STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155784	A. BUILDING -- B. WING	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE VILLAGE	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(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: 01/05/23 Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500 At this Emergency Preparedness survey, Creekside Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 100 and had a census of 75 at the time of this survey. Quality Review completed on 01/09/23	E 0000	This plan of correction constitutes the facility's written allegation of compliance for deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the ISDH inspection report. Due to the relative low scope and severity of this survey, the facility respectfully requests consideration for a desk review in lieu of a post-survey revisit.	
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: 01/05/23 Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500 At this Life Safety Code survey, Creekside Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000	This plan of correction constitutes the facility's written allegation of compliance for deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the ISDH inspection report. Due to the relative low scope and severity of this survey, the facility respectfully requests consideration for a desk review in lieu of a post-survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Ginter	Executive Director	01/20/2023

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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	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 built in 2010 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors and in spaces open to the corridors with hard wired smoke detectors in all the resident sleeping rooms. The building is fully protected by 350 kW diesel powered generator. The facility has a capacity of 100 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for an eight by ten foot wood shed used for storage. Quality Review completed on 01/09/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be	K 0211	**K211** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/20/2023

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	opened readily from the egress side whenever the building is occupied. This deficient practice could staff that use housekeeping supplies. Findings include: Based on observation with the Maintenance Supervisor on 01/05/23 at 2:43 p.m., the kitchen door leading to the service hall was locked with a key-turn lock from the outside and there was no release from the inside to open the door if locked. This condition could trap a person inside the kitchen if locked from the outside. Based on interview at the time of observation, the Maintenance Supervisor agreed the kitchen door was locked with an external lock and could not be opened from the inside when locked. The findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**practice:** The deficient practice did not affect any residents. The facility removed the key turn lock from the door. (See picture labeled "Lock removed dietary K211). **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:** No residents had the potential to be affected by this finding. All other doors of egress were checked on to ensure proper operation and path of egress. (See attachment labeled Doors/Signage Completed Audit- 2 pages) **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 added a task to check dietary doors on weekly door inspections on preventative maintenance. (See attachment labeled "Doors/Signage modified audit tool- 2pages) **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 Maintenance Director will monitor compliance through use of his preventative maintenance checklists. The Executive Director	

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			will review the preventative maintenance checklists performed by the Maintenance Director weekly for 4 weeks and monthly thereafter. If 100% compliance is not achieved an action plan will be developed. **By what date the systemic changes will be completed:** Compliance Date – January 20, 2023	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to clearly identify 2 of 8 exit doors leading to the public way. This deficiency could affect 20 residents and staff. Findings Include: Based on observation with the Maintenance Supervisor on 01/05/23 between 12:52 p.m. and 3:00 p.m., the exit doors in 200 and 400 halls each had a sign posted on the door stating that the door was "not an exit". These doors were marked with an illuminated emergency exit sign above the doors which lead to the public way. Based on interview at the time of observation, the	K 0293	K293 Exit Signage **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The paper signs on the doors were removed immediately and discarded during survey. (See picture labeled “removed sign not an exit 1.5.23 K293) **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	01/20/2023

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	Maintenance Supervisor stated that the signs were left over from COVID for staff and removed the paper signs upon the observation. Findings were discussed with the Administrator and Maintenance Supervisor at exit conference. 3.1-19(b)		**action(s) will be taken:** A full house inspection was completed on 1/19/23 to ensure that all exit doors had appropriate signage. (See attachment labeled "Doors/Signage completed audit – 2 pages) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance director/designee check all exit doors weekly with preventative maintenance to ensure proper functioning. The weekly inspection was edited to include an additional check of having correct emergency egress hardware and labeled properly as an exit. (See attachment "Doors/Signage modified audit tool – 2 pages) **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 Maintenance Director will monitor compliance through use of his preventative maintenance checklists. The Executive Director will review the preventative maintenance checklists performed by the Maintenance Director weekly for 4 weeks and monthly thereafter. If 100% compliance is not achieved an action plan will be developed.	

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			By what date the systemic changes will be completed: 01/20/23	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 2 sprinkler systems 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 normal water or air pressure is being maintained. NFPA 25 13.3.2.1	K 0353	K353 Sprinkler System – Maintenance and Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director performed the initial check on the wet gauges on 1/7/23. The maintenance Director also added inspection of wet gauges to his preventative maintenance checklist to be checked monthly.	01/20/2023

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	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: Based on records review with the Maintenance Supervisor on 01/05/22 at 12:13 p.m., no documentation could be located for 12 months of gauge and valve checks for the wet sprinkler system. During an interview at the time of record review, the Maintenance Supervisor stated they were unaware of the required checks and would start inspecting them with the dry system checks. Findings were discussed with the Maintenance Supervisor and Administrator at exit conference. 3.1-19(b)		(See attachment K353) **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 residents, visitors, and staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/designee added the monthly checks for the wet gauges to the preventative maintenance checklist. (See attachment K353) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director added the wet gauge check to the Fire Sprinkler System preventative maintenance log. Wet gauges will be checked monthly by Maintenance Director/ designee. **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 Maintenance Director will monitor compliance through use of his preventative maintenance checklists. The Executive Director will review the preventative maintenance checklists performed by the Maintenance Director weekly for 4 weeks and monthly	

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			thereafter. If 100% compliance is not achieved an action plan will be developed. **By what date the systemic changes will be completed:** Compliance Date = 1/20/23	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications	K 0372	K372 Subdivision of Building Spaces – Smoke Barrier **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director sealed the penetration in the identified smoke barrier with approved fire caulk on 1/5/23. (See pictures labeled “Fire wall penetration side 1 K372” and “Fire wall penetration side 2 K372”). **How other residents having the**	01/20/2023

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	systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments Findings include: Based on observations with the Maintenance Supervisor on 01/05/23 at 1:43 p.m., above the drop ceiling of the smoke barrier wall above the 100/300 hall doors there was an one-inch hole that went through the other side of the barrier. Based on interview at the time of observation, the Maintenance Supervisor agreed there was an unsealed penetration in the smoke barrier. The finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, visitors, and staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/designee checked all other smoke barriers immediately to ensure no unsealed penetrations in the smoke barriers. (See attachment K372 Audit 1.7.23) **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director and or designee will check all Smoke Barriers and Fire Walls for any penetration by utilizing the preventative maintenance checklist (See attachment labeled "Preventative Maintenance Schedule – 2 pages) **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 Maintenance Director will monitor compliance through use of his preventative maintenance checklists. The Executive Director will review the preventative maintenance checklists performed by the Maintenance Director	

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			weekly for 4 weeks and monthly thereafter. If 100% compliance is not achieved an action plan will be developed. **By what date the systemic changes will be completed:** Compliance Date = 1/20/23	