PRINTED: 06/28/2024
FORM APPROVED

	R MEDICARE & MEDIC		L		OMB NO. 0938-039
			CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155419	B. WING		06/11/2024
NAME OF I	DDOVIDED OD CLIDDI IEI	D.	STREE	ET ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIEI			N WHITLOCK AVE	
HICKOR	Y CREEK AT CRA	WFORDSVILLE	CRA	WFORDSVILLE, IN 47933	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	RIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg					
1 -1-3	An Emergency Pre	paredness Survey was	E 0000		
		ndiana Department of Health in			
	accordance with 42	-			
	Survey Date: 06/1	1/24			
	Facility Number: (000533			
	Provider Number:				
	AIM Number: 100	0267230			
		D 1 1711			
	1	Preparedness survey, Hickory			
		sville was found not in			
	_	mergency Preparedness Medicare and Medicaid			
	_	ders and Suppliers, 42 CFR			
	483.73	ucis and Suppliers, 42 Crix			
	103.73				
	The facility has 36	certified beds. At the time of			
	the survey, the cens				
	Quality Review con	mpleted on 06/12/24			
E 0041	482.15(e), 483.73	8(e), 485.625(e)			
SS=F		LTC Emergency Power			
Bldg		tion for Participation:			
	` '	nd standby power systems.			
		t implement emergency and			
		stems based on the			
		set forth in paragraph (a) of			
	this section and ir	•			
		set forth in paragraphs (b)(1)			
	(i) and (ii) of this s	section.			
	§483.73(e), §485	.625(e)			
		nd standby power systems.			
	` '	and the CAH] must			
		ency and standby power			
	l				
LABORATOF	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Joshua Jackson 06/27/2024

Any definencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 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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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155419	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COM	TE SURVEY TPLETED 11/2024			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CRAWFORDSVILLE			817 N	STREET ADDRESS, CITY, STATE, ZIP COD 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933					
(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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	_ ·	the emergency plan set (a) of this section.							
	Emergency gener generator must be the location required Care Facilities Conterim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §48 Emergency generating The [hospital, CAI implement the eminspection, testing requirements four	83.73(e)(1), §485.625(e)(1) rator location. The relocated in accordance with rements found in the Health de (NFPA 99 and Tentative runts TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing rung is renovated. 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must rergency power system g, and [maintenance] and in the Health Care FPA 110, and Life Safety							
	Emergency gener and LTC facilities source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the s it evacuates.							
	§483.73(g), and C The standards inc this section are ap reference by the I Federal Register	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the n accordance with 5 U.S.C. t part 51. You may obtain							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155419		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 06/11/2024				LETED		
		PROVIDER OR SUPPLIEF			817 N V	ADDRESS, CITY, STATE, ZIP COD VHITLOCK AVE FORDSVILLE, IN 47933	•	
	(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
		the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information this material at NA go to: http://www.archive_of_federal_regul. If any changes in incorporated by redocument in the Fannounce the characteristic (1) National Fire FBatterymarch Par Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Liedition, issued Au (viii) TIA 12-1 to NF 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013.	the sources listed below. a copy at the CMS urce Center, 7500 Security ore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to langes. Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 1, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 06/11/2024 155419 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 817 N WHITLOCK AVE HICKORY CREEK AT CRAWFORDSVILLE CRAWFORDSVILLE. IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility E 0041 E0041 06/28/2024 failed to implement the emergency power system **Emergency and Standby** inspection, testing, and maintenance requirements **Power Systems** found in the Health Care Facilities Code, NFPA What corrective action will be 110, and Life Safety Code in accordance with 42 accomplished for those CFR 483.73(e)(2). This deficient practice could residents found to be affected affect all occupants. by the deficient practice? The facility and its Maintenance Findings include: Supervisor will consistently follow and monitor its emergency power Based on records review and interview with the system inspection program in Maintenance Director on 06/11/24 between 10:15 accordance with 42 CFR 483.73(e) a.m. and 2:00 p.m., no documentation was (2). The inspection program will available for review to show the generator set in provide documentation showing service was exercised at least once monthly, for a the generator will be inspected minimum of 30 minutes since 02/09/2024. Based on once week and set in service and interview at the time of record review, the exercised at least once a month, Maintenance Director stated he had been on the for a minimum of 30 minutes. job for a week, checked for additional How other residents having the documentation for monthly generator tests, and potential to be affected by the none were available for review at the time of the same deficient practice will be survey. identified and what corrective action will be taken? Based on review of "Emergency Generator - Visual All residents have the potential to Inspection" documentation with the Maintenance be affected by this deficient Director during record review from 10:15 a.m. to practice. The facility will follow its 2:00 p.m. on 06/11/24, documentation of weekly emergency power system emergency generator inspections since 02/21/2024 inspection program as set forth was not available for review. Based on interview above. at the time of record review, the Maintenance What measures will be put into Director stated he had been on the job for one place and what systemic

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week, has checked for more weekly generator

weekly emergency generator inspections since

02/21/2024 was not available for review.

inspections and confirmed that documentation of

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changes will be made to

ensure that the deficient

practice does not recur?

The Maintenance Supervisor will record the percentage of load

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155419		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933				
(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		
	Director on 06/11/2 documentation for r for four of the last trigenerator only ran feach month. The moderate in 11/30/23 and 11/1/2 3:14 p.m. to 3:14 p. for 07/20/23 and 06 ran 1:15 p.m. to 1:1 the time of record round confirmed the hand confirmed the daforementioned moderate in 11/2 i	riew with the Maintenance 4 from 10:15 a.m. to 2:00 p.m., monthly generator load testing welve months shows the for 1 minute under load for onthly load documentation for 23 showed the generator ran m. Monthly load documentation /06/23 showed the generator 5 p.m. Based on an interview at eview, the Maintenance ad been on the job for a week locumentation for the nthly generator load testing for or was not 30 minutes.		tested on the Generator mont in the TELS system. How the corrective action with the monitored to ensure the deficient practice will not recur? The Life Safety POC QAPI to be utilized by the Maintenance Supervisor / designee weekly weeks, monthly x 6 months, a quarterly thereafter for one year with results reported to the Quassurance and Performance Improvement Committee over by the Executive Director. If a threshold is not achieved, an action plan will be developed ensure compliance. Date of compliance: 06/28/2024	ol will e x 4 and ear uality rseen 95%		
K 0000 Bldg. 01							
) o	Licensure was cond Department of Heal 483.90(a). Survey Date: 06/11/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety 0 Crawfordsville was Requirements for Pa	200533 55419 67230 Code survey, Hickory Creek at found not in compliance with articipation in	K 0000				
		, 42 CFR Subpart 483.90(a), re and the 2012 edition of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155419		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER		817 N \	ADDRESS, CITY, STATE, ZIP COD WHITLOCK AVE FORDSVILLE, IN 47933	
(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 0291 SS=C	Life Safety Code (I Health Care Occupa This one-story facil Type II (000) constraints sprinklered. The fact with hard wired smand spaces open to were equipped with detectors. The facility had a census of 32 at All areas within the customary access we providing facility so three detached build maintenance, and me storage that were under the con- NFPA 101	npleted on 06/12/24			
SS=C Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on record revinterview, the facili battery backup light annually for 90 min ensure the light worperiods of power or visual inspections a 19.2.9.1 requires en provided in accorda 7.9.3.1.1 (1) requires	ng g of at least 1-1/2-hour ed automatically in	K 0291	K 0291 Battery Back Up Lights What corrective action(s) will be taken for those residents found to have been affected the deficient practice? The facility and its Maintenant Supervisor will consistently for and monitor an emergency be backup light testing program is	by ce llow attery

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Supervisor / designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance

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	T OF HEALTH AND HU! R MEDICARE & MEDIC					TED: 06/28/2024 RM APPROVED B NO. 0938-039
	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155419	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 06/11 /	ETED
	PROVIDER OR SUPPLIER		817 N V	ADDRESS, CITY, STATE, ZIP COD VHITLOCK AVE FORDSVILLE, IN 47933		
(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0300 SS=C Bldg. 01	Section 18.3 and requirements that provided K-tags, b	KS section any LSC		Improvement Committee ove by the Executive Director. If a threshold is not achieved, an action plan will be developed ensure compliance. Date of compliance: 06/28/2024	95%	

Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview the facility failed to ensure the preventative maintenance for 18 of 18 battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents.

Based on records review with the Maintenance

Battery-Operated Smoke Detector Maintenance

Director on 06/11/23 at 12:55 p.m., the "Test

K 0300 K 0300 **Battery Operated Smoke Alarms**

> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility and its Maintenance

Supervisor will consistently follow and monitor a preventative maintenance program for 18 of 18 battery-operated smoke alarms in accordance with regulation. This maintenance program will provide documentation showing the facility completes weekly testing of battery-operated smoke alarms. How will you identify other

residents having the potential

to be affected by the same deficient practice and what

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Findings include:

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	PROVIDER OR SUPPLIER		817 N	T ADDRESS, CITY, STATE, ZIP COD I WHITLOCK AVE VFORDSVILLE, IN 47933	
(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 BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETION DATE
	operated smoke alar published instruction the alarms require we interview at the tim Maintenance Direct position last week a been documented as agreed the alarms slaccording to manufainstructions. The finding was reveand Maintenance Direct conference. 3.1-19(b)	ally testing of the battery rms. The manufacturer's rms for the smoke alarms stated veekly testing. Based on e of records review, the or stated he started his and confirmed the alarms had s being tested monthly, and rould be tested weekly acturer's published riewed with the Administrator irector during the exit		corrective action will be talk All residents have the potent be affected by this deficient practice. The facility will follot testing program as set forth What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Superviso record the results of the preventative program listed a in the TELS system. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e.; what quality assurance program will be into place? The Life Safety POC QAPI to be utilized by the Maintenan Supervisor / designee weekl weeks, monthly x 6 months, quarterly thereafter for one y with results reported to the C Assurance and Performance Improvement Committee ove by the Executive Director. If threshold is not achieved, ar action plan will be developed ensure compliance. Date of compliance: 06/28/2	r will above into r will above the put ool will ce y x 4 and rear Quality erseen a 95% a dito
K 0712 SS=F Bldg. 01	alarm signal and s	he transmission of a fire imulation of emergency fire ills are held at expected			

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTI			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155419			A. BUILDING 01 COMPLETED B. WING 06/11/2024				
155419		B. WI			00/11/2024		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD WHITLOCK AVE		
HICKOR	Y CREEK AT CRAV	VFORDSVILLE			FORDSVILLE, IN 47933		
(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 DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	DATE	
IAU	and unexpected ti conditions, at leas The staff is familia aware that drills at routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1. Based on record facility failed to cord of 4 quarters. LSC conducted quarterly conditions. This defand residents. Findings include: Based on record revelopment that the "Direct Supply Maintenance Direct a) There was no do fire drill conducted February, and Marce b) There was no do second shift fire dril quarter (April, May c) There was no do drill conducted in the November, and Dec Based on interview the Maintenance Direct was no document of the second shift for the drill conducted in the November, and Dec Based on interview the Maintenance Direct that the staff is familiary to the maintenance Direct that the staff is familiary to the staff is fam	mes under varying at quarterly on each shift. In with procedures and is re part of established ills are conducted between AM, a coded asy be used instead of 19.7.1.7 review and interview, the aduct quarterly fire drills for 3 19.7.1.6 requires drills to be an each shift under varied ficient practice affects all staff 19.7.1.6 requires drills to be an each shift under varied ficient practice affects all staff 19.7.1.6 requires drills to be an each shift under varied ficient practice affects all staff 19.7.1.6 requires drills to be an each shift under varied ficient practice affects all staff 19.7.1.6 requires drill forms with the corn the following was noted: cumentation of a second shift in the first quarter (January, h) of 2024. cumentation of a first and 11 conducted in the second punch of 2024 cumentation of a third shift fire the fourth quarter (October,	K 0'		K-0712 Quarterly Fire Drill Testing What corrective action will be done by the facility? The facility and its Maintenand Supervisor will consistently for and monitor its fire drill progra conduct quarterly fire drills in accordance with regulation. The fire drill program will provide documentation showing the factompletes these drills in accordance with regulation. A drill was conducted on each so Drills between 6 and 9 will incoverification of transmission of fire alarm signal to the monito station. Staff who participated the fire drill signed the sign in sheet for participation. How will the facility identify other residents having the	o6/28/2024 e ce Illow im to his icility fire hift. lude the ring	
		that there is no additional			potential to be affected by the	ne e	
	documentation avai	lable for review.			same practice and what corrective action will be take	en?	
	This finding was re-	viewed with the Administrator					
	and Maintenance D	irector at the exit conference.			All residents have the potentia	al to	
		t de la de			be affected by this deficient		
l l	I 2. Based on record in	review and interview, the	1		practice The facility will follow	/ its	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155419 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 817 N WHITLOCK AVE HICKORY CREEK AT CRAWFORDSVILLE CRAWFORDSVILLE. IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility failed to ensure 1 of 12 fire drills included testing program as set forth above. the verification of transmission of the fire alarm The Maintenance director was signal to the monitoring station in fire drills educated on fire drills, frequency, conducted between 6:00 a.m. and 9:00 p.m. for the documentation and completion of last 4 quarters. LSC 19.7.1.4 requires fire drills in sian in sheets. health care occupancies shall include the What measures will be put into transmission of a fire alarm signal and simulation place to ensure this practice does not recur? of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. ED will ensure a fire drill will be conducted each shift each quarter. Findings include: Drills conducted between 6 and 9 will include verification of Based on record review of "Direct Supply - TELS" transmission of the fire alarm fire drill forms" with the Maintenance Director on signal to the monitoring station. 06/11/24 at 10:40 a.m., the third shift fire drill in the The Maintenance Supervisor will first quarter (1/11/24 at 5:05 a.m.) of 2024 did not record the results of the fire drill document the transmission of signal to the program listed above in the TELS monitoring station. Based on interview at the time system. of record review, the Maintenance Director ED/designee will ensure sign in confirmed the transmission of signal was not sheets are completed for staff who documented for the aforementioned fire drill. participated in the drill. How the corrective action(s) This finding was reviewed with the Administrator will be monitored to ensure the and Maintenance Director at the exit conference. deficient practice will not recur, i.e.; what quality 3. Based on record review and interview, the assurance program will be put facility failed to provide complete fire drill into place? documentation for 2 of 12 fire drills performed The Life Safety POC QAPI tool will during the past 12 month period. This deficient be utilized by the Maintenance practice could affect all residents in the facility. Supervisor / designee weekly x 4 weeks, monthly x 6 months, and Findings include: quarterly thereafter for one year with results reported to the Quality Based on review of the facility's fire drill reports Assurance and Performance on 06/11/24 between 10:10 a.m. and 2:00 p.m. with Improvement Committee overseen the Maintenance Director present, the by the Executive Director. If a 95% documented fire drill reports performed on threshold is not achieved, an 11/29/23 at 2:05 p.m. (second shift of the fourth action plan will be developed to quarter), 07/28/23 at 12:20 p.m. (first shift of the ensure compliance.

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	ETED	
155419		B. WING 06/11/2024			2024		
				OTTO FEET A	A DEDEGG OVER OF A TE GIR COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LUCKODY	A CDEEK AT CDAY	VEODDS VII I E			VHITLOCK AVE		
HICKORY	Y CREEK AT CRAV	VFORDSVILLE		CRAWF	FORDSVILLE, IN 47933		
(X4) ID	SUMMARY S	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
	third quarter) did no	t include a sign in sheet of the			Date of compliance: 06/28/202	24	
	participating staff. I	Based on interview at the time					
	of record review, th	e Maintenance Director					
	confirmed the lack of	of staff sign in sheets for the					
	previously mention	ed fire drill reports.					
		viewed with the Administrator				ļ	
		irector during the exit					
	conference.						
	3.1-19(b)						
	3.1-15(b) 3.1-51(c)						
	3.1 31(c)						
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 01		s - Essential Electric					
· ·	System Maintenar						
	_	other alternate power					
	-	ated equipment is capable					
	of supplying service	ce within 10 seconds. If the					
	10-second criterio	n is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm the	nis capability for the life					
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	rmed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	nths for 4 continuous hours.					
		der load conditions include					
	a complete simula	ted cold start and					
	automatic or manu	ual transfer of all EES					
	loads, and are cor	nducted by competent					
		nance and testing of stored				ļ	
	• • • • • • • • • • • • • • • • • • • •	rces (Type 3 EES) are in				ļ	
		IFPA 111. Main and feeder				ļ	
		e inspected annually, and a				ļ	
	program for period	lically exercising the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155419 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 817 N WHITLOCK AVE HICKORY CREEK AT CRAWFORDSVILLE CRAWFORDSVILLE. IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the K 0918 K-0918 06/24/2024 facility failed to maintain a complete written record Written Record of Monthly of monthly generator load testing for 3 of the last **Generator Load Testing** 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving What corrective action will be the emergency electrical system to be in done by the facility? accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter The facility and its Maintenance 8. NFPA 110 8.4.2.4 requires spark-ignited Supervisor will consistently follow generator sets shall be exercised at least once a and monitor its written record of month with the available EPSS load for 30 minutes monthly generator load testing in or until the water temperature and the oil pressure accordance with regulation. This have stabilized. Chapter 6.4.4.2 of NFPA 99 record program will provide requires a written record of inspection, documentation showing the facility performance, exercising period, and repairs for the completes this load testing in generator to be regularly maintained and available accordance with regulation. for inspection by the authority having How will the facility identify jurisdiction. This deficient practice could affect all other residents having the occupants. potential to be affected by the same practice and what Findings include: corrective action will be taken? Based on records review and interview with the All residents have the potential to Maintenance Director on 06/11/24 between 10:15 be affected by this deficient a.m. and 2:00 p.m., no documentation was practice. The facility will follow and available for review to show the generator set in monitor its written record as set service was exercised at least once monthly, for a forth above. minimum of 30 minutes since 02/09/2024. Based on What measures will be put into interview at the time of record review, the place to ensure this practice

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155419 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 817 N WHITLOCK AVE HICKORY CREEK AT CRAWFORDSVILLE CRAWFORDSVILLE. IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Maintenance Director stated he had been on the does not recur? job for a week, checked for additional documentation for monthly generator tests, and The Maintenance Supervisor will none were available for review at the time of the record the results of the written survey. record listed above in the TELS system. This finding was reviewed with the Administrator How the corrective action(s) and Maintenance Director at the exit conference. will be monitored to ensure the deficient practice will not 2. Based on record review and interview, the recur, i.e.; what quality facility failed to ensure a written record of weekly assurance program will be put inspections for the emergency generator set was into place? maintained for 15 weeks of 52 week period in June The Life Safety POC QAPI tool will 2023 through June 2024. This deficient practice be utilized by the Maintenance could affect all residents, staff and visitors. Supervisor / designee weekly x 4 weeks, monthly x 6 months, and Findings include: quarterly thereafter for one year with results reported to the Quality Based on review of "Emergency Generator - Visual Assurance and Performance Inspection" documentation with the Maintenance Improvement Committee overseen Director during record review from 10:15 a.m. to by the Executive Director. If a 95% 2:00 p.m. on 06/11/24, documentation of weekly threshold is not achieved, an emergency generator inspections since 02/21/2024 action plan will be developed to was not available for review. Based on interview ensure compliance. at the time of record review, the Maintenance Date of compliance: 06/24/2024 Director stated he had been on the job for one week, has checked for more weekly generator inspections and confirmed that documentation of weekly emergency generator inspections since 02/21/2024 was not available for review. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155419		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURY A. BUILDING 01 COMPLETED B. WING 06/11/202			ETED		
NAME OF P	ROVIDER OR SUPPLIEF	S			ADDRESS, CITY, STATE, ZIP COD VHITLOCK AVE		
HICKOR	Y CREEK AT CRAV	VFORDSVILLE		CRAWF	FORDSVILLE, IN 47933		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	REGULATORY OF accordance with NF Emergency and Sta 8. NFPA 110 8.4.2. generator sets shall month with the avair or until the water to have stabilized. Charequires a written reperformance, exercing generator to be regular for inspection by the jurisdiction. This doccupants. Findings include: Based on record reviolation for 1 for four of the last the generator only ran feach month. The mental 1/30/23 and 11/1/2 3:14 p.m. to 3:14 p. for 07/20/23 and 06 ran 1:15 p.m. to 1:1 the time of record rec	FPA 110, the Standard for ndby Powers Systems, Chapter 4 requires spark-ignited be exercised at least once a ilable EPSS load for 30 minutes mperature and the oil pressure apter 6.4.4.2 of NFPA 99 excord of inspection, ising period, and repairs for the alarly maintained and available		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
		e Director at the exit					
	3.1-17(0)						

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