

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 10/27/2014
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/11/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/27/14</p> <p>Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080</p> <p>Surveyor: Mark Bugni, Safety Code Specialist</p> <p>At this PSR 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</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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K010027 SS=E	<p>and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 53 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 Dennis Austill, Life Safety Code Specialist on 11/05/14.</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 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</p>	K010027	K027 NFPA 101 Life	11/11/2014			

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	<p>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 residents using the Therapy Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/27/14 during a tour of the facility from 9:00 a.m. to 10:15 a.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 10/27/14 at 10:20 a.m.</p> <p>This deficiency was cited on 09/11/14. The facility failed to implement a</p>		<p>Safety Code Standard</p> <p>It is the practice of this facility to maintain smoke barrier doors in accordance with NFPA 101 Life Safety Code Standard.</p> <p>There were 22 residents that had a potential to be affected; however, no residents were directly affected.</p> <p>The affected doors were removed from the respective door frames. They were trimmed, sanded, or planed to accommodate the swelling that had occurred and rehung to fit the opening to allow the proper closing of the door.</p> <p>Doors will be checked for proper closing three times during the week until December 1st. At this point</p>	

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	systematic plan of correction to prevent recurrence. 3.1-19(b)		they will be checked weekly for the next six weeks. After that they will be checked monthly during the fire drill. Any doors shown not to be shutting properly will immediately be repaired. If they are beyond repair they will be replaced. All results will be reviewed during the facility's quarterly qa meetings for continued compliance. Date of Completion: November 11, 2017		