STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155406	A. BUILDING -- B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT PERU	390 W BOULEVARD PERU, 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 (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: 10/22/24 Facility Number: 000475 Provider Number: 155406 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	E 0000	Please accept this 2567 Plan of Correction for the Life Safety Code with Emergency Preparedness Survey ending 10/22/2024, as our letter of Credible Allegation and we respectfully request a desk review in lieu of a post survey revisit on or after November 11, 2024.	
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: 10/22/24 Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540 At this Life Safety Code survey, Hickory Creek at Peru was found not in compliance with	K 0000	Please accept this 2567 Plan of Correction for the Life Safety Code with Emergency Preparedness Survey ending 10/22/2024, as our letter of Credible Allegation and we respectfully request a desk review in lieu of a post survey revisit on or after November 11, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Shepherd	Executive Director	11/08/2024

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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 smoke detection in the corridors, spaces open to the corridors and battery operated detectors in resident sleeping rooms. The facility has a capacity of 36 and had a census of 30 at the time of this survey. All areas providing customary access to residents were sprinklered and all areas providing facility services were sprinklered except for the detached oxygen storage building and detached maintenance shed which were not sprinklered. Quality Review completed on 10/23/24			
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure	K 0353	F 353 Sprinkler System **What corrective action(s) will b e accomplished for those resid ents found to have been affecte d by the deficient practice.** ·No residents were affected. · Valve check documentation was added to our TELS system to verify the monthly wet system control values are inspected and	11/11/2024

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	normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: During records review with the Maintenance Director on 10/22/24 at 10:19 a.m., the documentation in the TELS computer system indicated gauges on the wet system were inspected weekly but the monthly wet system control valves inspections were not documented. Based on observation at 11:20 a.m., there were two supervised control valves for the sprinkler system. Based on an interview at the time of record review, the Maintenance Director stated the supervised valves are inspected but the checks are not recorded. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the inspection is documented. **How will you identify other resi dents having the potential to b e affected by the same deficien t practice and what corrective action will be taken.** ·No other residents have the potential to be affected. All wet system control valves were inspected by Maintenance Director. **·What measures will be put int o place or what systemic chang es will be made to ensure that t he deficient practice does not reoc cur.** · Valve check documentation was added to our TELS system to verify the monthly wet system control values are inspected and the inspection is documented. Maintenance Director will confirm value check inspection documentation is current within the TELS system. Executive Director will verify documentation complies. **How the corrective action will be monitored to ensure the defi cient practice will not recur, i.e ., what quality assurance program will be put into place.** ·IDT will review monthly during our monthly safety meetings TELS documentation compliance. ·"Life Safety POC QAPI Tool" will be utilized monthly x 6 months and quarterly thereafter for one	

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			year ED/IDT/Designee with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If 100% compliance rate is not achieved, a plan of action will be implemented by committee. Date of compliance: 11/11/2024.	
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 Director stated the O2 shed was left unlocked, had unsecured doors, and did not have precautionary signs indicating storage of oxidizing gasses and	K 0923	F 923 Gas Equipment – Cylinder and Container Storage **What corrective action(s) will b e accomplished for those resid ents found to have been affecte d by the deficient practice.** ·No residents were affected. The oxygen storage doors were repaired and are in working order. Lock was placed on the doors. Precautionary signs stating “storage of oxidizing gases and no smoking” purchased and posted on the shed. · **How will you identify other resi dents having the potential to b e affected by the same deficien t practice and what corrective action will be t aken.** ·No other residents have the potential to be affected. The oxygen storage shed doors were	11/11/2024

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	no smoking. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		repaired and in working order, a lock was placed on the doors. Precautionary signs stating "storage of oxidizing gases and no smoking" purchased and posted on the shed. All Staff were in serviced regarding procedure for obtaining oxygen and securing the shed doors. **·What measures will be put int o place or what systemic chang es will be made to ensure that t he deficient practice does not reoc cur.** · The oxygen storage shed doors were repaired and in working order, a lock was placed on the doors. Precautionary signs stating "storage of oxidizing gases and no smoking" purchased and posted on the shed. All Staff were in serviced regarding procedure for obtaining oxygen and securing the shed doors. **How the corrective action will be monitored to ensure the defi cient practice will not recur, i.e ., what quality assurance program will be put into place.** · Maintenance Director and/or designee will check shed doors 5 days a week for 30 days to confirm doors are shut and secured and confirm required signage is visible. These checks will continue monthly thereafter for	

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			6 months. The findings will be presented to the Quality Assurance Committee, If 100% compliance is not achieved in 6 months a plan of action will be implemented by committee. Date of Compliance: 11/11/2024.	