STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155436	A. BUILDING -- B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT WINAMAC	515 E 13TH ST WINAMAC, IN 46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/15/24 Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550 At this Emergency Preparedness survey, Hickory Creek at Winamac was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 32. Quality Review completed on 10/16/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/15/24 Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550 At this Life Safety Code survey, Hickory Creek at Winamac was found not in compliance with	K 0000	Hickory Creek at Winamac respectfully requests a desk review for paper compliance. All in-service and supporting documentation is attached for review. Thank you. The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen Nan Folkers	Executive Director	10/22/2024

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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	155436	A. BUILDING 01 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT WINAMAC	515 E 13TH ST WINAMAC, IN 46996

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms were equipped with battery operated smoke detectors. The facility has the capacity for 36 and had a census of 32 at the time of this survey. All areas within the facility where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached buildings: one used for oxygen storage, the second is the maintenance office, and the third is used for miscellaneous equipment and storage. Quality Review completed on 10/16/24			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 16 residents, 6 staff, and 2 visitors.	K 0374	Hickory Creek at Winamac respectfully requests a desk review for paper compliance. All in-service and supporting documentation is attached for review. Thank you. The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or	10/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155436	A. BUILDING 01 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT WINAMAC	515 E 13TH ST WINAMAC, IN 46996

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	Findings include: Based on observation made during a tour of the facility with the Maintenance Director on 10/15/24 at 1:44 p.m., the set of smoke barrier doors nearest to resident room #4 did not close completely when tested on three separate occasions. There was a one-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged the smoke barrier doors did not close completely and while looking that them noticed that they had been recently repainted, and the paint was rubbing at the top of the doors not allowing them too fully close. This finding was reviewed with the Maintenance Director only as the Executive Director was unavailable at the time the exit conference dur to a prior engagement. 3.1-19(b)		of any violation of regulation. **K 374 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The Executive Director completed education with the Maintenance Director for K374 Subdivision of Building Space-Smoke Barriers. (Attachments #1 and #1a.) **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The identified set of smoke barrier doors were repaired/adjusted, allowing them to close fully. (Attachments #2 and #2A). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** There were no other smoke barrier doors affected by the alleged deficient or identified during the survey. The Maintenance Director will ensure the smoke barrier doors fully close monthly. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place: The Executive Director will monitor the two smoke barrier doors monthly to ensure they fully close according to K 374 Subdivision of Building Spaces – Smoke Barrier Doors regulation. (Attachment #3). If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Committee for review and follow-up.	