exit pa enclosure, or horiz or hazardous area and kept in the clo open by a release 7.2.1.8.2 that auto doors throughout entire facility upon * Required manua * Local smoke det smoke passing the required smoke det smoke passing the required smoke det smoke passing the 1.2.2.2.7, 18.2.2. Based on observatio failed to ensure 1 of hazardous area encl in the closed positio release device comp	dents have customary access he facility has three detached facility services which were building was used as the component of the facility services which were building was used as the component of the facility services which were building was used as the component of the facility services was used for oxygen of the facility services as a sageway, stairway contal exit, smoke barrier, and enclosure are self-closing of the facility of the smoke complying with the smoke compartment or an activation of: all fire alarm system; and the ectors designed to detect rough the opening or a selection system; and the system, if installed; and contain the facility of 1 kitchen corridor doors to a cosure are self-closing and kept on, unless held open by a oblying with 7.2.1.8.2. This build affect 10 residents in the	K 022	23	The creation and submission this plan of correction does constitute an admission by t provider of any conclusion s forth in the statement of deficiencies, or of any violatiof regulation. We respectful request consideration for a desk review or paper	not his eet	06/08/2023
		ons during a tour of the facility Director (ED) and the			compliance, due to the low number of deficiencies and of the low scope and severity	or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/30/2023	
	PROVIDER OR SUPPLIE		340 E	r address, city, state, zip cod 18TH STREET HESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF Maintenance Direct p.m., the kitchen contrash and a storage making the kitchen the kitchen from the there was a trash contrash.)	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION tor (MD) on 05/30/23 at 1:35 ontained over 62 gallons of room with a door held open; a hazardous area. The door to e corridor was self-closing, but ontainer stored in the path of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Involved with this survey. K223 What corrective action(s) will be accomplished for those residents found to have been	
	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.			affected by the deficient practice: Trash can has been removed allowing the door to latch in the frame. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken:	the ne be
	This finding was re the exit conference 3.1-19(b)	viewed with the ED and MD at		action(s) will be taken: All other doors have been rev to ensure the path of closer is clear to allow door to latch interframe. No other issues were found. What measures will be put in place or what systemic changes will be made to ensure that the deficient	0
				practice does not recur: All staff educated on ensuring doors have a clear path of clo Review of doors for proper clowill be added to the monthly preventative maintenance schedule. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place:	ser. osure the
				The Executive Director will row with the maintenance director	

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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		
	ROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	REGULATORY OR LSC IDENTIFY ING INFORMATION			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			

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