STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155436	A. BUILDING -- B. WING	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT WINAMAC	515 E 13TH ST WINAMAC, IN 46996

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/01/23 Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550 At this Emergency Preparedness survey, Hickory Creek at Winamac 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 33. Quality Review completed on 11/03/23	E 0000	**Hickory Creek Winamac respectively requests a desk review for paper compliance. All in-service and monitoring forms are attached for review. Thank you.** **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.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/01/23 Facility Number: 000414 Provider Number: 155436 AIM Number: 100288550 At this Life Safety Code survey, Hickory Creek at Winamac was found not in compliance with	K 0000	**Hickory Creek Winamac respectively requests a desk review for paper compliance. All in-service and monitoring forms are attached for review. Thank you.** **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.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen Folkers	Executive Director	11/17/2023

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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	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 hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms were equipped with battery operated smoke detectors. The facility has the capacity for 36 and had a census of 33 at the time of this survey. All areas within the facility where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached buildings, one used for oxygen storage, and the others were a maintenance office and for miscellaneous equipment and storage. Quality Review completed on 11/03/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors needing to exit the facility in an emergency. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 11/01/23 from 1:10 p.m. to 2:25 p.m., the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code but the code was posted and read as "4 corners backwards - then *" at the following locations: A. the main entrance / exit to the facility on the South side of the building. B. the East exit between resident rooms #3 and #4. C. the North exit between resident rooms #10 and #11. Based on an interview at the time of each	K 0222	**K 222 Egress Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Administrator completed education with Maintenance Director for K222 Egress Doors regulation. (Attachment #1). **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:** Door codes were changed per K 222 regulation, for the identified egress doors, main entrance on South side of building, East exit between resident rooms # 3 and # 4, and North exit between resident rooms #10 and # 11. (Attachments # 2, # 3, and # 4). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** There were no other egress doors effected by the alleged deficient	11/19/2023

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	observation, the Maintenance Director acknowledged that the door code was posted but may not be common knowledge for all visitors coming into the facility adding that he would change the code to something more common knowledge. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		practice. The Maintenance Director will ensure the egress door code follows K 222 regulation. **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:** The Executive Director will monitor the three identified egress doors monthly to ensure compliance with K 222 Egress Doors and sign off on the monitor form. (Attachment # 5). Results of monitoring forms will be reviewed in monthly QAPI. **By what date the systemic changes will be completed: 11/19/2023.**	
K 0712 SS=E Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times 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 drills 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 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be	K 0712	**What corrective action(s) will be accomplished for those residents found to have been**	11/19/2023

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	conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Direct Supply - TELS Conduct a Fire Drill" documentation with the Maintenance Director on 11/01/23 at 10:41 a.m., there was no documentation for a second shift fire drill being conducted in the first quarter (January, February, and March) of 2023. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned fire drill as not being available for review adding that he had not taken over his position as the Maintenance Director until after the date of the missing fore drill and added that he would continue to keep them current and up to date in the future. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b) 3.1-51(c)		**affected by the deficient practice:** Review of all fire drills from January 1, 2023, to present were reviewed during the survey process and all fire drills were following K 712 regulation. **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 fire drills for November 2023 have been completed per K 712 regulation. **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 monthly fire drill schedule (Attachment # 6). The fire drill requirements are scheduled in TELS, and the Maintenance Director will receive notification for completion. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program was put into place:** The Executive Director will verify fire drills are held on each shift per K 712 regulation by reviewing the TELS preventative maintenance checks notifications and sign off that drills were completed. (Attachment # 7). Results of	

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			monitoring will be reviewed in monthly QAPI. **By what date the systemic changes will be completed: 11-19-2023.**	