Amanda Spall

PRINTED: 06/22/2023 FORM APPROVED

06/20/2023

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB	NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLET	ГED
		155442	B. WING		06/07/2023	
		100112	<u> </u>	_	00/01/12	020
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
		-	580 LE	MLEY STREET		
HICKOR'	Y CREEK AT FRAN	IKLIN	FRANKLIN, IN 46131			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	۱,	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
E 0000	REGUEATION I OF	CESC IDENTIFY THIS INFORMATION	1710			DATE
L 0000						
Dida						
Bldg	4 F B	1 0	E 0000			1
		paredness Survey was	E 0000		.	
		diana Department of Health in		The creation and submission	-	
	accordance with 42	CFR 483.73.		this plan of correction does		
				constitute an admission by t		
	Survey Date: 06/07	1/23		provider of any conclusion s	et	
				forth in the statement of		
	Facility Number: 0			deficiencies, or of any violati	ion	
	Provider Number:			of regulation.		
	AIM Number: 100	290720				
		Preparedness survey, Hickory				
		vas found not in compliance				
		eparedness Requirements for				
		caid Participating Providers				
	and Suppliers, 42 C	FR 483.73				
		certified beds. At the time of				
	the survey, the cens	us was 29.				
	Quality Review cor	mpleted on 06/08/23				
	The requirement at	42 CFR, Subpart 483.73 is NOT				
	MET as evidenced	by:				
E 0041	482.15(e), 483.73	(e), 485.625(e)				
SS=F	· ·	LTC Emergency Power				
Bldg	§482.15(e) Condit	tion for Participation:				
	(e) Emergency an	d standby power systems.				
	The hospital must	implement emergency and				
	standby power sys	stems based on the				
	emergency plan s	et forth in paragraph (a) of				
	this section and in	the policies and				
	procedures plan s	et forth in paragraphs (b)(1)				
	(i) and (ii) of this s					
	§483.73(e), §485.	625(e)				
	- , , -	d standby power systems.				
		<u>, </u>				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	((X6) DATE

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 06/07/2023	
	PROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET (LIN, IN 46131	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE	(X5) COMPLETION
PREFIX TAG	The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements foun Facilities Code, Ni Code. 482.15(e)(3), §483 Emergency gener and LTC facilities] source to power enand LTC facilities] source to power enand emergency, unles *[For hospitals at §483.73(g), and Can the standards incomposition of the standards in the standar	and the CAH] must ency and standby power the emergency plan set (a) of this section. 33.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new or when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. Hand LTC facility] must ergency power system and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency erational during the sit evacuates. §482.15(h), LTC at 5.44 5.625(g):] orporated by reference in	PREFIX TAG			COMPLETION DATE
		oproved for incorporation by Director of the Office of the				

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IYDS21

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY MPLETED 07/2023	
	PROVIDER OR SUPPLIE		580 LE	ADDRESS, CITY, STATE, ZIP MLEY STREET (LIN, IN 46131	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Federal Register is 552(a) and 1 CFF the material from You may inspect a Information Reson Boulevard, Baltim Archives and Red (NARA). For infor this material at Nago to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TlA 12-3 to NI 2012. (iv) TlA 12-4 to NI 2013. (v) TlA 12-5 to NF 2013. (vi) TlA 12-6 to NI 2014. (viii) NFPA 101, Li edition, issued Au (viii) TlA 12-1 to NI 11, 2011. (ix) TlA 12-2 to NI 30, 2012.	in accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It copy at the CMS acopy at the CMS acopy at the CMS acopy at the National ords 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 larges. Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 1, FPA 99, issued March 7, FPA 99, issued March 3, fe Safety Code, 2012				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLE	
		155442	B. WI	NG		06/07/2	023
NAME OF I	PROVIDER OR SUPPLIE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	ROVIDER OR SUPPLIE.	K.		580 LE	MLEY STREET		
HICKOR	Y CREEK AT FRAI	NKLIN		FRANKLIN, IN 46131			
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		FPA 101, issued October					
	22, 2013.						
	, ,	Standard for Emergency and					
	· -	ystems, 2010 edition,					
	including TIAs to chapter 7, issued August 6, 2009						
		view, observation and	E 00)41	What corrective action(s) will		06/20/2023
	·	ity failed to implement the			be accomplished for those		
	emergency power system inspection, testing and maintenance requirements found in the Health				residents found to have bee	n	
					affected by the deficient		
		le, NFPA 110, and Life Safety			practice:		
		e with 42 CFR 483.73(e)(2).			The supplemental 4-hour load		
	This deficient prac	tice could affect all occupants.			testing was performed on 6/19	9/23	
	Findings include:				and is available for review.		
					How other residents having		
		e de la casa de la cas			potential to be affected by th		
		view with the Administrator,			same deficient practice will		
		irector and the Field			identified and what corrective	/e	
		rvisor from 9:20 a.m. to 1:00			action(s) will be taken:		
	_	he following was noted:			All residents have the potentia		
		cy generator inspection			be negatively impacted when	tne	
		13 weeks of the most recent od was not available for review.			generator was not tested		
	_	generator inspection			appropriately. Corrective action was to run the 4 hour load test		
		the 13 week period of 10/03/22			and to educate the Maintenan	-	
		vas not available for review.			Supervisor.	ice	
		ting documentation for the			What measures will be put in	nto	
	-	ed emergency generator for the			place or what systemic		
		of November 2022 and			changes will be made to		
		as not available for review.			ensure that the deficient		
		period emergency generator			practice does not recur:		
	•	ion for four continuous hours			Maintenance Director was		
		gas fired emergency generator			educated on 4-hour load testing	ng	
	was not available f				requirements by ED on 6/20/2	-	
		ons with the Administrator,			The maintenance director will		
		irector and the Field			verify the thirty-sixth month pe		
		visor during a tour of the			emergency generator 4 hour l		
	_	o.m. to 1:45 p.m. on 06/07/23, the			testing is completed based on		
		gas fired emergency generator			preventative maintenance	1	
	-	building on the north side of			schedule.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. BUILDING B. WING		COMPLETED 06/07/2023	
	ROVIDER OR SUPPLIER		580 L	T ADDRESS, CITY, STATE, ZIP COD EMLEY STREET IKLIN, IN 46131	
(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 0000 Bldg. 01	the property. Based record review, the F agreed weekly general documentation and a documentation for the monthly periods was agreed supplementate for four hours within period was also not. These findings were Administrator, the M Field Maintenance Sconference. 3.1-19(b)	on interview at the time of field Maintenance Supervisor rator inspection monthly load testing he aforementioned weekly and s not available for review and I load testing documentation in the most recent three year available for review.	K 0000	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printed place: "" span=""> By what date the systemic changes will be completed: 6/20/23 Compliance Date = 6/20/23	he
	Department of Heal' 483.90(a). Survey Date: 06/07 Facility Number: 00 Provider Number: 1002 At this Life Safety C Franklin was found Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protec Life Safety Code, (I	00352 155442 290720 Code survey, Hickory Creek at not in compliance with			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING <u>01</u> COMPLETED					
		155442	B. WING 06/07/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(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)	TE	(X5) COMPLETION DATE
K 0291 SS=F Bldg. 01	This one story facility Type II (222) constructions sprinklered. The fact with smoke detection open to the corridors smoke detectors in a The facility has a care of 29 at the time of a All areas where resist were sprinklered. As storage services were detached garage who Quality Review common NFPA 101 Emergency Lighting Emergency Lighting Emergency Lighting duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on record revinterview; the facility testing for all batter with LSC 7.9. Section emergency lighting be conducted as foll (1) Functional testing with a minimum of weeks between tests seconds, except as conference of the conduction of th	ty was determined to be of ruction and was fully cility has a fire alarm system in in the corridors, spaces is and has battery powered all resident sleeping rooms. Spacity of 36 and had a census this survey. Idents have customary access all areas providing facility resprinklered except for one ich was not sprinklered. Impleted on 06/08/23 In g of at least 1-1/2-hour and automatically in grailed to document annual to backup lights in accordance from 7.9.3.1.1 states testing of systems shall be permitted to ows: In g shall be conducted monthly, and weeks and a maximum of 5 states than 30 otherwise permitted to be days with the approval of the isdiction. In g shall be conducted annually 1/2 hours if the emergency	K 0		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Emergency Battery Lighting to was completed and properly documented on 6/14/23. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents could potentially affected by emergency lighting.	est le e e e be	06/20/2023

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155442	B. W	ING		06/07/	/2023
				_			
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					MLEY STREET		
HICKOR	Y CREEK AT FRAN	IKLIN		FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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)	.IE	DATE
		lighting equipment shall be			working properly. Corrective A	ction	
	1	r the tests required by			taken was to complete the ann		
	7.9.3.1.1(1) and (3)				emergency battery powered	iddi	
	(5) Written records of visual inspections and tests				lighting test and to educate ou	ır	
	1 ' '	owner for inspection by the			Maintenance Supervisor.		
	authority having ju				Walitonarioo Sapervicer.		
		ice could affect all residents,			What measures will be put in	nto	
	staff and visitors.	all of all residents,			place or what systemic		
	Statt and visitors.				changes will be made to		
	Findings include:				ensure that the deficient		
					practice does not recur:		
	Based on review of Direct Supply TELS				The Maintenance Director or		
	"Emergency Lighting: Conduct a 90 minute				designee will test all emergen	CV	
	operational test" documentation dated 12/30/22				lighting for 90 minutes now an	-	
	_	ator, the Maintenance Director			annually to ensure it is operati		
		tenance Supervisor during			-	ng	
		9:20 a.m. to 1:00 p.m. on			properly and document	do	
		s of annual functional testing			appropriately in TELS. ED will	uo	
		all battery operated light			a TELS documentation audit		
		lity for the most recent twelve			monthly.		
		not available for review. The			What measures will be put in	ito	
	_	cumentation did not state the			place or what systemic		
		-minute testing for each			changes will be made to ensure that the deficient		
		_					
		n in the facility. Based on			practice does not recur:		
		e of record review, the tor and the Field Maintenance			The Maintenance Supervisor		
		tor and the Field Maintenance he facility has a total of four			provided education on emerge	-	
					battery light testing and freque	ency	
		hts, annual 90-minute testing ne end of 2022 but agreed the			thereof by ED on 6/19/23.		
	•				By what date the systemic		
		-minute testing for each			changes will be completed:		
	, , ,	ht location in the facility			06/20/23		
		ent twelve month period was			Compliance Date: 06/20/23		
		ased on observations with the					
		Maintenance Director and the					
	Field Maintenance Supervisor during a tour of the						
	facility from 1:00 p.m. to 1:45 p.m. on 06/07/23, a						
	total of four battery operated lights were noted in						
		n battery operated light					
		s respective test button was					
	pushed.		1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 06/07/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131		
(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)	(X5) COMPLETION DATE
K 0372 SS=F Bldg. 01	Field Maintenance conference. 3.1-19(b) NFPA 101 Subdivision of Build Barrie	e reviewed with the Maintenance Director and the Supervisor during the exit Iding Spaces - Smoke Iding Spaces - Smoke			
	Barrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smok in duct penetration systems where arries installed for smoke to the smoke barriers, 8.6.7.1(1)	nall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.			
	Based on observation failed to ensure 1 or protected to maintathe smoke barrier was requires smoke barrier was accordance with LS minimum ½ hour find efficient practice country and visitors. Findings include: Based on observation the Maintenance Displacements of the protection of	on and interview, the facility f 1 smoke barrier walls were in the fire resistance rating of rall. LSC Section 19.3.7.5 riers to be constructed in C Section 8.5 and shall have a re resistive rating. This build affect all residents, staff	K 0372	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice: Penetration caused by conduwas repaired by Maintenance Supervisor on 6/13/23 using frated caulk. How other residents having potential to be affected by the same deficient practice will identified and what correctivaction will be taken:	n it e fire the ne be

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155442	B. W	ING		06/07/	/2023
			1	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			MLEY STREET		
HICKOR	Y CREEK AT FRAN	IKLIN			LIN, IN 46131		
	1						T
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		.m. to 1:45 p.m. on 06/07/23,			All residents could be potentia	•	
	_	nch in diameter open ended the smoke barrier wall above			affected by there being a hole		
	_	ng above the corridor door set			the smoke barrier wall. Correct action taken was to repair the	uve	
	_	stroom by Room 13. Each			wall, do a whole house audit of	.f	
	1 -	blue water line which passed			smoke barriers and potential	' 1	
		barrier wall. Each conduit was			penetrations, and to audit the		
	_	the north side of the smoke			smoke barrier walls monthly to)	
		on interview at the time of the			ensure that they are intact.	-	
	observations, the Maintenance Director agreed				Whole house audit was compl	eted	
	the aforementioned openings in the smoke barrier				on 6/20/23.		
	wall above the corridor door set by Room 13 were				What measures will be put in	ito	
	not firestopped to maintain the fire resistance				place or what systemic		
	rating of the smoke	barrier wall.			changes will be made to		
					ensure that the deficient		
	_	e reviewed with the			practice does not recur:		
	· ·	Maintenance Director and the			Maintenance Supervisor was		
		Supervisor during the exit			educated on smoke barrier		
	conference.				construction and how to maint	ain	
					the smoke barrier walls in our		
	3.1-19(b)				building on 6/19/23 by ED.		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place: Maintenance Supervisor will		
					perform audit of smoke barrier	-	
					walls now and every month x		
					months to ensure they are inta		
					This will be added to our facilit		
					Preventative Maintenance Loc	-	
					By what date the systemic	-	
					changes will be completed:		
					6/20/23		
					Compliance Date = 6/20/23		
K 0712	NFPA 101						
SS=F	Fire Drills						İ

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155442	B. W	NG		06/07/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
HICKODY	/ CDEEV AT EDAN				MLEY STREET		
HICKOK	Y CREEK AT FRAN	INLIN		FRAINN	LIN, IN 46131		
(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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
Bldg. 01	Fire Drills						
	Fire drills include t	he transmission of a fire					
	alarm signal and simulation of emergency fire						
	conditions. Fire dri	ills are held at expected					
	and unexpected til	mes 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 dr	ills 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						
	1. Based on record r	review and interview, the	K 0	712			06/20/2023
	facility failed to pro	vide documentation of a fire			What corrective action(s) will	II	
	drill conducted on the	he second shift for 1 of 4			be accomplished for those		
	quarters and on the	third shift for 2 of 4 quarters.			residents found to have beer	1	
	This deficient practi	ice affects all residents, staff			affected by the deficient		
	and visitors.				practice:		
					Monthly Fire Drills will be		
	Findings include:				completed and documented pe		
					tentative schedule by Maintena		
		Direct Supply TELS: "Fire			Director or designee 1 x month	-	
		on with the Administrator, the			How other residents having t		
		or and the Field Maintenance			potential to be affected by the		
		ecord review from 9:20 a.m. to			same deficient practice will b		
	-	23, documentation of a fire drill			identified and what corrective	9	
		cond shift in the fourth			action will be taken:		
	•	ovember, December) 2022 was			All residents have potential to		
	not available for rev				affected by lack of fire drills be	_	
		fire drill conducted on the			completed. Corrective Action v		
		rd quarter (July, August,			to complete fire drill and educa	ate	
		ad in the first quarter (January,			the Maintenance Supervisor.		
	•	023 was also not available for			What measures will be put in	to	
		nterview at the time of record			place or what systemic		
	review, the Adminis				changes will be made to		
	-	visor stated the facility			ensure that the deficient		
	operates three shifts				practice does not recur:		
		fire drill conducted on the			Executive Director will audit		
	second and third shi	ifts in the aforementioned	1		monthly by the 25th of every		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET			
HICKOR'	Y CREEK AT FRA	NKLIN		KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O calendar quarters v These findings we	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION vas not available for review. re reviewed with the Maintenance Director and the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) month x12 months to ensure f drills are documented and completed per schedule. How the corrective action(s)	ire Entre
	Field Maintenance conference. 3.1-19(b)	Supervisor during the exit		will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place:	ut
	facility failed to co unexpected times u first shift for 3 of 4	review and interview, the onduct quarterly fire drills at under varying conditions on the quarters. This deficient ct all residents, staff and ity.		The Maintenance Director was educated in the use of TELS that assist with monitoring monthly drills on 6/19/23 by ED. The Executive Director will review TELS with the Maintenance Supervisor once a month to ensure fire drills occurred and	o v fire
	Based on review o Drills" documentar Maintenance Direc Supervisor during 1:00 p.m. on 06/07 conducted within t	f Direct Supply TELS: "Fire tion with the Administrator, the eter and the Field Maintenance record review from 9:20 a.m. to 1/23, first shift fire drills the most recent twelve month 2, 01/27/23 and on 04/11/23 were		documented appropriately. By what date the systemic changes will be completed: 06/20/23	
	conducted at, responsible 1:51 p.m. Based of review, the Admin Maintenance Super operates three shift aforementioned fire	ectively, 2:00 p.m., 1:15 p.m. and n interview at the time of record istrator and the Field rvisor stated the facility as per day and agreed the st shift fire drills were not peeted times under varying			
	Administrator, the	re reviewed with the Maintenance Director and the Supervisor during the exit			

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3.1-19(b)

Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155442	B. WI	NG		06/07/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL			ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, respectively. Additional testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, as less than or equal the LIM test switch activates both visual LIM circuits with a manual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the execords are maintassociated repairs containing date, results. 6.3.4 (NFPA 99) Based on record revinterview; the facility documentation of electricians.	oom or area tested, and iew, observation and	K 09	914	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		06/20/2023
	available for review NFPA 99, Health Care Edition, Section 6.3 listed as hospital-grand in locations who anesthesia shall be the exceeding 12 months.	in accordance with NFPA 99. are Facilities Code, 2012 .4.1.3 states receptacles not ade at patient bed locations ere deep sedation or general ested at intervals not is. NFPA 99, Health Care 2 Edition, Section 6.3.4.1.1			practice: Annual receptacle testing was completed on 6/14/23. How other residnets having t potential to be affected by the same deficient practice will b identified and what corrective action will be taken:	he e e	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
155442		B. WI	NG		06/07/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					MLEY STREET		
HICKOR'	Y CREEK AT FRAN	IKLIN		l	(LIN, IN 46131		
	Т		ı		, · · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			
		e receptacles testing shall be			All residents have the potentia	al to	
	•	ial installation, replacement or			be affected by the lack of an		
	_	vice. Section 6.3.3.2,			annual receptacle test. Correc		
		in Patient Care Rooms requires			Actions taken were to complete		
		ty of each receptacle shall be			the Annual Receptacle test ar	nd to	
	-	l inspection. The continuity of			educate the Maintenance		
		it in each electrical receptacle			Supervisor.		
		forrect polarity of the hot and			What measures will be put in	nto	
		in each electrical receptacle			place or what systemic		
		and retention force of the			changes will be made to		
		each electrical receptacle			ensure that the deficient		
		e receptacles) shall be not less			practice does not recur:		
		ounces). Section 6.3.4.2.1.2			Executive Director or designed		
		n, the record shall contain the			confirm that the receptacle tes	sting	
		reas tested, and an indication		was completed each year by			
		e met, or have failed to meet,			completing an audit.		
	_	quirements of this chapter.			How the corrective action(s)		
	This could affect al	l residents.			will be monitored to ensure t	the	
					deficient practice will not		
	Findings include:				recur, i.e., what quality		
					assurance program will be p	ut	
		view with the Administrator,			into place:		
	the Maintenance Di				The Maintenance Supervisor		
	_	visor from 9:20 a.m. to 1:00			educated on the receptacle te	sting	
	_	nnual electrical receptacle			procedure to complete the		
		ng documentation for the			receptacle testing annually an		
		month period was not			where to document in Tels by	FD	
		Based on interview at the			on 6/19/23. Tels audit will be		
		ew, the Field Maintenance			done monthly by ED/or design	nee.	
		electrical receptacle inspection			By what date the systemic		
	_	ntation within the most recent			changes will be completed:		
	_	d was not available for review.			6/20/23		
		ons with the Administrator,			Compliance Date = 6/20/23		
	the Maintenance Di						
	_	visor during a tour of the					
		.m. to 1:45 p.m. on 06/07/23,					
	_	g rooms have non-hospital					
		stalled in the rooms with some					
		oms having a mix of					
	hon-hospital grade and hospital grade receptacles		ı		1		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155442		155442	B. WING 06/07/2023			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					MLEY STREET		
HICKORY CREEK AT FRANKLIN			FRANKLIN, IN 46131				
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	installed in the roon	n.					
	These findings were						
		Maintenance Director and the					
		Supervisor during the exit					
	conference.						
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	_	s - Essential Electric Syste					
Bldg. 01	•	s - Essential Electric Syste s - Essential Electric					
Blug. 01	System Maintenar						
	_	<u> </u>					
	_	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	_	his capability for the life					
	-	branches. Maintenance					
	and testing of the generator and transfer						
	switches are performed in accordance with						
	NFPA 110.						
	Generator sets are inspected weekly,						
	exercised under load 30 minutes 12 times a						
	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours.						
	Scheduled test under load conditions include						
	a complete simula						
	· ·	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	-	rces (Type 3 EES) are in					
	• • •	IFPA 111. Main and feeder					
		e inspected annually, and a					
		-					
		dically exercising the					
	-	tablished according to					
	-	uirements. Written records					
		nd testing are maintained					
	and readily availar	ble. EES electrical panels					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 06/07/2023		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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)	(X5) COMPLETION DATE		
	and separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.1 1. Based on record facility failed to ensinspections for the was maintained for week period. NFPA generators shall be NFPA 110, Standar Power Systems. N Emergency Power including all appurtinspected weekly a 99, 6.4.4.2 requires performance, exercing generator to be registed for inspection by the jurisdiction. This corresidents, staff and Findings include: Based on review of "Emergency Gener no load)" document the Maintenance D Maintenance D Maintenance Superfrom 9:20 a.m. to 1 emergency generator 13 weeks of the period was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 week per 12/31/22 was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 13 weeks of the period was not avaitable emergency generator to the 14 week period was not avaita	(NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, the sure a written record of weekly facility's emergency generator 13 weeks of the most recent 52 A 99, 6.4.4.1.3 requires onsite maintained in accordance with rd for Emergency and Standby FPA 110, 8.4.1 requires an Supply System (EPSS) tenant components, shall be and exercised monthly. NFPA a written record of inspection, ising period, and repairs for the alarly maintained and available are authority having leficient practice could affect all	K 0918	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice: 4 hour load testing was comp by Maintenance Director on 6/20/23. Weekly and Monthly testing performed per schedul How other residents having potential to be affective by the same deficient practice will identified and what corrective action will be taken: All residents had the potential be affected by the generator of being tested properly. The Corrective Action taken was the load test and to educate the Maintenance Supervisor on generator tests and documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor educated on Generator Testing and documentation procedure weekly, monthly and every 36 month testing by ED on 6/19/2	n leted le. the he be re l to not or run he was ng e for s		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/07/2023			
NAME OF P	PROVIDER OR SUPPLIEF	· !		ADDRESS, CITY, STATE, ZIP COD			
HICKORY CREEK AT FRANKLIN			580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		tor and the Field Maintenance		How the corrective action(s)		
	-	ne facility has one LP gas fired		will be monitored to ensure	the		
		or and agreed weekly		deficient practice will not			
	-	ntation for the aforementioned		recur, i.e., what quality			
	13 week period was	s not available for review.		assurance program will be	put		
				into place:			
		e reviewed with the		Documentation will be revie			
		Maintenance Director and the		monthly by the Administrator			
		Supervisor during the exit		designee on the 28th of the r	nonth		
	conference.			x 12 months			
	2.1.10(1)			By what date the systemic			
	3.1-19(b)			changes will be completed: 6/20/23			
		review and interview, the		Compliance Date = 6/20/23			
	-	cument emergency generator					
	-	g for 2 months of the most					
	-	riod to meet the requirements					
		dard for Emergency and					
		stems, 2010 Edition, Chapter					
		2 states diesel generator sets					
		t least once monthly, for a					
		nutes, using one of the following					
	methods:						
		nintains the minimum exhaust					
		recommended by the					
	manufacturer						
		temperature conditions and at					
	-	cent of the EPS (Emergency					
	Power Supply) nam	-					
		es diesel-powered EPS					
		not meet the requirements of					
		ised monthly with the available					
		Power Supply System) load and					
		nnually with supplemental					
		in 50 percent of the EPS					
	-	ig for 30 continuous minutes					
		75 percent of the EPS					
	*	g for 1 continuous hour for a					
		f not less than 1.5 continuous					
1	hours. This deficient practice could affect all			1	ĺ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 06/07/2023				
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			580 LE	STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION visitors.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Findings include:							
	"Emergency Gener Load" documentati Maintenance Direc Supervisor during r 1:00 p.m. on 06/07, documentation for emergency generat November 2022 an available for review time of record review and the Field Maintenanthly load testin November 2022 an available for review These findings wer Administrator, the	The Direct Supply TELS ators Test Generator Under on with the Administrator, the tor and the Field Maintenance ecord review from 9:20 a.m. to //23, monthly load testing the facility's LP gas fired for for the two month period of d December 2022 was not //. Based on interview at the ew, the Maintenance Director tenance Supervisor agreed g documentation for d December 2022 was not //. e reviewed with the Maintenance Director and the Supervisor during the exit						
	3.1-19(b)							
	interview; the facili period emergency g emergency generate 99 and NFPA 110. Code, 2012 Edition 1 and Type 2 essen sources (EPSS) sha Class X, Level 1 ge NFPA 110, the Star Standby Powers Sy 8.4.9 states Level 1	review, observation and aty failed to document 36 month generator testing for 1 of 1 ors in accordance with NFPA NFPA 99, Health Care Facilities at Section 6.4.1.1.6.1 states Type tial electrical system power all be classified as Type 10, enerator sets per NFPA 110. Indard for Emergency and stems, 2010 Edition, Section EPSS shall be tested at least 66 months. Section 8.4.9.1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/07/2023					
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			580 LEI	STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE				
TAG	states Level 1 EPSS for the duration of i 4.2). Section 8.4.9. class is greater than to terminate the test Section 8.4.9.5 state test shall be specific 8.4.9.5.3. Section 8 EPS's, loading shall This deficient pract staff and visitors. Findings include: Based on record revelow the Maintenance Di Maintenance Di Maintenance Super p.m. on 06/07/23, the emergency generate four continuous hot fired emergency generator inspection maintenance docum 08/23/22 and 02/06 nameplate rating fo kW. Based on interreview, the Field M supplemental load thours within the mowas not available for observations with the Maintenance Direct Supervisor during a p.m. to 1:45 p.m. of LP gas fired emergency the building on the state of the state of the supplemental to	shall be tested continuously ts assigned class (See Section 2 states where the assigned 4 hours, it shall be permitted after 4 continuous hours. The set is the minimum load for this ed in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3 states for spark-ignited to the available EPSS load. The section of the facility's LP gas the string documentation for the facility's LP gas the string documentation for the facility's LP gas the string documentation for the facility's LP gas the string documentative the string documentation dated 02/21/22, 1/23 indicated the manufacturer's the generator was rated at 25 the string documentation for four the string documentation, the string documentation for four the string documentation, the string documentation for four the facility from 1:00 to 06/07/23, the facility has one ency generator located outside the north side of the property.	TAG	CROSS-REFERENCED TO THE APPROPR	IATE				
	These findings were Administrator, the I	e reviewed with the Maintenance Director and the							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155442	B. WING			06/07/2023	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	Field Maintenance	Supervisor during the exit					
	conference.						
	3.1-19(b)						

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