STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(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: 05/02/24 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Emergency Preparedness survey, Hickory Creek at Franklin was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 26. Quality Review completed on 05/03/24	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: 05/02/24 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Life Safety Code survey, Hickory Creek at Franklin was found not in compliance with	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Hickory Creek at Franklin respectfully requests a desk review of this Plan of Correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Spall	HFA	05/10/2024

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 26 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 05/03/24			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors installed in 18 of 18 resident sleeping rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be	K 0300	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All battery-operated smoke detectors were cleaned by the	05/08/2024

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	maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states 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, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Detectors: Test battery operated smoke detectors" with the Administrator and the Maintenance Director during record review from 9:05 a.m. to 12:35 p.m. on 05/02/24, resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility had been documenting battery operated smoke detectors in previous years but the facility replaced all resident sleeping room battery operated detectors with new ones at the end of 2022. The Maintenance Director stated the facility has not been documenting the cleaning of the battery operated smoke detectors since the replacement and agreed resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:35 p.m. to 1:25 p.m. on 05/02/24, all resident sleeping room smoke detectors are battery operated. Manufacturer's documentation affixed to the Kidde Model i9010 smoke detector		Maintenance Supervisor on 5/8/2024. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents can be negatively impacted when the battery-operated smoke detectors are not cleaned per manufacturer guidelines. Corrective action was to clean the battery-operated smoke detectors and to educate the Maintenance Supervisor. **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 Director was educated on monthly cleaning of the smoke detectors by the Executive Director. The Maintenance Director will verify the monthly battery-operated smoke detector cleaning is completed based on the preventative maintenance schedule. **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:** ="" p="">**Compliance Date: 5/11/24**	

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	installed on the ceiling in resident sleeping Room 14 stated "clean the detector annually". The manufacture date of June 8, 2022 was listed on the detector. The facility affixed a sticker to the detector stating the unit was installed on 12/08/22. Based on interview at the time of the observations, the Maintenance Director stated each resident sleeping room has the same type battery operated smoke detector installed in the room. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is			

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	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 18 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of resident sleeping Room 10. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:35 p.m. to 1:25 p.m. on 05/02/24, a trash can was placed on the floor up against the corridor door to Room 10 to prop the door in the fully open position. The door swung to close when the trash can was removed. Based on interview at the time of the observations, the Administrator and the Maintenance Director agreed the corridor door to resident Room 10 had	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The trash can that was impeding the path was removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents can be negatively impacted when doors leading to the corridor are impeded. Corrective action was to remove trash can, to educate the Maintenance Supervisor and Maintenance Supervisor will request to attend next resident	05/11/2024

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	an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		council meeting to provide resident education on propping doors open with items such as trash cans **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 Director was educated on the importance of monitoring pathway impediments by the Executive Director. The maintenance director or designee will audit corridor doors for impediments daily x 2weeks, weekly x4 weeks and monthly x 6 months. **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:** /p> ="" p=""> ="" p="">	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system			

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	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 12:35 p.m. to 1:25 p.m. on 05/02/24, a one inch in diameter hole was noted in the smoke barrier wall for a plastic flexible conduit which had fallen out of the hole in the smoke barrier wall above the suspended ceiling above the corridor door set by Room 13. The hole was not firestopped on the north side of the smoke barrier wall. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the smoke barrier wall above the corridor door set by Room 13 was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Penetration caused by conduit was repaired by Maintenance Supervisor on 5/2/24 using fire rated caulk. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents could be potentially affected by there being a hole in the smoke barrier wall. Corrective action taken was to repair the wall, do a whole house audit of smoke barriers and potential penetrations, and to audit the smoke barrier walls monthly to ensure that they are intact. The whole house audit was completed on 5/2/24. **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 was educated on smoke barrier construction and how to maintain the smoke barrier walls in our building on 5/8/24 by ED.	05/02/2024

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			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: Maintenance Supervisor will perform audit of smoke barrier walls now and every month x 12 months to ensure they are intact. This will be added to our facility Preventative Maintenance Log. **By what date the systemic changes will be completed: 5/2/24** **Compliance Date = 5/11/24**	