STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING -- B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION AND HEALTHCARE	210 STATE HWY 43 SPENCER, IN 47460

(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: 01/09/23 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 At this Emergency Preparedness survey, McCormick's Creek Rehabilitation and Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 87 certified beds. At the time of the survey, the census was 72. Quality Review completed on 01/11/23	E 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
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: 01/09/23 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 At this Life Safety Code survey, McCormick's	K 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sara mitchell	administrator	01/20/2023

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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	Creek Rehabilitation and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and has smoke detectors hardwired to fire alarm system in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 72 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/11/23		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, interview and observation, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with	K 0345	K346: Fire Alarm System - Testing and Maintenance	01/20/2023

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	LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 01/09/23 from 9:55 a.m. to 12:55 p.m., the last fire alarm system inspection dated 12/07/22 by the facility's fire alarm vendor indicated a quarterly inspection frequency. The report indicated "Deficiency Found FACP batteries fail." Based on interview at the time of record review, the Director of Maintenance confirmed the issue and stated he sent an email the morning of 01/09/23 to follow up about having the batteries replaced. During a tour of the facility on 01/09/23 at 1:50 p.m. with the Director of Maintenance, "Aug 2020" was observed wrote in black marker on the two batteries located in the Fire Alarm Control Panel. At of the time of the survey, the facility was unable to show documentation that repairs have been made. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. No one was identified to have been affected. 3) Measures put into place/ System changes: Facility had Koorsens come out and replace batteries. (attachment A) 4)How the corrective actions will be monitored:	

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			The Maintenance Director/designee will add the batteries to his fire alarm system inspection. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure complete documentation of all fire and smoke dampers in the facility was provided in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating, and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The	K 0521	**K521-HVAC-Heating Device** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? no residents were affected by it.** **2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: no residents were affected by it. Inspection was obtained from Spartan (attachment b)** **3.What measures will be put into place or what systemic changes will be made to ensure that the same deficient**	01/20/2023

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	damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance on 01/09/23 from 9:55 a.m. to 12:50 p.m., an invoice dated 10/29/22 for fire / smoke damper inspection was provided for review. Documentation showing the results of the inspection with location of the fire dampers was not available for review at the time of the survey. The last fire damper testing documentation was dated 09/21/17. Based on interview at the time of record review, the Director of Maintenance confirmed inspection documentation was not available for review and stated he was having difficulty obtaining the fire damper inspection report from the vendor who performed the service for the facility. This finding was reviewed with the Executive Director, Director of Maintenance at the exit conference. 3.1-19(b)		**practice does not recur? Will have company leave inspection sheet when they leave for the day. They left the bill but no inspection sheet.** **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:** Audits will be conducted by Mtc annually and reviewed with Administrator. Results will be brought to QA for review and assessment. **5. By what date the systemic changes will be completed?** 1/20/23	