

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/11/2014
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/11/14</p> <p>Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080</p> <p>Surveyor: Mark Bugni, Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Richmond was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for consideration for paper compliance.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K010025 SS=E	<p>has a capacity of 87 and had a census of 55 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which are not sprinkled.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 7 of 95 room walls were constructed to provide at least</p>	K010025	<b>K025 NFPA 101 Life Safety Code Standard</b>	09/24/2014

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	<p>a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 25 residents who reside on the Northeast Hall and Southeast Hall near the East Hall nurses station soiled linen room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the basement on 09/11/14 from 9:15 a.m. to 1:50 p.m., the following locations had ceiling and wall penetrations not firestopped;</p> <ol style="list-style-type: none"> <li>1. The laundry room ceiling had a two foot circular metal air return duct, which was open to the attic above, filled with fiberglass insulation.</li> <li>2. The laundry room east wall had a ten foot by six foot area of drywall missing.</li> </ol> <p>Based on an interview with the maintenance supervisor on 09/11/14 at 10:35 a.m., the water piping was replaced in the spring and the drywall has not been repaired.</p>		<p>It is the practice of this facility that smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4.</p> <p>There were 25 residents that had a potential to be affected; however, no residents were directly affected.</p> <p>(1.) (2.) In the laundry room</p>				

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	<p>3. The East Hall mechanical room west wall had a four foot by four foot area of drywall missing. Based on an interview with the maintenance supervisor on 09/11/14 at 11:20 a.m., the water piping was replaced in the spring and the drywall has not been repaired.</p> <p>4. Resident room 26 east wall by the door had two, one inch circular areas of drywall missing which were not fire stopped.</p> <p>5. The East Hall communication room south wall had a one half inch gap around a cable television penetration which was not fire stopped.</p> <p>6. The kitchen south wall had a two inch gap from an electric conduit penetration which was not fire stopped.</p> <p>7. The kitchen supervisor office south wall had a one quarter inch gap around a computer wire penetration which was not fire stopped.</p> <p>8. The dining room mop closet room west wall had a two foot by four foot area of drywall missing.</p> <p>The laundry room, East Hall mechanical room, resident room 26, East Hall communication room, kitchen, and dining room mop closet walls and ceilings with missing drywall or not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/11/14 at 2:15 p.m.</p>		<p>the metal air duct was covered and fire stopped. The east walls missing drywall section was filled to maintain proper fire protection.</p> <p>(3.) East wall mechanical room's drywall was replaced to maintain proper fire protection.</p> <p>(4.) Resident room 26 east wall by door fire gap was filled.</p> <p>(5.) East hall communication room south wall gap was fire stopped.</p> <p>(6.) The kitchen south wall around the electronic conduit penetration gap wall filled and properly fire stopped.</p> <p>(7.) The kitchen supervisor office south wall gap around the computer wire was</p>	

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	3.1-19(b)		<p>properly fire stopped.</p> <p>(8.) The dining room mop closet room west wall had the missing drywall replaced and proper fire stopped.</p> <p>All these repairs were completed by the Maintenance Supervisor.</p> <p>Managers while doing morning rounds and in their day to day duties will look for any missing drywall or gaps in the fire protection. Any missing sections or gaps will immediately be given to the Maintenance Supervisor and/or the Administer and be rectified. The Maintenance Supervisor will do quarterly checks on all ceiling and wall penetrations to ensure that they are all fire stopped. Any issues will be brought to the quarterly QA meeting for review for the next 6 months.</p>		

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K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 22 residents who reside on the Southwest Hall and Northwest Hall and any	K010027	<b>Date of Completion:</b> <b>September 24, 2014</b>  <b>K027 NFPA 101 Life Safety Code Standard</b>  It is the practice of this facility to maintain smoke barrier doors in accordance with NFPA 101 Life Safety Code Standard.  There were 22 residents that	09/24/2014
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K010029 SS=E	<p>residents using the Therapy Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/11/14 during a tour of the facility from 9:15 a.m. to 1:50 p.m. with the maintenance supervisor, the Southwest Hall set of smoke barrier doors by room 37, the Therapy Hall set of smoke barrier doors, and the Northwest Hall set of smoke barrier doors did not close completely, leaving between a two inch gap and a three inch gap where the doors came together. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/11/14 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾</p>				<p>had a potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made to the smoke barrier doors by the Maintenance Supervisor.</p> <p>Doors will be checked for proper closing when conducting the monthly fire drill.</p> <p>This will be monitored by Maintenance Supervisor and/or Administrator for 6 months and results taken to QA.</p> <p><b>Date of Completion: September 24, 2014</b></p>		

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	<p>hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 13 hazardous areas, such as a combustible storage room over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 25 residents who reside on the the Southeast Hall and Northeast Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/11/14 at 11:10 a.m. with the maintenance supervisor, the East Hall medical records room, which measured one hundred twenty square feet and stored eight shelves of thirty eight cardboard boxes containing paper, lacked a self closing device on the door. The lack of a self closing device on the East Hall medical records room was verified by the</p>	K010029	<p><b>K029 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not</p>	09/22/2014			

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	<p>maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/11/14 at 2:10 p.m.</p> <p>3.1-19(b)</p>		<p>exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>There were 25 residents that had the potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made and a door closer added to the East hall medical records room by the Maintenance Supervisor.</p> <p>Managers will making morning rounds will pay attention to any door closers that don't operate properly. All problems will be immediately brought to the Maintenance Supervisor and/or Administrator. Those door closers that are missing will be immediately replaced and those that are not working properly will be repaired or replaced. Any</p>	

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 4 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 2 residents who reside in room 14.</p> <p>Findings include:</p> <p>Based on observations on 09/11/14 during a tour of the facility with the maintenance supervisor from 9:15 a.m. to 1:50 p.m., the three sprinklers in the laundry room and the sprinkler in resident room 14 closet had one quarter inch to one inch gaps around the sprinkler escutcheon, where the sprinkler escutcheons were not tight fitting to the</p>	K010062	<p>issues that exist will be brought to review at quarterly QA for the next six months.</p> <p><b>Date of Completion: September 22, 2014</b></p> <p><b>K062 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility that the required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p>	09/23/2014

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	<p>ceiling. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/11/14 at 2:15 p.m.</p> <p>3.1-19(b)</p>		<p>There were 2 residents that had the potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made to the sprinkler escutcheons in the laundry room and room 14 closet by the Maintenance Supervisor.</p> <p>If work is being done in the attic, the Maintenance Supervisor will monitor that areas sprinkler area to make sure the sprinkler heads were not offset. All managers will doing rounds will pay attention to sprinkler heads observing for any gaps. If any gaps are found it will be brought to the immediate attention of the Maintenance Supervisor and/or Administrator. The gaps will immediately be fixed. Any issues with fixing the gaps will be brought to the quarterly QA meeting for the next 6</p>		

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K010064 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 8 of 18 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect all residents in the facility.</p> <p>Findings include:  Based on observations on 09/11/14 during a tour of the facility with the maintenance supervisor from 9:15 a.m. to 1:50 p.m., the fire extinguishers located</p>	K010064	<p>months.</p> <p><b>Date of Completion: September 23, 2014</b></p> <p><b>K064 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility that all portable extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10.</p> <p>All residents, staff, and visitors have the potential to be affected; however, no residents were directly affected.</p>	09/23/2014	

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K010143 SS=E	<p>in the Service Hall corridor, the East Hall corridor by the nurses station, the East Hall corridor by room 6, the East Hall corridor by room 25, the Southeast Hall corridor by room 3, the Southwest Hall corridor by room 34, the Southwest Hall corridor by the nurses station and two down the Northwest Hall corridor each measured between sixty five inches and seventy two inches from the top of the extinguisher to the floor, which was over the sixty inch maximum requirement. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/11/14 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p>		<p>Repairs were made to the height of all affected fire extinguishers by the Maintenance Supervisor.</p> <p>The proper height was checked by the administrator. All mounts for the extinguishers were affixed to the wall to prevent accidental misplacement in height.</p> <p>Administrator and Maintenance Supervisor will monitor and bring any issues in the height to the quarterly QA for the next 6 months.</p> <p><b>Date of Completion: September 23, 2014</b></p>		

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	<p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage/transfer location were provided with a sign indicating that transferring is occurring and mechanically ventilated. This deficient practice could affect 18 residents who reside on the Northwest Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/11/14 during a tour of the Northwest Hall liquid oxygen storage rooms from 12:45 p.m. to 1:20 p.m., the Northwest Hall liquid oxygen storage room, where seven full liquid oxygen containers were stored, had an electric switch on the wall which operated the mechanical fan but the fan failed to function on three attempts when the switch was turned on. Based on an</p>	K010143	<p><b>K143 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility when transferring oxygen that it is (a) separate from any portion of the facility where patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction. (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring,</p>	09/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2014
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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	<p>interview with the maintenance supervisor on 09/11/14 at 12:50 p.m., the mechanical fan is broken. Furthermore, the Northwest Hall outside liquid oxygen storage location, where two, one hundred eighty pound liquid oxygen containers were stored, lacked a sign indicating the transferring of oxygen occurs in the location. Based on an interview with the maintenance supervisor on 09/11/14 at 1:15 p.m., the inside Northwest Hall liquid oxygen room is used by nursing staff to transfer liquid oxygen into small containers for resident use and the maintenance supervisor uses the outside liquid oxygen storage room to transfer liquid oxygen into the larger metal containers for the inside liquid oxygen storage room. The lack of mechanical ventilation in the Northwest Hall liquid oxygen storage room and a sign indicating that transferring of oxygen is occurring at the Northwest Hall outside liquid oxygen storage location was verified by the maintenance supervisor at the time of observations and interview and acknowledged by the administrator at the exit conference on 09/11/14 at 2:15 p.m.</p> <p>3.1-19(b)</p>		<p>and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association.</p> <p>There were 18 residents that had a potential to be affected; however, no residents were directly affected.</p> <p>Repairs were made to the Northwest Hall liquid oxygen storage room mechanical fan by the Maintenance Supervisor.</p> <p>A transferring of oxygen sign was placed on the door going out to the Northwest Hall outside liquid oxygen storage location.</p> <p>The fan and the placement of the sign will be checked twice weekly for 6 months by medical records, maintenance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/11/2014
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374		
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			<p>director or administrator. Any missing signs and/or broken fan will be fixed or replaced immediately. All results of any issues will be brought to quarterly Qa for the next 6 months.</p> <p><b>Date of Completion:</b> <b>September 23, 2014.</b></p>		