STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155434	A. BUILDING -- B. WING	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT CONNERSVILLE	2600 N GRAND AVE CONNERSVILLE, IN 47331

(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: 10/08/24 Facility Number: 000319 Provider Number: 155434 AIM Number: 100286530 At this Emergency Preparedness survey, the Hickory Creek at Connersville 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 33. Quality Review completed on 10/10/24	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: 10/08/24 Facility Number: 000319 Provider Number: 155434 AIM Number: 100286530 At this Life Safety Code survey, Hickory Creek at	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lea Ann Loy	Executive Director	10/29/2024

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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	Connersville was found not in compliance with 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 facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and battery powered detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 33 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached wooden storage sheds and one detached metal liquid oxygen storage building which were not sprinklered. Quality Review completed on 10/10/24			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer	K 0324	**This plan of correction constitutes the written allegation of compliance for deficiencies cited. However, submission of this Plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and federal law.**	10/25/2024

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	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 4 staff, and no residents. Findings include: Based on observation and interviews during a tour of the facility with the Maintenance Director (MD) and the Field Maintenance Supervisor on 10/08/24 between 11:50 a.m. and 1:20 p.m. the gas range and freestanding fryer, located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the MD at the time of observation and again at the Exit Conference with the Maintenance Director (MD) and the Field Maintenance Supervisor present.		K 324 **It is the standard of this facility to ensure all cooking appliances are returned to designated areas under hood extinguishing system as designed and installed.** **1** What corrective action will be accomplished for those residents found to have been affected by the deficient practice. **The facility has written a new policy titled "Kitchen Cooking Equipment Return Policy" to include procedures to follow when moving and cleaning cooking equipment to ensure cooking equipment is returned to designated areas under hood extinguishing system. The policy includes procedure to ensure floor, wall, or hood is marked in a way to visually indicate where cooking equipment is to be located under hood extinguishing system.** **2** How other residents having the same potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken. **The Maintenance Director has assessed all cooking areas to ensure no other areas exist that would require a "Return Policy" to be implemented.**	

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	3.1-19(b)		**3** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? **The ED, Maintenance Director, and all kitchen staff have received education on the new "Kitchen Cooking Equipment Return Policy".** **The Culinary Supervisor will complete morning kitchen walk-through rounds daily on scheduled days of work, which will include visualizing cooking equipment for proper placement under hood extinguishing system. Rounding will be documented on Daily Kitchen walk-through rounding form. Any noted concerns will be addressed immediately with kitchen staff and brought to the Executive Director's attention.** **The Maintenance Director will check kitchen cooking equipment monthly to ensure proper placement under the hood extinguishing system. Monthly checks will be documented in TELS. Any noted concerns will be addressed immediately with kitchen staff and brought to the Executive Director's attention.**	

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			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? **As a means of quality assurance, the Maintenance Director will present an Ansul System report to the QA committee during scheduled QA meetings every other month. QA committee will discuss if further action is required.** **5** Compliance Date: **10/25/24**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 14 residents in one smoke compartment. Findings include: Based on observation and interviews during a	K 0353	**K353** **It is the standard of this facility to ensure that the sprinkler system is maintained in a manner to ensure sprinkler piping is not subjected to external loads by materials either resting on the pipe or hung from the pipe.** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. **The plastic zip ties have been**	10/25/2024

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	tour of the facility with the Maintenance Director (MD) and the Field Maintenance Supervisor on 10/08/24 between 11:50 a.m. and 1:20 p.m. the mechanical room had zip ties wrapped around a sprinkler line which were supporting copper pipe which had recently been replaced. The MD stated that pump motor and piping had recently been replaced and they must have zip tied it to the sprinkler line then. This finding was acknowledged by the MD at the time of observation and again at the Exit Conference with the Maintenance Director (MD) and the Field Maintenance Supervisor present. 3.1-19(b)		**removed from the sprinkler line copper pipe.** 2 How other residents having the same potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken. **The Maintenance Director has completed a thorough inspection of all visible sprinkler pipes to ensure no other zip ties are in place, as well as assurance that piping is free from obstruction or materials resting on or hung from the sprinkler pipe.** 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? **Maintenance Director has been re-educated on sprinkler system policy related to obstructions and material resting/hanging from sprinkler pipe.** **The Maintenance Director has also been instructed to inspect areas after vendors have worked in the facility to ensure a vendor has not placed material on or hung anything from the sprinkler pipes.**	

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			The Maintenance Director will check visual sprinkler system pipes quarterly to ensure all sprinkler pipes remain free from material resting or hanging from the sprinkler pipes. Monthly inspection will be documented in TELS quarterly. 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? **As a means of quality assurance, the Maintenance Director will present a Sprinkler System report to the QA committee during scheduled QA meetings every other month. QA committee will discuss if further action is required.** 5 Compliance Date**: 10/25/24**	