PRINTED: 11/15/2024

EPARTMENT OF HEALTH AND HU	FORM APPROVE		
ENTERS FOR MEDICARE & MEDIC	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
	155406	B. WING	10/22/2024
	•	CTREET ADDRESS CITY STATE 7IB COD	

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 390 W BOULEVARD HICKORY CREEK AT PERU PERU. IN 46970 (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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 Please accept this 2567 Plan of conducted by the Indiana Department of Health Correction for the Life Safety Code in accordance with 42 CFR 483.73. with Emergency Preparedness Survey ending 10/22/2024, as our Survey Date: 10/22/24 letter of Credible Allegation and we respectfully request a desk review Facility Number: 000475 in lieu of a post survey revisit on or Provider Number: 155406 after November 11, 2024. AIM Number: 100290540 At this Emergency Preparedness survey, Hickory Creek at Peru 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 30. Quality Review completed on 10/23/24 K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 Please accept this 2567 Plan of Licensure Survey was conducted by the Indiana Correction for the Life Safety Code Department of Health in accordance with 42 CFR with Emergency Preparedness 483.90(a). Survey ending 10/22/2024, as our letter of Credible Allegation and we Survey Date: 10/22/24 respectfully request a desk review in lieu of a post survey revisit on or Facility Number: 000475 after November 11, 2024. Provider Number: 155406 AIM Number: 100290540 At this Life Safety Code survey, Hickory Creek at

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

Peru was found not in compliance with

TITLE

(X6) DATE

Brenda Shepherd **Executive Director** 11/08/2024

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 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.

Event ID: X02Y21 Facility ID: 000475 Page 1 of 6 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155406		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 10/22/2024		
	PROVIDER OR SUPPLIER Y CREEK AT PERU		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970	
(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 (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
	Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code, (I Health Care Occupa This one story facility Type II (222) constraints sprinklered. The fa with smoke detection open to the corridor detectors in resident has a capacity of 36 time of this survey. All areas providing were sprinklered an services were sprinklered and services were sprinklered and services were sprinklered with a services were sprinklered and services were sprinklered	articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. It was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, spaces is and battery operated it sleeping rooms. The facility and had a census of 30 at the customary access to residents d all areas providing facility clered except for the detached ding and detached which were not sprinklered.	IAU		DATE
K 0353 SS=C Bldg. 01		- Maintenance and Testing	K 0353		11/11/2024
	sprinkler system in LSC 9.7.5 requires a shall be inspected a with NFPA 25, Star Testing, and Mainte Protection Systems. 5.1.1.2 indicates the inspection and testing gauges on wet pipe inspected monthly a	y failed to maintain 1 of 1 accordance with LSC 9.7.5. all automatic sprinkler systems and maintained in accordance adard for the Inspection, enance of Water-Based Fire NFPA 25, 2011 edition, Table e required frequency of ag. NFPA 25, 5.2.4.1 states sprinkler systems shall be and gauges on dry systems spected weekly to ensure		F 353 Sprinkler System What corrective action(s) wi e accomplished for those re ents found to have been affe d by the deficient practice. ·No residents were affected. · Valve check documentation added to our TELS system to verify the monthly wet system control values are inspected a	II b sid ecte was

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

Event ID:

X02Y21

Facility ID: 000475

75

If continuation sheet

Page 2 of 6

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		01	COMPLETED	
155406		B. WING 10/22/2024			10/22/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER				BOULEVARD	
HICKOR'	Y CREEK AT PERU	J			IN 46970	
(V4) ID	CLIMANAADSZ	CT A TEMENT OF DEFICIENCIE	ı		T	(V5)
(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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAU		pressure is being maintained.		IAU	the inspection is documented.	
		states valves should be			How will you identify other re	
		r valves secured locks or			dents having the potential to	
		1.1) shall be permitted to be			e affected by the same defici	
		This deficient practice could			t practice and what	
	affect all occupants	-			corrective action will be take	ın.
	1				·No other residents have the	
	Findings include:				potential to be affected. All we	et
					system control valves were	
	During records revi	ew with the Maintenance			inspected by Maintenance	
	Director on 10/22/2				Director.	
	documentation in th	ne TELS computer system			·What measures will be put i	nt
	indicated gauges on	the wet system were			o place or what systemic cha	• • • • • • • • • • • • • • • • • • •
	inspected weekly bu	at the monthly wet system			es will be made to ensure the	at t
	control valves inspections were not documented.				he	
	Based on observation at 11:20 a.m., there were two				deficient practice does not re	eoc
	supervised control valves for the sprinkler				cur.	
	system. Based on an interview at the time of				· Valve check documentation	was
	record review, the Maintenance Director stated				added to our TELS system to	
	-	es are inspected but the			verify the monthly wet system	• • • • • • • • • • • • • • • • • • •
	checks are not recorded.				control values are inspected a	
					the inspection is documented.	
	_	viewed with the Administrator			Maintenance Director will con	firm
		e Director during the exit			value check inspection	
	conference.				documentation is current withi	n
					the TELS system. Executive	
	3.1-19(b)				Director will verify documental	tion
					complies.	
					How the corrective action wi	
					be monitored to ensure the d	-
					cient practice will not recur,	i.e
					., what quality assurance program will be p	ut
					into place.	ut
					Into place. Into place. Into place.	n our
					monthly safety meetings TELS	
					documentation compliance.	
					·"Life Safety POC QAPI Tool"	will
					be utilized monthly x 6 months	
					and quarterly thereafter for on	
			1		i and quartony thorounter for on	-

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

Event ID:

X02Y21

Facility ID: 000475

If continuation sheet Page 3 of 6

PRINTED: 11/15/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155406		B. WING 10/22/2024			2024		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		DROVIDEDIS DI ANI OE CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
					year ED/IDT/Designee with re reported to the Quality Assura and Performance Improvemer Committee overseen by the Executive Director. If 100% compliance rate is not achieve plan of action will be implemently committee. Date of compliance: 11/11/20	nce nt ed, a nted	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 1 outside oxygen storage areas were locked and provided with a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This deficient practice could affect staff, visitors, and 10 residents using the northeast exit. Findings include: Based on observation with the Maintenance Director on 10/22/24 at 11:40 p.m., the sliding doors to the oxygen (O2) storage shed outside the northeast exit were unlocked and the doors were rusted out and no longer attached and secured to the shed. Also, the O2 shed was not provided with precautionary signs which states "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Based on an interview at the time of observation, the Maintenance		K 0	923	F 923 Gas Equipment – Cylind and Container Storage What corrective action(s) will e accomplished for those resents found to have been affed by the deficient practice. No residents were affected. Toxygen storage doors were repaired and are in working or Lock was placed on the doors Precautionary signs stating "storage of oxidizing gases and smoking" purchased and poster on the shed. How will you identify other redents having the potential to e affected by the same deficit t practice and what corrective action will be aken. No other residents have the potential to be affected. The	I b sid cte The der. d no ed	11/11/2024

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

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	PROVIDER OR SUPPLIE		390 W	ADDRESS, CITY, STATE, ZIP COD BOULEVARD IN 46970	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING DIFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMM ELTION
TAG	no smoking. This finding was re	eviewed with the Administrator ce Director during the exit	TAG	repaired and in working order lock was placed on the doors. Precautionary signs stating "storage of oxidizing gases as smoking" purchased and post on the shed. All Staff were in serviced regrocedure for obtaining oxygrand securing the shed doors. What measures will be put or place or what systemic cles will be made to ensure the deficient practice does not cur. The oxygen storage shed dowere repaired and in working order, a lock was placed on the doors. Precautionary signs stating "storage of oxidizing gases as smoking" purchased and post on the shed. All Staff were in serviced regrocedure for obtaining oxygrand securing the shed doors. How the corrective action where the cient practice will not recurs, what quality assurance program will be into place. Maintenance Director and/ordesignee will check shed doord days a week for 30 days to confirm doors are shut and secured and confirm required signage is visible. These chewill continue monthly thereaf	and no sted arding en int nang nat t reoc oors ghe arding en

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

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP COD 390 W BOULEVARD PERU, IN 46970					
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
				6 months. The finding presented to the Qual Assurance Committee compliance is not ach months a plan of actic implemented by commodate of Compliance: 1	ity e, If 100% ieved in 6 on will be nittee.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: X02Y21 Facility ID: 000475 If continuation sheet Page 6 of 6