STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155424	A. BUILDING -- B. WING	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT COLUMBUS	5480 E 25TH STREET COLUMBUS, IN 47203

(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: 09/03/2024 Facility Number: 000284 Provider Number: 155424 AIM Number: 100290690 At this Emergency Preparedness survey, Hickory Creek at Columbus was found not 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 30. Quality Review completed on 09/06/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this plan of correction does not constitute any conclusion set forth in the statement of deficiencies of any violations of regulations. The facility respectfully requests a desk review.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This	E 0006	E006 **What corrective action(s) will be implemented for those residents found to have been affected by deficient practice?** -The hazard vulnerability assessment was completed by ED on 9/16/2024 **How other residents having**	09/27/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mikayla Schneider	Executive Director	09/20/2024

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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	deficient practice could affect all occupants. Findings include: During record review on 09/03/2024 between 11:00 AM and 1:15 PM with the Maintenance Supervisor and Field Maintenance Supervisor, no documentation for a facility-based and community-based risk assessment was available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated he was unable to locate the risk assessment. This finding was reviewed with the Maintenance Supervisor, Field Maintenance Supervisor, and Director of Nursing at the exit conference.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** -ED was in serviced on the importance of the hazard vulnerability assessment by the RVPO on 9/16/2024 **What measures will be put into place to and what systemic changes will be made to ensure that the deficient practice will not recur?** -ED will review this every month in our safety meeting. **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 for prevention?** We will monitor this in QAPI Bi-monthly.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual,	E 0039	E039 **What corrective action(s) will be implemented for those residents found to have been affected by deficient practice?** - The emergency preparedness plan was reviewed and updated with an after-action event for water outage on 1/22/2024 but was not readily available due to ED being	09/27/2024

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	facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: During record review on 09/03/2024 between 11:00 AM and 1:15 PM with the Field Maintenance Supervisor and Maintenance Supervisor, the facility had not documented an additional full-scale drill, mock disaster drill, or table-top exercise or workshop to test the emergency plan as required. Based on interview at the time of record review, the Maintenance Supervisor agreed documentation of at least two exercises for testing emergency preparedness policies and procedures within the most recent twelve month period was		out. Maintenance in-serviced on importance of having second drill in the EOP binder. Updated tornado drill on 9/18/2024. This was added to the binder. **How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** -Maintenance supervisor is newer to his role and has been in-serviced on the EOP Binder. All new employees are trained and tested on emergency preparedness upon hire, annually as well. **What measures will be put into place too and what systemic changes will be made to ensure that the deficient practice will not recur?** - all department heads will be in-serviced on the location and importance of the Emergency preparedness plan. **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 for prevention?** -Emergency preparedness Plan will be reviewed and updated each month in QAPI Monthly for 3 months and then quarterly for 6 months until there is satisfactory compliance with all staff being fully aware with return demonstration through Q & A.	

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	not available for review. These findings were reviewed with the Field Maintenance Supervisor, Maintenance Supervisor, and the Director of Nursing during the exit conference.			
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: 09/03/2024 Facility Number: 000284 Provider Number: 155424 AIM Number: 100290690 At this Life Safety Code survey, Hickory Creek at Columbus 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 Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detecors installed in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 30 at the time of this visit. All areas where the residents have customary	K 0000	The creation and submission of this plan of correction does not constitute any conclusion set forth in the statement of deficiencies of any violations of regulations. The facility respectfully requests a desk review.	

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	access were sprinklered and all areas providing facility services were sprinklered. The facility has one detached storage shed which was not sprinklered. Quality Review completed on 09/06/24			
K 0200 SS=F Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 2 of 2 egress exterior gates near the smoking areas, swung in the direction of egress travel. LSC 7.2.1.4.2 states door leaves required to be of the side-hinged or pivoted-swinging type shall swing in the direction of egress travel. This deficient practice could affect staff, residents, and visitors while exiting this area through the gate. Findings include: Based on observation on 09/03/2024 between 1:15 PM and 2:00 PM with the Maintenance Supervisor and Field Maintenance Supervisor, the 2 smoking area egress gates swung into the fenced in area instead of swinging in the direction of egress to the sidewalk outside the gate. Based on interview at the time of observation, the Maintenance Supervisor and Field Maintenance Supervisor agreed the gates swung into the fenced in area This finding was reviewed with the Maintenance Supervisor, Field Maintenance Supervisor, and Director of Nursing at the exit conference. 3.1-19(b)	K 0200	K200 **-What correction action(s) will be accomplished for those residents found to have been affected by the deficient practice:** -gates will be switched to swing outward. **-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**: -Ensuring that maintenance and ED check the gates when any contraction is done. **-What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** - We will ensure that the gates always swing outward. **- 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;?**	09/27/2024

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			- The gates will be reviewed in the safety meeting monthly.	