PRINTED: 08/03/2023

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/29/2023		
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD 25TH STREET			
HICKOR	Y CREEK AT COLU	JMBUS	COLUMBUS, IN 47203					
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE	
E 0000 Bldg	conducted by the In accordance with 42 Survey Date: 06/29 Facility Number: 0 Provider Number: 100 At this Emergency Creek at Columbus with Emergency Production and Suppliers, 42 C The facility has 36 the survey, the censurvey, the censurvey conductive conduct	00284 155424 290690 Preparedness survey, Hickory was found not in compliance eparedness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of the was 30. mpleted on 07/06/23 42 CFR, Subpart 483.73 is NOT	E 00	000	The creation and submission this plan of correction does constitute an admission by the provider of any conclusions in the statement of deficient of any violations of regulation. Due to the relative low scops severity of this survey, the farespectfully requests a desk review in lieu of a post surver revisit.	not his et forth cies, or n. e and acility		
E 0004 SS=F Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),						

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

§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).

(X6) DATE

TITLE

Jessica Crafton-Hundley Health Facility Administrator 07/31/2023

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/29/2023	
	F PROVIDER OR SUPPLIE			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Federal, State ar preparedness recomprehensive exprogram that measection. The emergency Period develop and main preparedness pland updated at lease to the following element of the following element (a) Emergency Period develop and main preparedness pland updated at lease to the following element of the following element	lan. The [facility] must natain an emergency an that must be [reviewed], east every 2 years. The plan of following: It §482.15 and CAHs at nergency Plan. The [hospital mply with all applicable nd local emergency quirements. The [hospital or op and maintain a emergency preparedness ets the requirements of this an all-hazards approach. It ies at §483.73(a):] The LTC facility must natain an emergency an that must be reviewed,					

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Event ID:

9K0021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/29/2023	
	PROVIDER OR SUPPLIER		5480 E	ADDRESS, CITY, STATE, ZIP COD E 25TH STREET MBUS, IN 47203	-
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
PREFIX TAG	REGULATORY OR Based on record reversal failed to maintain any plan that was review annually in accordate. Findings include: Based on review of documentation date Maintenance Superfrom 9:10 a.m. to 11 documentation for a preparedness prograwithin the most record available for reversal for a was dated as being the was not within the reperiod. Based on in review, the Field M 10/15/21 was the date mergency prepared.	riew and interview, the facility in emergency preparedness wed and updated at least ince with 42 CFR 483.73(a). ice could affect all occupants.	E 0004	The emergency preparedness was actually reviewed and up but was not readily available Field Maintenance person at time of survey while the Exec Director was out of the office mandatory training. A new Maintenance Supervishas been hired and has been serviced on this for any future concerns and/or situations. All department leaders will be serviced on the location and importance of the Emergency Preparedness Plan. Emergency Preparedness Plawill be reviewed each month QAPI monthly for 3 months a then quarterly for 6 months u there is satisfactory compliant with all staff being fully awares.	s plan 08/19/2023 odated to the the cutive at a sor in the cutive at in the cutive and in the cutive and in the cutive at a sor in the cutive at a sortion at a s
E 0006 SS=F Bldg	Maintenance Super- Nursing during the 403.748(a)(1)-(2), (1)-(2), 441.184(a) 483.475(a)(1)-(2), (1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2) §418.113(a)(1)-(2) §460.84(a)(1)-(2), §483.73(a)(1)-(2),	visor and the Director of exit conference. 416.54(a)(1)-(2), 418.113(a) 0(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) 0(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment 1, §416.54(a)(1)-(2), 1, §441.184(a)(1)-(2), 1, §441.184(a)(1)-(2),			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155424	A. BU B. W	JILDING		COMPL 06/29	
		133424	B. W.			00/29/	2023
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT COLU	JMBUS			25TH STREET IBUS, IN 47203		
(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), §485.727(a)(1)-(2),	+	TAG	DEFICIENCE		DATE
), §486.360(a)(1)-(2),					
	§491.12(a)(1)-(2),						
	,	lan. The [facility] must					
	develop and maintain an emergency						
	1	n that must be reviewed,					
	and updated at least every 2 years. The plan must do the following:]						
	Thus do the follow	/ing.j					
	(1) Be based on a	ind include a documented,					
	facility-based and	community-based risk					
		ing an all-hazards					
	approach.*						
	1 ' '	gies for addressing s identified by the risk					
	Plan. The Hospice maintain an emerge that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategemergency events assessment, include the consequences disasters, and oth	e §418.113(a):] Emergency e must develop and gency preparedness plan ewed, and updated at least e plan must do the end include a documented, community-based risk ing an all-hazards gies for addressing sidentified by the risk ding the management of so of power failures, natural er emergencies that would 's ability to provide care.					
	develop and main	s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155424	B. Wl	ING		06/29/	2023
	PROVIDER OR SUPPLIER			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	do the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. Based on record revialed to maintain a plan that was (1) be documented, facility risk assessment, utilize which was reviewed month period and (2) addressing emerger risk assessment in a 483.73(a) (1) and 44 deficient practice contains a session of the service was assessment and deficient practice contains a session of the service was assessment in a 483.73(a) (1) and 44 deficient practice contains a session of the service was assessment in a 483.73(a) (1) and 44 deficient practice contains a session of the service was a service was	ast annually. The plan must Ind include a documented, community-based risk ing an all-hazards ing missing residents. Igies for addressing is identified by the risk Identified a documented, Identified by the risk Ide	E 00	006	The emergency preparedness was actually reviewed and upout was not readily available to Field Maintenance person at the time of survey while the Execution of the office a mandatory training. A new Maintenance Supervisor has been hired and has been serviced on this for any future concerns and/or situations.	dated of the he littive at a	08/19/2023
	Findings include:				All department leaders will be	in	
	Based on review of				serviced on the location and		
		d 10/15/21with the Field			importance of the Emergency		
	I Maintenance Super	visor during record review	I		Preparedness Plan		I

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155424				06/29/	ETED 2023
ROVIDER OR SUPPLIER		5	5480 E	DDRESS, CITY, STATE, ZIP COD 25TH STREET BUS, IN 47203		
(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
documented facility risk assessment revi most recent twelve r available for review time of record revie Supervisor stated 10 most recent review of program documenta These findings were	-based and community-based ewed by the facility within the month period was not . Based on interview at the w, the Field Maintenance 0/15/21 was the date of the of emergency preparedness tion.			will be reviewed each month in QAPI monthly for 3 months an then quarterly for 6 months un	n d til e	
403.748(b), 416.54 441.184(b), 482.19 484.102(b), 485.63 485.727(b), 485.93 491.12(b), 494.62(c) Development of El §403.748(b), §416 §441.184(b), §460 §483.73(b), §483.4 §485.68(b), §485.9 §494.62(b). (b) Policies and pr	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 1.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 1.360(b), §491.12(b),					
preparedness police on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The police be reviewed and ususpears.	cies and procedures, based plan set forth in paragraph risk assessment at f this section, and the an at paragraph (c) of this ies and procedures must updated at least every 2					
	SUMMARY S (EACH DEFICIENCE REGULATORY OR PEGULATORY OR From 9:10 a.m. to 11 documented facility risk assessment review to available for review time of record review time of record review to program documenta. These findings were Maintenance Supervisor stated 10 most recent review of program documenta. These findings were Maintenance Supervisor Maintenance Superviso	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION from 9:10 a.m. to 11:45 a.m. on 06/29/23, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated 10/15/21 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Field Maintenance Supervisor and the Director of Nursing during the exit conference. 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) 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). (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 communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION from 9:10 a.m. to 11:45 a.m. on 06/29/23, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated 10/15/21 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Field Maintenance Supervisor and the Director of Nursing during the exit conference. 403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.475(b), 485.727(b), 485.625(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures \$403.748(b), \$416.54(b), \$418.113(b), \$441.184(b), \$460.84(b), \$482.15(b), \$483.475(b), \$483.475(b), \$483.475(b), \$484.102(b), \$485.68(b), \$483.475(b), \$484.102(b), \$485.68(b), \$485.625(b), \$485.727(b), \$485.68(b), \$486.360(b), \$491.12(b), \$494.62(b) (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 communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at \$483.73(b):] Policies	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION from 9:10 a.m. to 11:45 a.m. on 06/29/23, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated 10/15/21 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Field Maintenance Supervisor and the Director of Nursing during the exit conference. 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) 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). (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 communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at \$483.73(b):] Policies	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION from 9:10 a.m. to 11:45 a.m. on 06/29/23, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated 10/15/21 was the date of the most recent review of emergency preparedness program documentation. These findings were reviewed with the Field Maintenance Supervisor and the Director of Nursing during the exit conference. 403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 485.625(b), 486.360(b), 485.625(b), \$485.727(b), \$485.372(b), \$486.360(b), \$485.727(b), \$486.360(b), \$481.112(b), \$485.822(b), \$486.360(b), \$481.112(b), \$485.920(b), \$486.360(b), \$481.112(b), \$485.920(b), \$486.360(b), \$481.12(b), \$485.920(b), \$486.360(b), \$481.112(b), \$485.9	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REQUILATORY OR LSC IDENTIFYING INFORMATION TAG REQUILATORY OR LSC IDENTIFYING INFORMATION Will be reviewed each month in OAPI mill be reviewed each month in OAPI mill be reviewed each month in OAPI monthly for 3 months and then quarterly for 6 months until there is satisfactory compliance with all staff being fully aware. Will be reviewed each month in OAPI monthly for 3 months and then quarterly for 6 months until there is satisfactory compliance with all staff being fully aware. With al

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		A. BUILDING B. WING	onstruction 	COMI	PLETED 9/2023	
	PROVIDER OR SUPPLIER Y CREEK AT COLU		5480 E	ADDRESS, CITY, STATE, ZIP (25TH STREET MBUS, IN 47203	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 COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	on the emergency (a) of this section, paragraph (a)(1) of communication plate section. The policities reviewed and uterial to the reviewed and imples on the emergency (a) of this section, paragraph (a)(1) of communication plate section. The policities and previewed and update in the policities and previewed and update in the reviewed and update in the policities and previewed and imples preparedness policities on the emergency (a) of this section, paragraph (a)(1) of communication plate section. The policities on the policities and procedures. In the policities are represented to the reviewed and update in the emergency (a) of this section, paragraph (a)(1) of communication plate section. The policities are represented to the reviewed and update in the reviewed	cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this ies and procedures must apdated at least annually. ements for PACE and 60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the an at paragraph (c) of this ies and procedures must enent of medical and gencies, including, but not uipment, power, or water d emergencies; and natural threaten the health or sipants, staff, or the public. Procedures must be atted at least every 2 years. Sies at §494.62(b):] Policies The dialysis facility must				

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Facility ID: 000284

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155424		A. BUILDING COMP.			(X3) DATE COMPL 06/29 /	ETED	
	PROVIDER OR SUPPLIEF			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
(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
E 0029 SS=F Bldg	years. These emenot limited to, fire, failures, care-relative supply interruption likely to occur in the area. Based on record review and preparedness policities and proced diseases (EID). The bear reviewed and up accordance with 42 practice could affect with the most record review of documentation date Maintenance Super from 9:10 a.m. to 1 preparedness policities within the most record review Supervisor stated 10 most recent review program documentation date These findings were Maintenance Super Nursing during the 403.748(c), 416.5	ergencies include, but are equipment or power ted emergencies, water in, and natural disasters ine facility's geographic view and interview, the facility is update its emergency es and procedures to include ures for emerging infectious e policies and procedures must dated at least annually in CFR 483.73(b). This deficient it all occupants. ""Disaster Plan" di 10/15/21 with the Field visor during record review 1:45 a.m. on 06/29/23, emergency es and procedures reviewed ent twelve month period was view. Based on interview at the two, the Field Maintenance 0/15/21 was the date of the of emergency preparedness action. The reviewed with the Field visor and the Director of exit conference. 4(c), 418.113(c), 5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), 20(c), 486.360(c),	EO		The emergency preparedness was actually reviewed and up but was not readily available to Field Maintenance person at to time of survey while the Execution Director was out of the office a mandatory training. A new Maintenance Supervisch has been hired and has been serviced on this for any future concerns and/or situations. All department leaders will be serviced on the location and importance of the Emergency Preparedness Plan. Emergency Preparedness Plawill be reviewed each month in QAPI monthly for 3 months are then quarterly for 6 months urthere is satisfactory compliant with all staff being fully aware.	s plan dated o the he utive at a or in in n n n n n ntitil	08/19/2023
	•	communication Plan 6.54(c), §418.113(c),					

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPL	
		155424	B. WING		06/29/	2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
HICKOR'	Y CREEK AT COLU	JMBUS		25TH STREET IBUS, IN 47203		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	§483.73(c), §483.4 §485.68(c), §485.4 §485.920(c), §486 §494.62(c). (c) The [facility] man emergency preplan that complies local laws and muat least every 2 yes facilities].	0.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 6.360(c), §491.12(c), ust develop and maintain eparedness communication is with Federal, State and ist be reviewed and updated ears [annually for LTC	F 0020	The		09/10/2022
	failed to develop an preparedness comm with Federal, State, reviewed and updat	view and interview, the facility and maintain an emergency nunication plan that complies and local laws which was ed at least annually in CFR 483.73(c). This deficient all occupants.	was actually reviewed and updated but was not readily available to the Field Maintenance person at the time of survey while the Executive Director was out of the office at a		08/19/2023	
	Maintenance Super from 9:10 a.m. to 1 documentation for a preparedness comm the facility within the period was not avail interview at the time Maintenance Superdate of the most recept preparedness program.	d 10/15/21with the Field visor during record review 1:45 a.m. on 06/29/23, a complete emergency nunication plan reviewed by the most recent twelve month lable for review. Based on the of record review, the Field visor stated 10/15/21 was the ment review of emergency and documentation.		A new Maintenance Supervisor has been hired and has been serviced on this for any future concerns and/or situations. All department leaders will be serviced on the location and importance of the Emergency Preparedness Plan. Emergency Preparedness Plawill be reviewed and updated month in QAPI monthly for 3 months and then quarterly for months until there is satisfacted compliance with all staff being aware with return demonstration through Q & A.	in in each 6 ory fully	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155424		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/29/2023
	PROVIDER OR SUPPLIER Y CREEK AT COLUMBUS	5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
E 0037 SS=F Bldg	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	
		155424	B. W	ING		06/29/	2023
27.12			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			25TH STREET		
	Y CREEK AT COLU	JMBUS	•	COLUM	IBUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		employees, and individuals					
	providing services under arrangement, consistent with their expected roles.						
	(ii) Demonstrate s						
	emergency proced	_					
		gency preparedness training					
	at least every 2 ye						
		view and rehearse its					
		redness plan with hospice					
		ling nonemployee staff),					
		asis placed on carrying out					
	· ·	ecessary to protect patients					
	and others.						
	(v) Maintain docur	mentation of all emergency					
	preparedness traii	ning.					
	(vi) If the emerger	ncy preparedness policies					
	and procedures a	re significantly updated, the					
	hospice must con-	duct training on the					
	updated policies a	and					
	procedures.						
	*[For PRTFs at §4	l41.184(d):] (1) Training					
	program. The PR	TF must do all of the					
	following:						
	``	n emergency preparedness					
		edures to all new and					
	-	viduals providing services					
	under arrangemer						
	consistent with the						
		ning, provide emergency					
		ning every 2 years.					
	(iii) Demonstrate s	_					
	emergency proced						
		mentation of all emergency					
	preparedness trail	_					
		cy preparedness policies					
	·	re significantly updated, the uct training on the updated					
	policies and proce	- · · · · · · · · · · · · · · · · · · ·					
	Policios and proce	, au 00.					
			- 1				l

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155424	B. W	ING		06/29/	/2023
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
					25TH STREET		
HICKOR	Y CREEK AT COLU	NINRO2		COLUM	1BUS, IN 47203		
(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	DEFICIENC!)		DATE
	-	60.84(d):] (1) The PACE do all of the following:					
	_	<u> </u>					
	(i) Initial training in emergency preparedness policies and procedures to all new and						
	existing staff, individuals providing on-site						
	services under arrangement, contractors,						
		volunteers, consistent with					
	their expected role	es.					
		ency preparedness training					
	at least every 2 ye						
		staff knowledge of					
		dures, including informing					
		at to do, where to go, and					
		n case of an emergency. mentation of all training.					
	` '	ncy preparedness policies					
		re significantly updated, the					
		uct training on the updated					
	policies and proce	- · · · · · · · · · · · · · · · · · · ·					
	_	es at §483.73(d):] (1)					
		. The LTC facility must do all					
	of the following:						
	.,	n emergency preparedness					
		edures to all new and viduals providing services					
	_	nt, and volunteers,					
	consistent with the						
		ency preparedness training					
	at least annually.	311					
	-	mentation of all emergency					
	preparedness train	ning.					
	(iv) Demonstrate s	staff knowledge of					
	emergency proced	dures.					
	*[Ear COBEs at S.	195 69/d\:1/1\ Training The					
	CORF must do all	485.68(d):](1) Training. The					
		raining in emergency					
		icies and procedures to all					
		staff individuals providing					

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ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DA7	ΓΕ SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>		IPLETED
		155424	B. W	ING		06/2	29/2023
	PROVIDER OR SUPPLIER			5480 E	ADDRESS, CITY, STATE, ZIP 25TH STREET IBUS, IN 47203	COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
	1	rangement, and volunteers,					
		eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
		mentation of the training.					
	1 ' '	staff knowledge of					
	· ,	_					
		dures. All new personnel and assigned specific					
	1	garding the CORF's					
		vithin 2 weeks of their first					
		ning program must include					
		ocation and use of alarm					
		als and firefighting					
	equipment.						
	. ,	ncy preparedness policies					
	1	re significantly updated, the					
		uct training on the updated					
	policies and proce	edures.					
		35.625(d):] (1) Training					
		H must do all of the					
	following:						
	``	n emergency preparedness					
		edures, including prompt					
	reporting and exti	-					
	l •	nere necessary, evacuation					
		nnel, and guests, fire					
	•	poperation with firefighting					
	and disaster author	orities, to all new and					
	existing staff, indi	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
		ency preparedness training					
	at least every 2 ye	ears.					
	(iii) Maintain docu	mentation of the training.					
	(iv) Demonstrate	staff knowledge of					
	emergency proce	_					
		ncy preparedness policies					
	` '	re significantly updated, the					

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CAH must conduct training on the updated

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	N OF CORRECTION	IDENTIFICATION NUMBER 155424		ILDING	INSTRUCTION	COMPL 06/29/	ETED
	F PROVIDER OR SUPPLIEF			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET IBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	ΓE	(X5) COMPLETION DATE
	The CMHC must pemergency prepared procedures to all individuals providing arrangement, and their expected role documentation of must demonstrate emergency proced CMHC must provide preparedness trails assed on record reversible of the training and testing program. The LTC following: (i) Initiate preparedness policing and existing staff, in under arrangement, with their expected preparedness training Maintain document Demonstrate staff is procedures in accord (1). This deficient procedures in according to the procedures of the procedure of the procedures of the procedures of the procedure of the procedures of the procedure of the procedu	485.920(d):] (1) Training. provide initial training in redness policies and new and existing staff, ng services under volunteers, consistent with es, and maintain the training. The CMHC estaff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. View and interview, the facility emergency preparedness program includes a training facility must do all of the latraining in emergency es and procedures to all new individuals providing services and volunteers, consistent roles; (ii) Provide emergency ng at least annually; (iii) ation of the training; (iv) mowledge of emergency dance with 42 CFR 483.73(d) practice could affect all	E 00	037	The emergency preparedness was actually reviewed and upon but was not readily available to Field Maintenance person at the time of survey while the Execution Director was out of the office a mandatory training. A new Maintenance Supervisor has been hired and has been serviced on this for any future concerns and/or situations. All new employees are trained tested on emergency preparedness upon hire, annuals well as volunteers. All department leaders will be serviced on the location and importance of the Emergency Preparedness Plan. Emergency Preparedness Pla will be reviewed and updated on the location and updated on the location and importance of the Emergency Preparedness Plan.	dated of the ne dated of the n	08/19/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424	ľ	UILDING	ONSTRUCTION	(X3) DATE (COMPL 06/29/	ETED
	PROVIDER OR SUPPLIER Y CREEK AT COLU			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	documentation on the program conducted month period was not time of the survey. These findings were Maintenance Super Nursing during the				month in QAPI monthly for 3 months and then quarterly for months until there is satisfactor compliance with all staff being aware with return demonstration through Q & A.	ory fully	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 49 EP Testing Requii §416.54(d)(2), §4 §460.84(d)(2), §48 §483.475(d)(2), §48	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
	OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [forexercises to test the content of the c	16.54, CORFs at §485.68, cons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan ility] must do all of the					
	community-based (A) When a community accessible, confunctional exercises (B) If the [facinatural or man-material community accessible accessibl	full-scale exercise that is every 2 years; or munity-based exercise is enduct a facility-based e every 2 years; or flity] experiences an actual ade emergency that requires mergency plan, the [facility]					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155424	B. W	ING		06/29/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			25TH STREET		
HICKOR'	Y CREEK AT COLU	JMBUS			IBUS, IN 47203		
(X4) ID	ı	STATEMENT OF DEFICIENCIE	<u> </u>	ID	·		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	i	gaging in its next required		1110			5.112
	•	or individual, facility-based					
	_	e following the onset of the					
	actual event.						
	(ii) Conduct an additional exercise at least						
	` '	posite the year the full-scale					
		cise under paragraph (d)(2)					
	(i) of this section is conducted, that may						
		limited to the following:					
	(A) A second full-s	scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise	e; or					
	(B) A mock disast	er drill; or					
	(C) A tabletop exe	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a						
	•	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					
		espices that provide care in					
		e. The hospice must					
		to test the emergency					
		ally. The hospice must do					
	the following:						
	_	a full-scale exercise that is					
	community based	every 2 years; or					
	(A) When a comm	nunity based exercise is not					
	accessible, condu	ıct an individual facility					
	based functional e	exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
	exempt from enga	aging in its next required full					

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	R MEDICARE & MEDIC					OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			IPLETED	
		155424	B. WING		06/2	29/2023	
NAME OF	PROVIDER OR SUPPLIE		STREET .	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	I KO VIDEK OK SUI I EILI			25TH STREET			
HICKOR	RY CREEK AT COLU	JMBUS	COLUN	MBUS, IN 47203			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT.	ION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE OPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	1	based exercise or individual					
	•	ctional exercise following the					
	onset of the emer						
		dditional exercise every 2					
	1 .	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	, ,	-scale exercise that is					
	functional exercise	l or a facility based					
	(B) A mock disas	ercise or workshop that is					
		and includes a group					
	discussion using a	~ .					
	_	emergency scenario, and a					
		tements, directed					
	•	pared questions designed					
	to challenge an e	·					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					
	per year. The hos	spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
		ıct an annual individual					
	1	ctional exercise; or					
		experiences a natural or					
		ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event						
	(ii) Conduct an ac	dditional annual exercise	1				

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following:

that may include, but is not limited to the

(A) A second full-scale exercise that is

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPL	
		155424	B. W	ING		06/29/	2023
NAME OF E	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD	-	
					25TH STREET		
HICKOR'	Y CREEK AT COLU	JMBUS		COLUM	IBUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		or a facility based					
	functional exercise						
	(B) A mock disaster drill; or						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
		rio, and a set of problem					
	I	ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.	oppingly reappages to and					
	1 ' '	ospice's response to and					
		ntation of all drills, tabletop					
	exercises, and emergency events and revise the hospice's emergency plan, as needed.						
	l the nospice's eme	rigericy plan, as needed.					
	*IFor PRFTs at &4	41.184(d), Hospitals at					
	§482.15(d), CAHs						
	. , ,	PRTF, Hospital, CAH] must					
		to test the emergency					
		r. The [PRTF, Hospital,					
	CAH] must do the						
	_	n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	, ,	ct an annual individual,					
		tional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency					
	•	s exempt from engaging in					
		ıll-scale community based					
	I	ty-based functional exercise					
	following the onse	t of the emergency event.					
	(ii) Conduct a	an [additional] annual					
		at may include, but is not					
	limited to the follo	wing:					
	(A) A second full-	scale exercise that is					
	community-based						
	1 -	tional exercise; or					

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424		UILDING	NSTRUCTION		LETED 1/2023
	PROVIDER OR SUPPLIER		•	5480 E	DDRESS, CITY, STATE, ZIP COD 25TH STREET BUS, IN 47203	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEENTIFYING DIFFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION
TAG	(B) A mo (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem state messages, or preto challenge an erection of the emeration is not limited to (A) A second full-scale community (A) A second full-scale conduct exercises and revise the [farmeded.] *[For PACE at §44 (2) Testing. The Founduct exercises plan at least annuorganization must (i) Participate in a state of the emeration of the emera	emergency scenario, and a atements, directed pared questions designed mergency plan. he [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as 60.84(d):] PACE organization must s to test the emergency itally. The PACE t do the following: an annual full-scale exercise is not uct an annual individual, ctional exercise; or experiences an actual natural ergency that requires emergency plan, the PACE agaging in its next required inity based or individual, ctional exercise following the gency event. An additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, so the following: escale exercise that is a or individual, a facility exercise; or		TAG	DEFICIENCY)		DATE
	(D) A HIOCK disas	ioi ailii, oi					1

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424	r í	JILDING	NSTRUCTION	(X3) DATE COMPI 06/29	LETED
	OF PROVIDER OR SUPPLIED DRY CREEK AT COLU			5480 E	DDRESS, CITY, STATE, ZIP COD 25TH STREET BUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	(C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an eto challenge an eto challenge and exercises, and enthe PACE's emer *[For LTC Facilities (2) The [LTC facility to test the emergency problem of the emergency problem o	ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop nergency events and revise gency plan, as needed. es at §483.73(d):] ity] must conduct exercises ency plan at least twice per nannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise elebased; or nunity-based exercise is not act an annual individual, estional exercise. Sility] facility experiences an man-made emergency plan, the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event. In the empt from engaging its next ale community-based or abased functional exercise elet of the emergency event.					

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	OF CORRECTION	IDENTIFICATION NUMBER 155424	A. BUILDING B. WING	onstruction 	COMI	PLETED 9/2023
	PROVIDER OR SUPPLIER Y CREEK AT COLU		5480 E	ADDRESS, CITY, STATE, ZIP (25TH STREET MBUS, IN 47203	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 COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	set of problem star messages, or prepto challenge an entition (iii) Analyze the [Liresponse to and mall drills, tabletope events, and revise emergency plan, at a [For ICF/IIDs at § (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an at that is community-(A) When a community-(A) When a community-based function of the entition onset of the emergical community-based function of the entition onset of the emergical community-based facility-based function (B) A second full-scommunity-based facility-based function (B) A mock disaster (C) A tabletop exelled by a facilitator discussion, using a clinically-relevant as the formula of problem star and the following:	pared questions designed hergency plan. TC facility] facility's haintain documentation of exercises, and emergency the [LTC facility] facility's has needed. 483.475(d)]: CF/IID must conduct he emergency plan at least he ICF/IID must do the handle and annual full-scale exercise hased; or unity-based exercise is not an annual individual, tional exercise; or experiences an actual de emergency plan, the ICF/IID gaging in its next required hity-based or individual, tional exercise following the gency event. ditional annual exercise hout is not limited to the here an individual, tional exercise; or er drill; or roise or workshop that is and includes a group an anarrated, emergency scenario, and a				

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	T OF HEALTH AND HU! R MEDICARE & MEDIC					FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155424	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/29/2023	
NAME OF	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD 25TH STREET		
HICKOR	Y CREEK AT COLU	JMBUS			1BUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	to challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test to least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility- every 2 years; or. (B) If the HH. natural or man-ma activation of the e exempt from enga full-scale commun facility based func- onset of the emer- (ii) Conduct an ad years, opposite th	mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed. 34.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual ade emergency plan, the HHA is aging in its next required nity-based or individual, stional exercise following the gency event. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i)		TAG	DEFICIENCY		DATE
	include, but is not (A) A second community-based facility-based func (B) A mock di	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,					

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clinically-relevant emergency scenario, and a

messages, or prepared questions designed

set of problem statements, directed

to challenge an emergency plan.

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155424 B. WING	COMPLETED 06/29/2023
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS STREET ADDRESS, CITY, STATE, ZIP COD 5480 E 25TH STREET COLUMBUS, IN 47203	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	OBE COMPLETION
(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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (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 OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following: (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 plan. (ii) Analyze the RNHCl's response to and (iii) Analyze the RNHCl's response to and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 06/29/2023				ETED	
	PROVIDER OR SUPPLIER			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR maintain documer exercises, and em the RNHCl's emer Based on record rev failed to conduct ex plan at least twice p unannounced staff o procedures. The LT following: (i) Participate in an is community-based a. When a communi accessible, conduct facility-based functi b. If the LTC facilit or man-made emerg of the emergency pl from engaging its n community-based o full-scale functional the onset of the actu (ii) Conduct an add include, but is not li a. A second full-sca community-based o functional exercise. b. A mock disaster c. A tabletop exerci facilitator that inclu a narrated, clinically and a set of problem messages, or prepar challenge an emerg (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer accordance with 42	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Intation of all tabletop Bergency events, and revise gency plan, as needed. Friew and interview, the facility Bercises to test the emergency Bergency every er year, including Brills using the emergency C facility must do the annual full-scale exercise that Bergency that requires activation and the LTC facility is exempt beat required full-scale and individual, facility-based beat exercise that may mited to the following: Be exercise that is an individual, facility-based desire a group discussion, using and exercise that is an individual, facility-based desire a group discussion, using and exercise that is an individual, facility-based desire a group discussion, using and exercise that is an individual, facility-based desire a group discussion, using and exercise that is an individual, facility-based desire a group discussion, using and exercise that is and a group discussion, using and exercise that is and a group discussion and a desire a group discus	EO	ID PREFIX TAG	An After Action Report for Pov Outage on 6/20/23 was actual available on date of survey bu again, the Executive Director ont at the facility due to attend a mandatory training on the dasurvey. A new Maintenance Supervisco has been hired and has been serviced on this for any future concerns and/or situations. All new employees are trained and tested on emergency preparedness upon hire, annual well as All department leaders will be serviced on the location and importance of the Emergency Preparedness Plan. Emergency Preparedness Pla will be reviewed and updated month in QAPI monthly for 3 months and then quarterly for months until there is satisfactor compliance with all staff being aware with return demonstration through Q & A.	ver ly t was ling ay of ally, in n each 6 ory fully	(X5) COMPLETION DATE 08/19/2023
	deficient practice co	ould affect all occupants.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/29/2023	
	PROVIDER OR SUPPLIER			5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET IBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
	Findings include: Based on review of documentation date	"Disaster Plan" d 10/15/21with the Field					
	from 9:10 a.m. to 1 has not documented mock disaster drill, workshop to test the Based on interview the Field Maintenar documentation for t preparedness policie most recent twelve available for review These findings were Maintenance Super	es and procedures within the month period was not e reviewed with the Field wisor and the Director of					
K 0000 Bldg. 01	Nursing during the exit conference.		K 00	000	The creation and submission this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violations of regulation. Due to the relative low scope severity of this survey, the fact respectfully requests a desk review in lieu of a post survey revisit.	ot s forth es, or and ility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155424		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 06/29/2023						
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			5480 E	STREET ADDRESS, CITY, STATE, ZIP COD 5480 E 25TH STREET COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
K 0300 SS=F Bldg. 01	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detecors installed in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 30 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has one detached storage shed which was not sprinklered. Quality Review completed on 07/06/23 NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC		TAU		DATE			
	provided K-tags, be information, along Safety Code or NF should be included Based on observation failed to replace bate installed in 18 of 18 accordance with NF Edition, Section 14. testing, and mainter the requirements of equipment manufact Section 14.4.8.1 sta	19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. on and interview, the facility tery operated smoke alarms resident sleeping rooms in FPA 72. NFPA 72, 2010 2.1.1.1 states inspection, nance programs shall satisfy this Code and conform to the turer's published instructions. tes unless otherwise e manufacturer's published	K 0300	10 year Smoke Alarms have purchased and installed in all resident rooms. New Maintenance Supervisor be trained on the proper Prev Maintenance and care for the devices as well as manufactur guidelines.	· will rentive se			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>01</u>		COMPLETED		
155424		B. W	B. WING			06/29/2023	
				CTD FFT A	ADDRESS SITE STATE SID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 25TH STREET		
HICKORY	V CDEEK AT COLL	IMPLIC					
HICKOR	Y CREEK AT COL	JIMBUS		COLUIV	1BUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	instructions, single	- and multiple-station smoke			ED/designee will monitor this		
	alarms shall be repl	laced when they fail to respond			through TELS systems and		
	to operability tests	but shall not remain in service		random checks with the			
	longer than 10 year	rs from the date of manufacture.			assistance of Field Maintenan	ce	
	This deficient pract	tice could affect all residents,			professionals.		
	staff and visitors.						
					This will also be monitored thr	ough	
	Findings include:				QAPI monthly for 3 months then		
					quarterly for 6 months and the	n	
	Based on observati	ons with the Field			annually or as needed.		
		visor during a tour of the					
	facility from 11:45	a.m. to 12:25 p.m. on 06/29/23,					
	manufacturer's doc	umentation affixed to the Kidde					
	Model i9040 batter	y operated smoke alarm					
		ling in resident sleeping Room					
		nanufactured 05/23/13. The					
		umentation also stated					
		s". Based on interview at the					
		tions, the Field Maintenance					
	_	he facility has a total of 18					
		ooms, the same type of smoke					
		n each sleeping room and all the					
		the same manufacture date.					
		ance Supervisor stated the					
		the 10 year replacement					
	_	scheduled to replace each					
		placement has not yet been					
	done.						
	1	re reviewed with the Field					
	_	rvisor and the Director of					
	Nursing during the	exit conference.					
	2.1.10(1.)						
	3.1-19(b)						
K 0353	NFPA 101						
SS=C		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing - Maintenance and Testing					
Diag. 01	1 .	er and standpipe systems					
	1						
are inspected, tested, and maintained in							

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155424		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/29/2023		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		5480 COL	ET ADDRESS, CITY, STATE, ZIP COD E 25TH STREET UMBUS, IN 47203 PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	IATE	COMPLETION DATE
	Inspection, Testin Water-based Fire Records of system inspection and test secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure 1 of maintained with space abinet and a sprink NFPA 25, Standard and Maintenance of Systems, 2011 Edit supply of spare sprinklers that have any way can be proshall correspond to ratings of the sprink sprinklers shall be a the temperature in the temperature in the temperature in the cabinet to be used it in the sprinkler wrench should be used it in the temperature of the cabinet to be used it in the sprinkler wrench should be used it in the temperature of the cabinet to be used it in the sprinkler wrench should be used in the sprinkler wrench should be used in the sprinkler wrench should be used in the sprinkler with the sprinkler wrench should be used in the sprinkler with the sprinkler wrench should be used in the sprinkler with the sprinkler	supply source RKS information on non-required or partial er system. In and NFPA 25 on and interview, the facility of 1 sprinkler systems was are sprinklers, a spare sprinkler cler wrench on the premises. If or the Inspection, Testing, of Water-Based Fire Protection ion, Section 5.4.1.4 states a inklers (never fewer than six) on the premises so that any been operated or damaged in mptly replaced. The sprinklers the types and temperature clers on the property. The sept in a cabinet located where which they are subjected will at degrees Fahrenheit. A special call be provided and kept in the in the removal and installation deficient practice could affect	K 0353	2 New Pendant Sprinkler Heavere Purchased and Replace 7/25/2023. A new New Maintenance Supervisor will be educated a serviced on all aspects of the sprinkler system as well as preventive maintenance that required ED/Designee will monitor this through TELS Systems and through checking the closet with the extra sprinkler heads are on a regular bases. This will become part of the Oprocess monthly for 3 months then quarterly for 6 months, at then every 6 months until the	ed on and in is where kept QAPI s, and	08/19/2023

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Findings include:

Based on observations with the Field

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committee is satisfied that it can

be discontinued.

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155424		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/29/2023			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP COD 5480 E 25TH STREET COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0712 SS=C Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 12:25 p.m. on 06/29/23, only four spare sprinklers were located in the spare sprinkler cabinet at the sprinkler system riser in the closet in the main dining room. None of the four spare sprinklers were pendants which were observed installed throughout the facility. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed there were fewer than six spare sprinklers in the spare sprinkler cabinet and the spare sprinkler supply did not include pendant sprinklers. These findings were reviewed with the Field Maintenance Supervisor and the Director of Nursing during the exit conference. 3.1-19(b) NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7		K 0712	The Maintenance Director tha conducted these fire drills at the times is not longer employed withis facility.	hese		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPI	COMPLETED	
155424		155424	B. WING			06/29/2023		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS				5480 E	ADDRESS, CITY, STATE, ZIP COD 25TH STREET MBUS, IN 47203			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Our new Maintenance Super	visor		
	Findings include:				has been educated and train	ed to		
					conduct quarterly fire drills at	e drills at		
		"Fire Drill Report" and Direct			unexpected times under vary	•		
	Supply TELS Logb	ook "Fire Drills"		conditions on all shift. This will		vill be		
	documentation with the Field Maintenance		strictly monitored by the					
	Supervisor during r	ecord review from 9:10 a.m. to	ED/Designee by utilizing the TELS		TELS			
	11:45 a.m. on 06/29/23, second shift fire drills		Systems and mapping out a					
	conducted within the	ne most recent twelve month			confidential schedule to utiliz	e.		
	period on 08/31/22.	, 02/17/23 and 05/22/23 were						
	_	ctively, 4:30 p.m., 4:30 p.m. and	The Field Maintenance Director					
	•	n interview at the time of record	will assist and review these upon					
	review, the Field M	faintenance Supervisor agreed	each visit and report back to the					
		second shift fire drills were			Executive Director.			
	not conducted at un	expected times under varying						
	conditions.				This information will be revie	wed at		
	These findings were reviewed with the Field				QAPI each month for the			
					remainder of the year.			
	Maintenance Supervisor and the Director of							
Nursing during the exit conference. The Director								
	of Nursing confirmed the facility operates three							
	shifts per day. 3.1-19(b)							

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