STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155353	A. BUILDING -- B. WING	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

(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: 10/24/24 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Emergency Preparedness survey, Hickory Creek at Greensburg 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 26. Quality Review completed on 10/24/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/24/24 Facility Number: 000244 Provider Number: 155353 AIM Number: 100288790 At this Life Safety Code survey, Hickory Creek at Greensburg was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brooke Thies	Executive Director	11/19/2024

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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HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN 47240

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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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 26 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/24/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the 2 of 4 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility. Findings include:	K 0222	**K 222 Egress Doors** 1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. On 10/24/2024 the Maintenance Director/designee posted the exit code at 2 of 4 exits where the code was not posted (1) Side exit door and (2) Rear exit door near the Oxygen storage location.	10/25/2024

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	155353	A. BUILDING 01 B. WING	10/24/2024

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	Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/24/24 between 11:10 a.m. and 12:15 p.m., the (1) Side exit door and (2) the Rear exit door near the Oxygen storage location, marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exits. The MD stated that he wasn't sure why the code was not posted at these two locations but agreed that it would be corrected by the end of the day. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and the Administrator present. 3.1-19(b)		2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: 20 residents, staff, and visitors have the potential to be affected from this alleged deficient practice. On 10/24/24 the Maintenance Director/Designee inspected all doors for posted exit codes with no findings. 3 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 10/24/24 the Administrator in-serviced the Maintenance Director/Designee that all doors are to have exit codes posted to meet set standards. The Maintenance Director/Designee will inspect that all exit doors have codes posted monthly. 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The monthly inspection results will be presented by the Maintenance Director/Designee at the monthly QA meeting. Inspection results and system components will be reviewed by the QA committee	

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			with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **5 Completion Date: 10/25/2024**	
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Based on observation and interview, the facility failed to ensure 1 of 1 portable space heaters were not used in the facility and that a policy regarding use was available for review. This deficient practice could affect up to 1 resident. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/24/24 between 11:10 a.m. and 12:15 p.m., The MD stated that a portable space heater had been in use in Resident Room #3. He believed a family member had placed it in the room since the PTAC unit was not functioning properly. The facility did not have a Portable Space Heater Policy available for review at the time of the survey. The heater was removed from the room and the MD stated that they would immediately replace the HVAC unit in RR#3 that day with one from an empty room while they wait for parts for the broken unit. This finding was reviewed with the MD at the time of discovery and again at the exit conference with the MD and the Administrator present. 3.1-19(b)	K 0781	**K 781 – Portable Space Heaters** 1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice**: No residents suffered any ill affects from the alleged deficient. On 10/24/24, the Maintenance Director/Designee removed the space heater from the room. In addition, the PTAC unit was fixed on 10/24/24 and is functioning properly. 2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: 1 resident had the potential to be affected by this alleged deficient practice. The Maintenance Director/Designee inspected all resident rooms for space heaters with no other negative findings.	10/25/2024

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			3 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 10/24/2024 the Administrator in-serviced the Maintenance Director/Designee that space heaters are prohibited to meet set standards. The Maintenance Director/Designee will inspect resident rooms weekly. All staff educated on the prohibition of space heaters in resident rooms by ED/designee. 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** A weekly inspection by the Maintenance Director/Designee for 1 month, then monthly for 6 months related to space heaters. Results will be presented by the Maintenance Director/Designee at the monthly QA meeting. Inspection results and system components will be reviewed by the QA committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **5 Completion Date: 10/25/2024**	