STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2024				
	PROVIDER OR SUPPLIED Y CREEK AT ROC		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000 Bldg		paredness Survey was ndiana Department of Health in 2 CFR 483.73.	E 00	000				
	Survey Date: 07/01	./24						
	Facility Number: 0 Provider Number: AIM Number: 100	155430						
	Creek at Rochester with Emergency Pr Medicare and Med- and Suppliers, 42 C	Preparedness survey, Hickory was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.73. The facility has a had a census of 29 at the time						
	The requirement at MET as evidenced	42 CFR, Subpart 483.73 is NOT by:						
	Quality Review con	nducted on 07/02/24						
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2) (1)-(2), 485.625(a 485.727(a)(1)-(2) 486.360(a)(1)-(2) (1)-(2) Plan Based on Al §403.748(a)(1)-(2 §418.113(a)(1)-(2 §460.84(a)(1)-(2) §483.73(a)(1)-(2) §484.102(a)(1)-(2)	416.54(a)(1)-(2), 418.113(a) a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) a)(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) I Hazards Risk Assessment b), §416.54(a)(1)-(2), c), §441.184(a)(1)-(2), c), §483.475(a)(1)-(2), c), §485.68(a)(1)-(2), c), §485.727(a)(1)-(2), c), §485.727(a)(1)-(2),						

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

TITLE (X6) DATE

Tommi Pruitt Executive Director 08/06/2024

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UBLO21 Facility ID: 000326 If continuation sheet Page 1 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		A. BUILDING B. WING		COM	TE SURVEY IPLETED 01/2024	
	PROVIDER OR SUPPLIER Y CREEK AT ROCH		340 E 1	ADDRESS, CITY, STATE, ZIP 8TH STREET ESTER, IN 46975	PCOD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	§485.920(a)(1)-(2) §491.12(a)(1)-(2),), §486.360(a)(1)-(2), §494.62(a)(1)-(2)				
	develop and main preparedness plar	an. The [facility] must tain an emergency n that must be reviewed, ast every 2 years. The plan ing:]				
	` '	nd include a documented, community-based risk ing an all-hazards				
	(2) Include strateg emergency events assessment.	ies for addressing sidentified by the risk				
	Plan. The Hospice maintain an emerg that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utilizapproach. (2) Include strategemergency events assessment, incluthe consequences disasters, and other consequences.	nd include a documented, community-based risk ing an all-hazards				
	develop and main preparedness plar	s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. The plan must				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 2 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155430	B. WI	NG		07/01/	/2024
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based and assessment, utiliz approach, includir (2) Include stratege emergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include stratege emergency events assessment. Based on record revialed to maintain a plan that was (1) badocumented, facilit risk assessment, utilized including missing restrategies for addresidentified by the risk with 42 CFR 483.7. This deficient praction of the proposition of the pro	and include a documented, community-based risk ing an all-hazards and missing residents. Jies for addressing is identified by the risk. [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and mintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency amintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency event aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and mintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and mintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must do the following: [3483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 must develop and mintain aparedness plan that must updated at least every 2 must develop and mintain aparedness plan that must updated at least every 2 must develop and maintain aparedness plan that must updated at least every 2 must develop and maintain aparedness plan that must updated at least every 2 must develop and maintain aparedness plan that must updated at least every 2 must develop and mintain aparedness plan that must updated at least every 2 mu	E 00	006	REQUESTING DESK REVIENE E006 It is the policy of Hickory Creene Rochester to have a plan base all hazards vulnerability risk assessment that address the resident population, including those at risk, as well as the typof services that the facility has ability to provide during an emergency and the continuity operations including delegation authority and succession planed to include a Hazard Vulnerability Assessment for Hickory Creek Rochester. The	ek ed on pe s to of ons of s.	07/17/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326 If continuation sheet Page 3 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED
		155430	B. W	ING	_	07/01	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t.			8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER		ROCHE	ESTER, IN 46975		
(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 BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	owever, she was not able to			plan includes natural events,		
	1 -	tion of a risk assessment to			human events other events. A		
	determine the hazar	ds.			residents, including those at ri	isk	
	TE1 ' C' 1'				will be addressed in the		
	_	viewed with the Administrator			emergency preparedness plan		
	and Maintenance D	irector at the exit conference.			well as the type of services the		
					facility is able to provide in an		
					emergency. 2 All residents have the		
					2 All residents have the potential to be affected by the		
					practice.		
					3 All staff will be in-serviced	d on	
					the policy by the Maintenance		
					Director or designee.		
					4 A plan based on all hazar	ds	
					vulnerability assessment will b		
					reviewed monthly for 6 month		
					bi-annually thereafter by the		
					Executive Director or designed	e to	
					ensure all residents including		
					those at risk are addressed as	8	
					well as the type of services the	е	
					facility could provide in an		
					emergency, and continuity of		
					operations including delegatio	ns of	
					authority.		
					The results of the monthly rev		
					will be reviewed in the monthly	У	
					QAPI meeting to discuss the	4la a	
					suitability of the plan and whe		
					changes need to be made to i Date of Compliance: July 17,		
					Date of Compliance, July 17, 7	2 024	
E 0007	403.748(a)(3), 410	6.54(a)(3), 418.113(a)(3),					
SS=F	1 ' ' ' '	2.15(a)(3), 483.475(a)(3),					
Bldg	1 ' ' ' '	.102(a)(3), 485.625(a)(3),					
	1 ' ' ' '	.727(a)(3), 485.920(a)(3),					
	491.12(a)(3), 494.						
	EP Program Patie						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21

Facility ID: 000326

6

If continuation sheet

Page 4 of 22

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING		COMPL	
		155430	B. WI	ING		07/01/	/2024
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
HICKOR	Y CREEK AT ROCI	HESTER			8TH STREET ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY 1		DATE
	§441.184(a)(3), §483.73(a)(3), §44 (3), §485.68(a)(3) §485.727(a)(3), §494.62(a)(3). [(a) Emergency P develop and main preparedness plar and updated at lea must do the follow (3) Address [patie including, but not the type of services	485.920(a)(3), §491.12(a)(3), lan. The [facility] must tain an emergency n that must be reviewed, ast every 2 years. The plan					
	continuity of opera	ations, including delegations uccession plans.**					
	develop and main preparedness plat and updated at let must do all of the (3) Address reside but not limited to, services the LTC provide in an eme	The LTC facility must tain an emergency In that must be reviewed, ast annually. The plan following: ent population, including, persons at-risk; the type of facility has the ability to ergency; and continuity of ing delegations of authority					
	ASC, hospice, PA RHC/FQHC, or ES	s at risk" does not apply to: CE, HHA, CORF, CMCH, SRD facilities.] view and interview, the facility	E 00	007	REQUESTING DESK REVIEN	N	07/17/2024
	failed to ensure the addressed resident j	emergency preparedness plan population, including, but not			E007		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 5 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2024		
	PROVIDER OR SUPPLIER		340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET ESTER, IN 46975	
(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 APPROPRI	
	(EACH DEFICIEN REGULATORY OF CFR 483.73(a)(3). affect all occupants Findings include: Based on record rev 07/01/24 between 9 documentation coul emergency prepared population, includin at-risk. Based on ir review, the Administration but was documentation addr. This finding was record.	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION This deficient practice could		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) It is the policy of Hickory Cree Rochester to have emergency procedures that address the resident population, including those at risk, as well as the ty of services that the LTC facilit has to ability to provide during emergency and the continuity operations including delegatic authority and succession plan The Emergency Preparedness plan has been amended to in the risk assessment in the emergency preparedness plan binder. Hickory Creek has a in place that includes our pers at risk and the type of service needed for the resident. The assessment policy and proce have been updated and put in binder as well. All residents, including those at risk will be addressed in the emergency preparedness plan as well as type of services the facility ha the ability to provide in an emergency. All residents have the potentic be affected by the practice. The Emergency preparedness plan will be updated and will be reviewed on an annual basis the Maintenance Director or designee to ensure all resided including those at risk are	completion DATE ek y pe ty g an of ons of ns. ss clude n plan sons s risk dure n the the as to all to s oe by
				addressed as well as the type services the facility could provin an emergency, and continuoperations including delegation authority.	vide uity of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 6 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO	NSTRUCTION 	(X3) DATE S	
		155430	B. WI			07/01/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER	ROCHESTER, IN 46975				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
					All staff will be in- serviced on policy by the Maintenance Director or designee. The results of any future reviet the Emergency Preparedness Plan will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 17, 2	ws of	
E 0025 SS=F Bldg	482.15(b)(7), 483. 485.625(b)(7), 485. Arrangement with §403.748(b)(7), §4(7), §460.84(b)(8), (7), §485.920(b)(6), §4 [(b) Policies and p must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policible reviewed and uyears [annually for minimum, the policible address the follow *[For Hospices at §441.184,(b) Hospices at §441.184,(b) Hospices at §47.184,(b) Hospices at	418.113(b)(5), §441.184(b) a, §482.15(b)(7), §483.73(b) b), §485.625(b)(7), 494.62(b)(6). Tocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at if this section, and the can at paragraph (c) of this ies and procedures must updated at least every 2 LTC facilities]. At a cies and procedures must					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 7 of 22

PRINTED: 08/07/2024

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIE Y CREEK AT ROC			STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975			
(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
	patients. *[For PACE at §4 §483.475(b), CAP at §485.920(b) ar §494.62(b):] Police (6), (8)] The dever with other [facilities receive patients in cessation of oper continuity of services at a procedures. (7) The arrangements with providers to receive limitations or cessation arrangements with providers to receive limitations or cessation of the arrangements with providers to receive limitations or cessation of the arrangements with providers to receive limitations or cessation of the continuity of set of the continu	inuity of services to facility 60.84(b), ICF/IIDs at Hs at §486.625(b), CMHCs and ESRD Facilities at ties and procedures. (7) [or lopment of arrangements res] [or] other providers to an the event of limitations or ations to maintain the ces to facility patients. §403.748(b):] Policies and the development of th other RNHCls and other twe patients in the event of resistion of operations to inuity of non-medical color patients. The patients in the event of the development of other LTC facilities and other the patients in the event of that of operations to maintain revices to facility resident. This could affect all occupants. The patients in the event of the patients and other the patients are patients and other the patients and other the patients are patients and other the patients are patients and other the patients are patients at the patients are patients and the patients are patients at the patients are patients at the patients are patients at the patients at the patients are patients at the patients are patients at the patie	E 00	025	REQUESTING DESK REVIEVED E025 It is the policy of Hickory Cree Rochester to have an arrange with Rochester Community Coto receive patients in the even limitations or cessation of operations to maintain the continuity of services to facility resident, and the continuity of operations including delegation authority. 1 The Emergency Preparedness plan has been amended to include an	ek ment enter t of	07/17/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

account the patient population and the ability for

services. This facility is unable to accommodate

the receiving facility to provide continuity of

and provide continuity of care to the varying

Event ID: UBLO21

Facility ID: 000326

arrangement with Hickory

limitations or cessation of

Rochester Community Center to

receive residents in the event of

If continuation sheet

Page 8 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/01/2024
	PROVIDER OR SUPPLIEI		340 E	ADDRESS, CITY, STATE, ZIP COI 18TH STREET ESTER, IN 46975)
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF degree of medical s Corporation residen ventilators. Based record review, the a corporate office and transfer agreement This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Rervices needed by the Ints i.e., residents using on interview at the time of Administrator contacted the Id confirmed this was their with other facilities. Eviewed with the Administrator Director at the exit conference.	ROCHI ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY) operations to maintain the continuity of services. 2 All residents have the potential to be affected be practice. An agreement he signed with Rochester Corector of limitations or cestoperations to maintain the continuity of services. 3 All staff will be in-serviced the policy by the Executive Director or designee. 4 An arrangement with Rochester Community Coreceive residents in the elimitations or cessation of operations to maintain the continuity of services will reviewed bi-annually the the Executive Director or to ensure all residents in those at risk are address well as the type of service facility could provide in a emergency, and continuity operations including delegations in the continuity of the biannual will be reviewed in the Community. The results of the biannual will be reviewed in the Community of the plan and whether of the plan	DATE COMPLETION DATE DATE COMPLETION
K 0000 Bldg. 01					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $UBLO21 \qquad {\tt Facility \, ID:} \quad 000326$

If continuation sheet

Page 9 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155430	B. Wl	NG		07/01/	2024
NAME OF P	PROVIDER OR SUPPLIER	2	_		ADDRESS, CITY, STATE, ZIP COD 8TH STREET		
HICKOR'	Y CREEK AT ROCH	HESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Recertification and State	K 0	TAG	DEFICIENCY		DATE
	•	as conducted by the Indiana	KU	000			
	-	Ith in accordance with 42 CFR					
	483.90(a).						
	G D 07/01	/O.A					
	Survey Date: 07/01/24						
	Facility Number: 00						
	Provider Number: 1						
	AIM Number: 1002	290770					
	At this Life Safety	Code survey, Hickory Creek at					
	Rochester was found not in compliance with						
	Requirements for P	-					
		, 42 CFR Subpart 483.90(a),					
	_	re and the 2012 Edition of the					
		ction Association (NFPA) 101, LSC), Chapter 19, Existing					
		ancies and 410 IAC 16.2.					
		ity was determined and					
		pe II (222) construction and					
		The facility has a fire alarm detection in the corridors and					
		the corridor. The facility has					
	_	oke detectors in all resident					
		ne building is partially					
		ane fueled 60 kW emergency					
	-	lity has a capacity of 36 and					
	had a census of 29 a	at the time of this survey.					
	All areas where resi	idents have customary access					
		he facility has three detached					
		facility services which were					
	_	e building was used as for					
		e for miscellaneous storage					
	and the other was u	sed for oxygen storage.					
	Quality Review con	nducted on 07/02/24					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UBLO21 Facility ID: 000326

If continuation sheet Page 10 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155430	B. WI	NG		07/01/	/2024
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0281	NFPA 101						
SS=E	Illumination of Mea	_					
Bldg. 01	Illumination of Mea						
		ans of egress, including exit					
	_	nged in accordance with 7.8					
		r continuously in operation					
	· •	matic operation without					
	manual intervention.						
	18.2.8, 19.2.8						
	Based on observation and interview, the facility			281	REQUESTING DESK REVEIN	V	07/01/2024
	failed to ensure the egress lighting for 1 of 3 exit means of egress was arranged so the failure of				14004		
		s arranged so the failure of fixture would not leave the area			K281	.1.	
					It is the policy of Hickory Cree Rochester to have illumination		
	in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single						
	lighting unit does not result in an illumination				means of egress at all exits.		
	level of less than 0.2 foot-candle in any				ensure the safety of all resider entering and exiting the facility		
		nis deficient practice could			1 Immediately following the		
	affect staff and up to	_			Safety Survey Maintenance	LIIE	
	arreet starr and up to	o 13 residents.			Director put in a new light at the	10	
	Findings include:				front entrance. 2 All residents have the	ie .	
	Based on observation	ons during tour of the facility			potential to be affected by the		
		ator on 07/01/24 between 12:35			practice. The Maintenance		
	p.m. and 1:35 p.m.,	the exit means of egress from			Director completed the inspec	tion	
		f the facility was not			of the facility to ensure no other		
	completely illumina	ated towards the public way.			exterior lights were needing		
	One egress light fix	ture was located on each side			replaced.		
	of the exterior of the	e front doors of the facility;			3 Maintenance Director will		
	however, only one v	was operational and			round each week to ensure ex	át	
	illuminated at the ti	me of observation during tour.			means of egress are appropria	ately	
		at the time of observation, the			lit with operational and illumina	ated	
		ed that only one fixture was			fixtures.		
	providing illuminati	ion of the exit discharge.			4 Director of	ļ	
					Maintenance/designee will		
		viewed with the Administrator			complete weekly audit of entire	e	
	and Maintenance D	irector at the exit conference.			facility to ensure all light are	ļ	
					working correctly. The	ļ	
	3.1-19(b)				Maintenance Director will revie	€W	
			1		each weekly report with the	ļ	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/01/2024	
	PROVIDER OR SUPPLIER		340 E	ADDRESS, CITY, STATE, ZIP COD 18TH STREET HESTER, IN 46975	
(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
				administrator to ensure practic are effective.	ces
				The results will be reviewed ongoing during the facility QA meeting process. Date of Compliance: July 1, 2	
K 0331 SS=E Bldg. 01	exposed interior s as fixed or movab columns, and hav Class A or Class I	ceiling Finish eiling finishes, including urfaces of buildings such le walls, partitions, e a flame spread rating of 3. The reduction in class of sprinkler system as 8.1 is permitted. 3.3.2			
	failed to ensure 1 of paneling, had a flan Class B in accordant 10.2.3.4 states prod accordance with AS Method for Surface Building Materials. Test for Surface Building Materials following classes in spread and smoke d (a) Class A Interior spread 0-25; smoke any material classif spread test scale and	on and interview, the facility I Therapy Room, with wood he spread rating of Class A or ce with 19.3.3.1. LSC 101 hets required to be tested in ITM E 84, Standard Test Burning Characteristics of or ANSI/UL 723, Standard for raining Characteristics of shall be grouped in the accordance with their flame evelopment. Wall and Ceiling Finish. Flame development 0-450. Includes fied at 25 or less on the flame 1 450 or less on the smoke test thereof, when so tested, shall	K 0331	K331 It is the intent of the facility to ensure that any exposed woo without flame rated spray is sealed appropriately. 1 What corrective action wi accomplished for those reside found to have been affected be deficient practice? Education provided to maintenance directed to interior wall and ceil finishes. Exposed wood in the therapy room has been treate with fire rated spray.	d II be ents by the ctor ling edd

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 12 of 22

08/07/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/01/2024 155430 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 340 E 18TH STREET HICKORY CREEK AT ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE not continue to propagate fire. residents having the potential to (b) Class B Interior Wall and Ceiling Finish. Flame be affected by the same deficient spread 26-75; smoke development 0-450. Includes practice and what corrective action any material classified at more than 25 but not will be taken? All residents have more than 75 on the flame spread test scale and the potential to be affected by the 450 or less on the smoke test scale. alleged deficient practice. The (c) Class C Interior Wall and Ceiling Finish. Flame Maintenance Director to ensure spread 76-200; smoke development 0-450. that any exposed wood without Includes any material classified at more than 75 flame rated spray is sealed but not more than 200 on the flame spread test appropriately. scale and 450 or less on the smoke test scale. What measures will be put This deficient practice could affect staff and up to into place or what systemic 2 residents in the Therapy Room. changes you will make to ensure that the deficient practice does not Findings include: recur? Weekly audit of entire facility to ensure compliance. Based on observation and interview during a tour How the corrective action will of the facility with the Administrator on 07/01/24 be monitored to ensure the between 12:35 p.m. and 1:35 p.m., the Therapy deficient practice will not recur, Room contained wood paneling covering what quality assurance program approximately 48 inches of the lower half of the will be put into place? Weekly walls. Based on interview at the time of the facility walk through will be observations, the Administrator could not provide completed by the Maintenance documentation to show the flame spread rating of Supervisor/designee weekly x4 the paneling. weeks, monthly x2 months, and annually thereafter. This finding was reviewed with the Administrator The results will be reviewed and Maintenance Director at the exit conference. ongoing during the facility QAPI meeting process. 3.1-19(b) Date of Compliance: July 18, 2024 K 0341 **NFPA 101** SS=E Fire Alarm System - Installation Bldg. 01 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm

Code to provide effective warning of fire in any part of the building. In areas not continuously

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2024				
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	alarm control unit. detection is also ir appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1, Based on observation failed to ensure 1 of continuously in property. NFPA 72, National 2010 Edition, Section defects and malfund deficient practice condition and visitors. Findings include: Based on observation panel with the Administrator agreed that the wrong time. This finding was reconstructed.	s are monitored for 9.6, 9.6. 1.8 on and interview, the facility f 1 fire alarm system was per operating condition. Fire Alarm and Signaling Code, on 14.2.1.2.2 states system etions shall be corrected. This ould affect all residents, staff, on of the fire alarm control ainistrator on 07/01/24 at 1:08 date and time on the fire alarm accorrect. The indicated date 1/24 and 12:08 p.m. Based on the of observation, the the date fire alarm control panel	K 0341	REQUESTING DESK REVIEW K341 It is the intent of the facility to ensure that the fire alarm contipanel will have the correct tim 1. What corrective action wi accomplished for those reside found to have been affected by deficient practice? No resider have been affected. Education provided to maintenance director/designee related date time on the fire alarm control panel. The fire control panel we corrected to display the appropriate time. 2. How will you identify other residents having the potential be affected by the same deficing practice and what corrective a will be taken? All residents have the potential to be affected by alleged deficient practice. The Maintenance Director to ensure that the date and time is correct on the fire panel. 3. What measures will be point place or what systemic changes you will make to ensure that the deficient practice doe.	trol e. Il be ents by the ints n e and vas er to ient action ave the er er to ut ure		

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155430	B. Wl	NG		07/01	/2024	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N .	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
⟨ 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System Spinkler System - 2012 EXISTING Nursing homes, a by construction ty throughout by an sprinkler system i 13, Standard for t Systems. In Type I and II co protection measur substituted for sprintlers areas where state sprinklers. In hospitals, sprin clothes closets of where the area of 6 square feet and the closet footprin Standard for Instat Systems.	- Installation Installation nd hospitals where required			recur? Daily audit of the fire panel to ensure compliance 4. How the corrective act be monitored to ensure the deficient practice will not rewhat quality assurance progwill be put into place? Daily facility walk through will be completed by the Maintena Supervisor/designee. The will be reviewed ongoing dufacility QAPI meeting proce Date of Compliance: July 03	e. cur, gram y nce results uring the ss.		

FORM CMS-2567(02-99) Previous Versions Obsolete

19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility

Event ID:

UBLO21

K 0351

Facility ID: 000326

If continuation sheet

REQUESTING DESK REVIEW

Page 15 of 22

07/02/2024

CENTERS FOR MEDICARE & MEDICAID SERVICES ON								
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>01</u>		COMPLETED			
		155430	B. W	B. WING			07/01/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	8			18TH STREET			
HICKOR	Y CREEK AT ROCH	HESTER			ESTER, IN 46975			
						T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		spray pattern for sprinkler						
		ructed in 1 of 1 housekeeping			K351			
		e with 19.3.5.1. NFPA 13, 2010			1 What corrective action w			
		.5.1 states sprinklers shall be			accomplished for those reside			
		nimize obstructions to			found to have been affected I	-		
	_	d in 8.5.5.2 and 8.5.5.3 or			deficient practice? No reside			
		s shall be provided to ensure			have been affected by the all	-		
		of the hazard. Sections 8.5.5.2			deficient practice. The cardb			
	_	permit continuous or			boxes were removed from the	e East		
		ructions less than or equal to			Hall closet			
		e sprinkler deflector or in a			2 How will you identify other			
	^	ore than 18 inches below the			residents having the potentia			
	sprinkler deflector that prevent the spray pattern			be affected by the same deficient				
		ng. This deficient practice		practice and what corrective action				
	could affect staff an	nd up to 15 residents.		will be taken? All staff have been				
					educated on not obstructing t	he		
	Findings include:				spray pattern for sprinkler he	ads,		
					nothing can be 18inches from	n the		
		ons during a tour of the facility			sprinkler head. 7/02/2024. All			
	with the Administra	ator on 07/01/24 between 12:35			areas have been inspected b	y the		
	p.m. and 1:35 p.m.,			Maintenance Director to ensur		ıre		
		t in the East Hall had		there are no obstructions for th		the		
		ntaining trash can liners			sprinkler heads.			
		nches from the sprinkler			3 What measures will be p	out		
	deflector. The boxe	es would obstruct the flow of			into place or what systemic			
	water if the sprinkle	er was activated. Based on			changes you will make to ens	sure		
	interview at the tim	e of observation, the			that the deficient practice doe	es not		
		Housekeeper agreed the boxes			recur? Maintenance/designe	ee will		
		nes of the sprinkler deflector.			do weekly checks of all room	s/		
	_	emoved the boxes from			storage areas to ensure			
	obstructing the spri	nkler deflector prior to exit.			compliance.			
					4 How the corrective actio	n will		
		viewed with the Administrator			be monitored to ensure the			
	and Maintenance D	irector at the exit conference.			deficient practice will not recu	ır,		
					what quality assurance progr	am		
	3.1-19(b)				will be put into place? Weekl	у		
					facility walk through will be			
					completed by the Maintenand	ce		

Supervisor/designee. The results will be reviewed ongoing during the

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155430	B. WING			07/01/2024	
				CTDEET 4	ADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD 8TH STREET		
HICKORY CREEK AT ROCHESTER							
HICKORY	CREEK AT ROCE	TESTER		RUCHE	ESTER, IN 46975		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTE		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)		DATE				
				facility QAPI meeting process.			
					Date of Compliance: July 02, 2	2024	
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
		corridor openings in other					
	•	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		ig fire for at least 20					
		fully sprinklered smoke					
	-	only required to resist the					
		e. Corridor doors and doors					
	to rooms containin	_					
		rials have positive latching					
		atches are prohibited by					
	_	hese requirements do not					
	flammable or com	spaces that do not contain					
		en bottom of door and floor					
		ceeding 1 inch. Powered					
	_	vith 7.2.1.9 are permissible					
		device capable of keeping					
	-	hen a force of 5 lbf is					
		no impediment to the					
		rs. Hold open devices that					
	-	door is pushed or pulled are					
		ed protective plates of					
	· •	re permitted. Dutch doors					
	_	6 are permitted. Door					
	-	beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	•					
		fire window assemblies are					
	-	sprinklered compartments					
	-	ctions in area or fire					
		s or frames in window					

FORM CMS-2567(02-99) Previous Versions Obsolete

assemblies.

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet

Page 17 of 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155430	B. W.		<u>VI</u>	07/01	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 8TH STREET		
HICKOR	Y CREEK AT ROC	HESTER			ESTER, IN 46975		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	483, and 485 Show in REMARI fire protection rati devices, etc. Based on observati failed to ensure 1 of on the West Hall h latching and would. This deficient prace 15 residents in the Findings include: Based on observati 07/01/24 at 1:05 p. laundry room did r when tested. When to the floor prevent on interview at the Administrator ackr would not self-close This finding was re-	Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing on and interview, the facility of 1 laundry room corridor door and no impediment to closing, I resist the passage of smoke. It is the passage of smoke tice could affect staff and up to West Hall. On with the Administrator on m., the corridor door to the not self-close into the frame in opened fully the door stuck ting it from self-closing. Based time of observation, the nowledged the corridor door see into the door frame. Eviewed with the Administrator Director at the exit conference.	KO	363	REQUESTING DESK REVIE K363 1 What corrective action was accomplished for those reside found to have been affected by deficient practice? No reside have been affected by the alled deficient practice. Door to law room has been fixed to ensur door closes properly by the Maintenance Director 2 How will you identify other residents having the potential be affected by the same deficient practice and what corrective awill be taken? All residents have the potential to be affected by alleged deficient practice. All self-closing doors were check by Maintenance to ensure proclosure 3 3. What measures will be into place or what systemic changes you will make to ensure that the deficient practice door recur? The maintenance/designee will do weekly checks of all self-closid doors ensuring compliance. 4 4. How the corrective active active in the deficient practice will not recurred.	ill be ents by the ints eged undry e the er lato cient eaction ave ave e put es not bing tion ee ur,	07/18/2024

PRINTED: 08/07/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155430 B. WING 07/01/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 340 E 18TH STREET HICKORY CREEK AT ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE will be put into place? Weekly facility walk through will be completed by the Maintenance Supervisor/designee. The results will be reviewed ongoing during the facility QAPI meeting process. Date of Compliance: July 18, 2024 K 0511 **NFPA 101** SS=E Utilities - Gas and Electric Bldg. 01 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 07/18/2024 REQUESTING DESK REVIEW failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in bathroom 3 was properly K511 maintained for protection against electric shock. What corrective action will be NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault accomplished for those residents Circuit-Interrupter Protection for Personnel, found to have been affected by the states, ground-fault circuit-interruption for deficient practice? No residents personnel shall be provided as required in 210.8. have been affected by the alleged This deficient practice could affect staff and up to deficient practice. A GFCI 18 residents. receptacle was replaced by Maintenance Director. Findings include: How will you identify other residents having the potential to Based on observation and interview with the be affected by the same deficient Administrator during a facility tour on 07/01/24 practice and what corrective action between 12:35 p.m. and 1:25 p.m., when the GFCI will be taken? All residents have

FORM CMS-2567(02-99) Previous Versions Obsolete

electric receptacle in Bathroom 3 was tested with a

GFCI tester the GFCI receptacle failed to trip and

Administrator agreed the GFCI electric receptacle

did not properly work when tested and the tester

did not break the electrical circuit. Based on

interview at the time of observation, the

UBLO21 Event ID:

Facility ID: 000326

the potential to be affected by

Maintenance has changed the

GFCI plug in bathroom 3, and it

works properly. All other GFCI

receptacles were checked to

alleged deficient practice,

If continuation sheet

Page 19 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155430		î ´	JILDING	onstruction 01	(X3) DATE COMPL 07/01/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975					
HICKORY CREEK AT ROCHESTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE	
	was indicating a "Bad Ground" wiring issue. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)				ensure receptables are working properly. 3 What measures will be positive properly. 3 What measures will be positive properly. 3 What measures will be positive properly. 4 How the deficient practice does recur? Maintenance/designed do weekly checks of all GFCI plugs in the building. 4 How the corrective action be monitored to ensure the deficient practice will not recurred what quality assurance prograwill be put into place? 1 times week for 4 weeks, monthly for months then on going will be completed by the Maintenanc Supervisor/designee. The rewill be reviewed ongoing during facility QAPI meeting process Date of Compliance: July 18,	ut ure s not e will r, am per 4 e sults ng the		
K 0906 SS=D Bldg. 01	Supply Gas and Vacuum Supply System Op Adaptors or convection Cylinders are han 11.6.2. Only cylin containers, and th in rooms containir or cylinders. No fi stored with cylinde storage units inter are not used to tra away from source caps are secured cylinder is in use.	Piped Systems - Central perations ersion fittings are prohibited. dled in accordance with ders, reusable shipping eir accessories are stored ng central supply systems lammable materials are ers. Cryogenic liquid nded to supply the facility ansfill. Cylinders are kept s of heat. Valve protection in place, if supplied, unless Cylinders are not stored in ces. Cylinders in use and						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UBLO21 Facility ID: 000326

If continuation sheet Page 20 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/01/2024 155430 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 340 E 18TH STREET HICKORY CREEK AT ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) Based on observation and interview, the facility K 0906 REQUESTING DESK REVIEW 07/25/2024 failed to ensure 1 of 1 outdoor oxygen storage locations was provided with proper ventilation. K906 NFPA 99, 11.3.1* Storage for nonflammable gases 1 What corrective action will be equal to or greater than 85 m3 (3000 ft3) at STP accomplished for those residents shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section found to have been affected by the 5.1.3.3.3 Ventilation for Outdoor Locations deficient practice? No residents states outdoor locations surrounded by have been affected by the alleged impermeable walls shall have protected ventilation deficient practice. A vent was openings located at the base of each wall to allow installed by the Maintenance free circulation of air within the enclosure. This Director. deficient practice could affect only staff when How will you identify other transfilling. residents having the potential to be affected by the same deficient Findings include: practice and what corrective action will be taken? No residents have Based on observation and interview with the the potential to be affected by Administrator during a facility tour on 07/01/24 alleged deficient practice. between 12:35 p.m. and 1:25 p.m., the plastic Maintenance has put in a vent to storage shed located outside the rear of the allow free circulation of the air building containing 8 bulk liquid oxygen storage within the enclosure. containers did not have ventilation to allow free What measures will be put circulation of the air within the enclosure. Based into place or what systemic on interview at the time of observation, the changes you will make to ensure Administrator identified the shed as storage for that the deficient practice does not

FORM CMS-2567(02-99) Previous Versions Obsolete

the bulk liquid oxygen containers.

Event ID:

UBLO21

Facility ID: 000326

If continuation sheet

recur? Maintenance Director will

Page 21 of 22

PRINTED: 08/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155430	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2024		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP COD 340 E 18TH STREET ROCHESTER, IN 46975				
(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)	TE	(X5) COMPLETION DATE
	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)				ensure vent is clean and allow flow. 4 How the corrective action be monitored to ensure the deficient practice will not recur what quality assurance progra will be put into place? On goi walk through will be completed the Maintenance Supervisor/designee of any ne buildings. The results will be reviewed ongoing during the fa QAPI meeting process. Date of Compliance: July 18, 2	n will Try Try Try Try Try Try Try T	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UBLO21 Facility ID: 000326 If continuation sheet Page 22 of 22