| CENTERS FO | R MEDICARE & MEDIC | CAID SERVICES | | | | OM | IB NO. 0938-039 |
|--|--|---|------|---------------------|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | | | JILDING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
| | PROVIDER OR SUPPLIE | | | 901 N | ADDRESS, CITY, STATE, ZIP COD 16TH STREET CASTLE, IN 47362 | • | |
| (X4) ID PREFIX TAG E 0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY 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) | TE | (X5) COMPLETION DATE |
| Bldg | conducted by the In accordance with 42 Survey Date: 04/1 Facility Number: 0 Provider Number: 100 At this Emergency Creek at New Cast with Emergency Production Medicare and Medicare and Medicare and Suppliers, 42 0 The facility has 36 the survey, the center of the survey of the | 1/23 000341 155459 0286550 Preparedness survey, Hickory le was found not in compliance reparedness Requirements for licaid Participating Providers CFR 483.73 certified beds. At the time of | E 00 | 000 | E000 Hickory Creek at New CastleSurvey IDNI9H21Surve Exit Date 04/11/2023Plan of Correction Due 05/13/2023Th Plan of Correction constitute the written allegation of compliance for the deficience cited. However, submission this Plan of Correction is not admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to m requirements established by state and federal law. Hickor Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 5/19/2023. We respectfully request paper compliance. | Creek at New arvey IDNI9H21Survey a 04/11/2023Plan of the open constitutes are allegation of the officiencies are allegation of the officiencies are allegation of the officiency and that a deficiency that one was cited at the Plan of the open constituted to meet the open constituted by a federal law. Hickory New Castle desires of Correction to be the facility's an of Compliance. | |
| E 0039 SS=C Bldg | 441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § | .18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[For ASCs at §416.54, CORFs at §485.68,

TITLE (X6) DATE

Cathy Young Executive Director 05/11/2023

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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY | |
|--|---|--|-------|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | <u></u> | COMPL | ETED |
| | | 155459 | B. W | ING | | 04/11/ | /2023 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | 1 | 6TH STREET | | |
| HICKOR' | Y CREEK AT NEW | CASTLE | | | ASTLE, IN 47362 | | |
| | - | | | | , | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCE | | DATE |
| | | ons" under §485.727, | | | | | |
| | - | 20, RHCs/FQHCs at RD Facilities at §494.62]: | | | | | |
| | 9491.12, and ESF | RD Facilities at §494.02]. | | | | | |
| | (2) Testing. The [facility] must conduct exercises to test the emergency plan | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | annually. The [facility] must do all of the following: | | | | | | |
| | lg. | | | | | | |
| | (i) Participate in a full-scale exercise that is | | | | | | |
| | community-based | every 2 years; or | | | | | |
| | (A) When a comr | nunity-based exercise is | | | | | |
| | not accessible, conduct a facility-based | | | | | | |
| | functional exercise | e every 2 years; or | | | | | |
| | . , , - | ility] experiences an actual | | | | | |
| | | ade emergency that requires | | | | | |
| | | mergency plan, the [facility] | | | | | |
| | • | gaging in its next required | | | | | |
| | 1 | or individual, facility-based | | | | | |
| | | e following the onset of the | | | | | |
| | actual event. | | | | | | |
| | 1 ' ' | ditional exercise at least | | | | | |
| | | posite the year the full-scale | | | | | |
| | | cise under paragraph (d)(2) | | | | | |
| | , , | s conducted, that may | | | | | |
| | | limited to the following: scale exercise that is | | | | | |
| | | or individual, facility-based | | | | | |
| | functional exercise | | | | | | |
| | (B) A mock disast | | | | | | |
| | 1 ' ' | ercise or workshop that is | | | | | |
| | . , | and includes a group | | | | | |
| | discussion using a | - · | | | | | |
| | | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an er | · | | | | | |
| | | acility's] response to and | | | | | |
| | | ntation of all drills, tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | Ī | | - 1 | | | | I |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
|--|---|--|--|---|---|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIEI | | | 901 N 1 | DDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OI | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE | (X5) COMPLETION DATE |
| | *[For Hospices at (2) Testing for hose the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emerge of the emergency exempt from engascale community-facility-based functional exercis of this section is of include, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an electric section is considered. | spices that provide care in a c. The hospice must a to test the emergency cally. The hospice must do a full-scale exercise that is every 2 years; or munity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the gency event. Additional exercise every 2 to eyear the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is a or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. | | | | | |
| | | hospice must conduct he emergency plan twice | | | | | |

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Event ID:

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Facility ID: 000341

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
|--|--|---|---------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 16TH STREET ASTLE, IN 47362 | |
| (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 |
| | (i) Participate in a that is community- (A) When a commaccessible, condufacility-based functional exercise emergency event. (ii) Conduct an activate may include, linguistic following: (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, cemergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emergency sements. | cunity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an cospice's response to and natation of all drills, tabletop tergency events and revise rgency plan, as needed. | | | |
| | (2) Testing. The [F conduct exercises plan twice per yea CAH] must do the | PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital, | | | |

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Event ID:

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Facility ID: 000341

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION | (X3) DATE SURV COMPLETED 04/11/2023 | • |
|--------------------------|--|---|--|--|---------------------------------------|--------------------------|
| | PROVIDER OR SUPPLIER | | 901 N 1 | ADDRESS, CITY, STATE, ZIP CO 16TH STREET ASTLE, IN 47362 | DD . | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE COMPROPRIATE | (X5) MPLETION DATE |
| | accessible, condu- facility-based funct (B) If the [PRTF, I- an actual natural of that requires activ- plan, the [facility] its next required for individual, facility following the onse (ii) Conduct accessed or and the limited to the follo (A) A second full- community-based facility-based function (B) A moderate (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or pre- to challenge an energy (iii) Analyze the and maintain documentation decensed (2) Testing. The Founduct exercises plan at least annuor organization must (i) Participate in a that is community (A) When a community (A) When a community (A) When a community (B) and the second community (A) When a community (B) when a community (C) when a c | nunity-based exercise is not act an annual individual, etional exercise; or Hospital, CAH] experiences or man-made emergency eation of the emergency is exempt from engaging in ull-scale community based ity-based functional exercise et of the emergency event. In an [additional] annual eat may include, but is not wing: In exercise that is a or individual, a etional exercise or workshop that for and includes a group an anarated, emergency scenario, and a etements, directed pared questions designed mergency plan. The [facility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the includes a group and the effacility's] response to the emergency plan, as and emergency events collity's] emergency plan, as and emergency plan, and emergency | | | | |

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Event ID:

NI9H21

Facility ID: 000341

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | | |
|--|---|--|-------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | | COMPLETED | |
| | | 155459 | B. WING | | 04/11/2023 | |
| NAME OF F | PROVIDER OR SUPPLIER | - } | | T ADDRESS, CITY, STATE, ZIP COD | - | |
| | | | | 16TH STREET | | |
| HICKOR | Y CREEK AT NEW | CASTLE | NEW | CASTLE, IN 47362 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE | RIATE | |
| TAG | i | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | | ctional exercise; or | | | | |
| | ' ' | xperiences an actual natural | | | | |
| | | ergency that requires | | | | |
| | activation of the emergency plan, the PACE is exempt from engaging in its next required | | | | | |
| | - | | | | | |
| | | nity based or individual, | | | | |
| | | tional exercise following the | | | | |
| | onset of the emer | | | | | |
| | , , | n additional exercise every | | | | |
| | | he year the full-scale or | | | | |
| | | e under paragraph (d)(2)(i) | | | | |
| | of this section is conducted that may include, but is not limited to the following: | | | | | |
| | | scale exercise that is | | | | |
| | , , | or individual, a facility | | | | |
| | based functional e | - | | | | |
| | (B) A mock disas | | | | | |
| | ' ' | ercise or workshop that is | | | | |
| | | and includes a group | | | | |
| | discussion, using | | | | | |
| | _ | emergency scenario, and a | | | | |
| | set of problem sta | | | | | |
| | - | pared questions designed | | | | |
| | to challenge an er | _ | | | | |
| | _ | PACE's response to and | | | | |
| | | ntation of all drills, tabletop | | | | |
| | | nergency events and revise | | | | |
| | | gency plan, as needed. | | | | |
| | | | | | | |
| | *[For LTC Facilitie | - , , - | | | | |
| | | ty] must conduct exercises | | | | |
| | _ | ency plan at least twice per | | | | |
| | 1 - | announced staff drills using | | | | |
| | | ocedures. The [LTC facility, | | | | |
| | ICF/IID] must do t | <u> </u> | | | | |
| | | an annual full-scale exercise | | | | |
| | that is community | | | | | |
| | ' ' | nunity-based exercise is not | | | | |
| | | ct an annual individual, | | | | |
| I | facility-based fund | ctional exercise | 1 | I | 1 | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155459 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION | COM | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
|---|--|---|---------------------|--|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIEF | | 901 N 1 | ADDRESS, CITY, STATE, ZIP CO 16TH STREET ASTLE, IN 47362 |)D | _ |
| (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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | actual natural or requires activation LTC facility is exe required a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem stamessages, or pre to challenge an ei (iii) Analyze the [i response to and rall drills, tabletop events, and revise emergency plan, at (2) Testing. The life exercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID enatural or man-material activation of the community of the incommunity of th | ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | ľ í | UILDING | INSTRUCTION | (X3) DATE COMPL 04/11/ | ETED |
|---------------|--|--|-----|---|--|------------------------------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD 6TH STREET | | |
| HICKOR | Y CREEK AT NEW | CASTLE | | | ASTLE, IN 47362 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION PRIFTY (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION DATE |
| 1710 | | gaging in its next required | | 1110 | | | DITTE |
| | | nity-based or individual, | | | | | |
| | facility-based functional exercise following the | | | | | | |
| | onset of the emer | | | | | | |
| | , , , | ditional annual exercise | | | | | |
| | _ | but is not limited to the | | | | | |
| | following: | scale exercise that is | | | | | |
| | community-based | | | | | | |
| | I | ctional exercise; or | | | | | |
| | (B) A mock disast | er drill; or | | | | | |
| | , , | ercise or workshop that is | | | | | |
| | led by a facilitator and includes a group | | | | | | |
| | discussion, using a narrated, | | | | | | |
| | • | emergency scenario, and a | | | | | |
| | set of problem sta | pared questions designed | | | | | |
| | to challenge an er | | | | | | |
| | _ | CF/IID's response to and | | | | | |
| | | ntation of all drills, tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | the ICF/IID's eme | rgency plan, as needed. | | | | | |
| | *[For HHAs at §48 | - | | | | | |
| | | e HHA must conduct | | | | | |
| | | he emergency plan at | | | | | |
| | l following: | e HHA must do the | | | | | |
| | · · · · · · · · · · · · · · · · · · · | full-scale exercise that is | | | | | |
| | community-based | | | | | | |
| | | ommunity-based exercise | | | | | |
| | is not accessible, | conduct an annual | | | | | |
| | | based functional exercise | | | | | |
| | every 2 years; or. | | | | | | |
| | | A experiences an actual | | | | | |
| | | ade emergency that requires | | | | | |
| | | mergency plan, the HHA is aging in its next required | | | | | |
| | | nity-based or individual, | | | | | |
| | | ctional exercise following the | | | | | |
| | , ====== | | | | | | |

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Event ID:

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Facility ID: 000341

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| | INT OF DEFICIENCIES N OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | | ILDING | NSTRUCTION | (X3) DATE COMPL 04/11/ | ETED |
|--------------------------|--|--|---|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIED RY CREEK AT NEW | | | 901 N 1 | DDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | onset of the emer (ii) Conduct an act years, opposite the functional exercise of this section is continued, but is not (A) A second community-based facility-based functionally-based facility-based facility-based functionally-relevant set of problem state messages, or preto challenge an el (iii) Analyze the Hamaintain document exercises, and enthe HHA's emergent to PO must do the (i) Conduct a papor workshop at lease exercise is led by group discussion, relevant emergency planactual natural or requires activation OPO is exempt for required testing enof the emergency of the emerg | gency event. Iditional exercise every 2 Ide year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is a or an individual, ctional exercise; or isaster drill; or o exercise or workshop that for and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or is designed to challenge an iff the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset | | | | | |

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Event ID:

NI9H21

Facility ID: 000341

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| | ENT OF DEFICIENCIES N OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | (X2) MUL A. BUIL B. WING | DING | NSTRUCTION | (X3) DATE COMPL 04/11 / | ETED |
|--------------------------|--|--|---|--------------------|--|--------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIED | | STREET ADDRESS, CITY, STATE, ZIP COD 901 N 16TH STREET NEW CASTLE, IN 47362 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PF | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | exercises, and en the [RNHCl's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCl must do to the conduct apaper at least annually. Group discussion narrated, clinically scenario, and a sedirected message designed to challed (ii) Analyze the RI maintain document exercises, and enthe RNHCl's eme Based on record refailed to conduct explan at least twice put must do all of the foil Participate in an is community-base a. When a community accessible, conduct facility-based funct b. If the ICF/IID fanatural or man-mace activation of the enfacility is exempt foull-scale community facility-based full-scale community accessible, conduct an addinclude, but is not be a second full-scale conduct an addinclude, but is not be a second full-scale conduct an addinclude, but is not be a second full-scale. | e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a v-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. view and interview, the facility tercises to test the emergency er year. The ICF/IID facility following: annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. cility experiences an actual de emergency plan, the ICF/IID from engaging its next required ty-based or individual, cale functional exercise for 1 onset of the actual event. itional exercise that may imited to the following: | E 003 | 9 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were effected. Facility held full scale elopement drill exercis on 5/5/2023. 2. 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 have the potential to be affected. No residents were affected by alleged deficient practice. Executive Director has scheduled Emergency Preparedness drills for June | e nt d | 05/19/2023 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED | | | ED | | |
|---|--|---|------|--------------|---|--|-------------------|
| | | 155459 | B. W | 'ING | | 04/11/20 | 23 |
| | PROVIDER OR SUPPLIER | | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE C | (X5) OMPLETION |
| TAG | functional exercise. b. A mock disaster of c. A tabletop exercise facilitator that incluse a facilitator, using a emergency scenario statements, directed questions designed to plan. (iii) Analyze the ICI maintain documentate exercises, and emergician facility's en accordance with 42 deficient practice of Findings include: Based on record revexecutive Directors of dy/11/23 between 9 facility did document exercise of choice with two required annual provide documentate a required full-scale community-based of the past year. The Fithat a large scale exemple of the process of the process of the process of the past year. The Fithat a large scale exemple of the process of the pr | se or workshop that is led by a des a group discussion led by narrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency F/IID facility's response to and ation of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This build affect all occupants. The wand interview with the and Maintenance Director on :50 a.m. and 11:40 a.m., the not participation in a tabletop which counted as one of the lexercises but could not ion of an actual emergency or exercise that is reduced in the individual, facility-based for ED stated that it did not appear ercise was conducted. knowledged by the or at the time of discovery and ive Director and Maintenance of exit. | | TAG | and December yearly.3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Executive Director held an elopement drill exercise on 5/5/2023. Executive Director scheduled drills for June an December yearly.4. How to corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be p into place. Executive Director has schedule tabletop drill for June and Full scale drill for December. Executive Direct will report on any issues four during monthly QAPI meetin and follow QAPI recommendations.5. Date completion 5/19/2023 | has d he ut or or nd | DATE |
| SS=F Bldg | Hospital CAH and §482.15(e) Condit (e) Emergency an | LTC Emergency Power ion for Participation: d standby power systems. implement emergency and | | | | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
|--|---|---|--|---------------------|---|---------------------------------------|----------------------------|
| | DF PROVIDER OR SUPPLIED DRY CREEK AT NEW | | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY 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) | TE | (X5) COMPLETION DATE |
| | emergency plan s this section and ir | set forth in paragraphs (b)(1) | | | | | |
| | The [LTC facility a implement emerg systems based or | nd standby power systems. and the CAH] must ency and standby power in the emergency plan set in (a) of this section. | | | | | |
| | Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an | 83.73(e)(1), §485.625(e)(1) rator location. The elocated in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA nd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new or when an existing ng is renovated. | | | | | |
| | Emergency generation The [hospital, CA implement the eminspection, testing requirements four | 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] nd in the Health Care IFPA 110, and Life Safety | | | | | |
| | Emergency generand LTC facilities source to power e | 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | A. B | A. BUILDING COM | | | TE SURVEY MPLETED 11/2023 | |
|--|--|--|-----------------|--------------|---|---------------------------------|--------------------|
| | PROVIDER OR SUPPLIER | | | 901 N 10 | DDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | • | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR | IATE | (X5) COMPLETION |
| TAG | power systems op | R LSC IDENTIFYING INFORMATION Derational during the | | TAG | DEFICIENCY) | | DATE |
| | *[For hospitals at §483.73(g), and OThe standards incompleted this section are appreference by the DEF ederal Register if 552(a) and 1 CFR the material from You may inspect a Information Resource Boulevard, Baltim Archives and Rec (NARA). For information Resource the Complete in the material at NA go to: http://www.archive.of_federal_regular in the Fannounce the charance the charance the charance the charance the charance the charance in the Fannounce in the Fannounce in the Fannounce the charance in the Fannounce the charance in the Fannounce the charance in the Fannounce in the F | s it evacuates. §482.15(h), LTC at EAHs §485.625(g):] corporated by reference in corporated for incorporation by Director of the Office of the n accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It copy at the CMS Ince Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or Pes.gov/federal_register/code ations/ibr_locations.html. It is edition of the Code are eference, CMS will publish a federal Register to nges. Protection Association, 1 k, D, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to | | | | | |
| | 2014. | | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155459 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/11/2023 | |
|---|--|--|--|---------------------|--|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 16TH STREET ASTLE, IN 47362 | | |
| (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 APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NI 22, 2013. (xii) NFPA 110, S Standby Power S including TIAs to 2009. Based on record revialed to implement inspection, testing, found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all occupants Findings include: During record revialed Au Maintenance D 9:50 a.m. and 11:40 documentation for generator, however documentation of a was confirmed by t stated he was unaw | FPA 101, issued August FPA 101, issued October PA 101, issued October FPA 101, issued October FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, Fiew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA Ty Code in accordance with 42 Fhis deficient practice could This deficient practice could This deficient provided The emergency LP This description of the emergency LP The could not provide three year 4 hour test. This he Maintenance Director, who have of the requirement. The Maintenance Director and Maintenance dive Director and Maintenance | E 00 |)41 | 1. What corrective action will be accomplished for tho residents found to have been affected by the deficient practice. Maintenance Directompleted a 3 year 4 hour generator test on 5/10/2023 2. How other residents having the potential to be affected by the same deficien practice will be identified and what corrective action will be taken? No residents were affected. 3. What measures will be put into place and what systemic changes will be matto ensure that the deficient practice does not recur. Maintenance Director completed the 4 hour generator test on 5/10/2023. hour load test has been adde to Life Safety check off book. | nt de | 05/19/2023 |

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

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155459 | A. BUILDING B. WING | | COMPLETED 04/11/2023 |
|--------------------------|---|---|---------------------|---|----------------------|
| | ROVIDER OR SUPPLIER | | | | |
| (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 |
| | | | | 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what qualitassurance program will be pinto place? Maintenance Director/designee will report on 4 hour load test during monthly QAPI meeting notin that this needs to be comple every three years. 5. Date of completion 5/19/2023 | ty out g |
| K 0000 Bldg. 01 | Licensure Survey w Department of Healt 483.90(a). Survey Date: 04/11 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C New Castle was fou Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protec Life Safety Code (L | 00341 155459 286550 Code survey, Hickory Creek at nd not in compliance with | K 0000 | E000 Hickory Creek at New CastleSurvey IDNI9H21Surve Exit Date 04/11/2023Plan of Correction Due 05/13/2023Tl Plan of Correction constitute the written allegation of compliance for the deficience cited. However, submission this Plan of Correction is not admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to m requirements established by state and federal law. Hickor Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. | nis es es of t an |

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

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | ľ í | JILDING | nstruction 01 | (X3) DATE : COMPL 04/11 / | ETED |
|----------------------------|--|---|-----|---------------------|---|--|----------------------------|
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD 6TH STREET | | |
| HICKOR' | Y CREEK AT NEW | CASTLE | | NEW C | ASTLE, IN 47362 | | |
| (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) | ΤE | (X5) COMPLETION DATE |
| | Type II (222) constr The facility has a fir detection in the corr corridors, and batter in all resident sleepi capacity of 36 and h of this visit. | ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the ry-operated smoke detectors ing rooms. The facility has a had a census of 24 at the time | | | Compliance is effective 5/19/2023. We respectfully request paper compliance. | | |
| | access were sprinkle facility services were | residents have customary ed and all areas providing re sprinkled except for one or storage which was not impleted on 04/17/23 | | | | | |
| K 0363 SS=E Bldg. 01 | than required enclexits, or hazardour of smoke and are solid-bonded core capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or compute the covering is not except the covering is not except the covering with a context of the covering of the coverin | rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain | | | | | |

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| | VT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | (X2) MULTIPLE C A. BUILDING B. WING | construction 01 | (X3) DATE SURVEY COMPLETED 04/11/2023 |
|--------------------------|--|--|-------------------------------------|---|--|
| | PROVIDER OR SUPPLIEF | | 901 N | ADDRESS, CITY, STATE, ZIP COD 16TH STREET CASTLE, IN 47362 | |
| (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 APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | closing of the doo release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 2 or resist the passage of practice could affect Findings include: Based on observation with the Maintenan between 11:45 a.m. corridor doors had a doorknobs which per the door: A) A 1/4-inch gap to doorknob in the "Brown of the gap to the door." B) A 1/4-inch gap to the doorknob in the "Brown of the gap to the door." | fire window assemblies are a sprinklered compartments octions in area or fire is or frames in window. Parts 403, 418, 460, 482, and a single of the facility of over 20 corridor doors would from the facility of the facilit | K 0363 | 1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice? Maintenance Direct sealed the noted penetration with fire caulk immediately for 2 of 2 doors. 2. How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action will be taken? 4 residents had potential to be affected. No residents were affected. 3. What measures will be put into place and what systemic changes will be me | ose n ctor ns for ent d dee |

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

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155459 | A. BUILDING B. WING | 01 | COMPLETED 04/11/2023 |
|----------------------------|--|--|---------------------|---|----------------------|
| | PROVIDER OR SUPPLIER Y CREEK AT NEW | | 901 N | ADDRESS, CITY, STATE, ZIP COD 16TH STREET ASTLE, IN 47362 | |
| (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 |
| | | or at the time of discovery and ive Director and Maintenance | | to ensure that the deficient practice does not recur? Maintenance Director will complete weekly round checking all doors for noted penetrations. Any issues fo will be addressed immediate 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be pinto place? Maintenance Director/designee will complete Annual Life Safety QAPI tool weekly times 4 weeks and monthly times 6 weeks. If 100% compliance not achieved an action plan will be developed. 5. Date of completion 5/19/2023 | ty ut |
| K 0918 SS=F Bldg. 01 | Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterior monthly test, a pro annually confirm the safety and critical and testing of the | a - Essential Electric Syste b - Essential Electric lice and Testing other alternate power lated equipment is capable lice within 10 seconds. If the line is not met during the licess shall be provided to line capability for the life libranches. Maintenance ligenerator and transfer light system light sys | | | |

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| | T OF HEALTH AND HU R MEDICARE & MEDIC | | | | OMB NO. 0938-039 | |
|----------|--|---|-----------------|--|------------------|----|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | LE CONSTRUCTION | (X3) DATE SURVEY | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDIN | G <u>01</u> | COMPLETED | |
| | | 155459 | B. WING | | 04/11/2023 | |
| NAME OF | PROVIDER OR SUPPLIEI | ? | STR | EET ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | N 16TH STREET | | |
| HICKOR | Y CREEK AT NEW | CASTLE | NE | W CASTLE, IN 47362 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFI | CROSS-REFERENCED TO THE APPROPE | BE COMPLETIO | N |
| TAG | † | R LSC IDENTIFYING INFORMATION | TAC | | DATE | |
| | NFPA 110. | | | | | |
| | | e inspected weekly, | | | | |
| | | oad 30 minutes 12 times a | | | | |
| | | intervals, and exercised | | | | |
| | - | onths for 4 continuous hours. | | | | |
| | | nder load conditions include | | | | |
| | 1 | ated cold start and | | | | |
| | | ual transfer of all EES | | | | |
| | | nducted by competent | | | | |
| | 1 - | enance and testing of stored | | | | |
| | | ırces (Type 3 EES) are in | | | | |
| | | NFPA 111. Main and feeder | | | | |
| | | re inspected annually, and a | | | | |
| | | dically exercising the | | | | |
| | | tablished according to | | | | |
| | | uirements. Written records | | | | |
| | | nd testing are maintained | | | | |
| | - | ble. EES electrical panels | | | | |
| | | arked, readily identifiable, | | | | |
| | • | n normal power circuits. | | | | |
| | I | ssibility of damage of the | | | | |
| | | r source is a design | | | | |
| | consideration for | | | | | |
| | | (NFPA 99), NFPA 110, | | | | |
| | NFPA 111, 700.1 | , | 17.0010 | | 05/10/20/ | 22 |
| | | view and interview, the facility | K 0918 | 1. What corrective actio | 00/19/202 | 23 |
| | | of 1 Emergency Power accordance with NFPA 110, | | will be accomplished for the | I | |
| | , , | | | residents found to have be | en | |
| | | gency and Standby Power 4.9, as required by NFPA 99 | | affected by the deficient | | |
| | 1 - | ies Code, Section 6.4.1.1.6.1. | | practice? Maintenance Director completed a 3 yea | ar 4 | |
| | | 8.4.9 states that all Level 1 | | hour generator test on | 11 - | |
| | | Systems shall be tested at least | | 5/10/2023 | | |
| | | hree years. Where the | | 2. How other residents | | |
| | | eater than 4 hours, it shall be | | having the potential to be | | |
| | | ate the test after 4 hours. | | affected by the same defici | ient | |
| | 1 - | 5.4.1.1.6.1 states that Type 1 and | | practice will be identified a | | |
| | 1 - 11111 / 50001011 (| | 1 | practice will be identified a | | |

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Type 2 essential electrical system power sources

shall be classified at Type 10, Class X, Level 1

generator sets. This deficient practice could

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affected.

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what corrective action will be

taken? No residents were

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | (X2) MULTI A. BUILDI B. WING | | STRUCTION 01 | (X3) DATE COMPI 04/11 | |
|----------------------------|--|--|------------------------------------|---------|--|---|----------------------|
| | PROVIDER OR SUPPLIER Y CREEK AT NEW | | 90 | 01 N 16 | DRESS, CITY, STATE, ZIP COD TH STREET STLE, IN 47362 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR affect all building of Findings include: During record revie and Maintenance D 9:50 a.m. and 11:40 documentation for t generator, however documentation of a was confirmed by the stated he was unaway. This finding was ac Maintenance Direct | w with the Executive Director irector on 04/11/23 between a.m., the facility provided esting of the emergency LP could not provide three year 4 hour test. This me Maintenance Director, who are of the requirement. knowledged by the or at the time of discovery and ive Director and Maintenance | TA | SFIX AG | PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CROSS-REFERENCED WILL BE APPROVIDED TO THE APPROVIDER CROSS-REFERENCED WILL BE APPROVIDED TO THE APPROVIDE CROSS-REFERENCED WILL BE APPROVIDED TO THE APPROVIDE CROSS-REFERENCED TO THE APPROVIDE | be made at 3. 4 dded book. co ice ality e put ort | (X5) COMPLETION DATE |
| K 0927 SS=E Bldg. 01 | Gas Equipment - Transfilling of oxyganother is in accor Transfilling of High Oxygen Used for lany gas from one prohibited in patie to liquid oxygen ox | Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155459 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/11/2023 | | |
|--|--------------------------|--|--|-----|---------------------|--|-------------------|----------------------------|
| | | ROVIDER OR SUPPLIER | | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 16TH STREET ASTLE, IN 47362 | | |
| | (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY 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) | TE | (X5) COMPLETION DATE |
| | | under 11.5.2.3.1 (liquid oxygen containers under sconditions under 11.5.2.2 (NFPA 99) Based on records refailed to ensure staft trans-filling proceduroom where oxyger NFPA 99 2012 edit trans-filling the contrained in the transdeficient practice of cone smoke compart. Based on record reverse Executive Director 04/11/23 between 9 documentation was indicate staff that transformer trained but no docus show that the require accomplished. Based observation, the ED are trained during of provide the training. This finding was accomparted to the service of the s | NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) Eview and interview, the facility of was properly trained on the transferring takes place. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. In the individual trainer(s) has been properly filling procedures. This begin trainer for the individual trainer(s) has been properly filling procedures. This begin trainer for trainer | K 0 | 927 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nursing staff has been educated on oxygen trans-filling on 5-5-23 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be trained upon hire and annually. Up to 10 residents have potential to be affected No residents were affected No residents were affected 3. What measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not recur? DON/Designee will check off nursing staff upon hire for oxygen trans-filling and annually. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be p into place? DON/Designee w report on new hire training | nt d d e | 05/19/2023 |

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | |

| | T OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155459 | r í | ILDING | onstruction 01 | (X3) DATE COMPL 04/11 / | ETED |
|--------------------------|-------------------------------------|--|-----|---------------------|--|--------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER Y CREEK AT NEW | | | 901 N 1 | ADDRESS, CITY, STATE, ZIP COD 6TH STREET ASTLE, IN 47362 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | 3 | (X5) COMPLETION DATE |
| | | | | | during monthly QAPI meet and follow QAPI recommendations. | ngs | |
| | | | | | 5. Date of completion 5/19/2023 | | |
| | | | | | | | |

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