

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/04/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN 46792
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K 0000  Bldg. 01	<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: 10/04/16</p> <p>Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380</p> <p>At this Life Safety Code survey, Heritage Pointe 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) and 410 IAC 16.2. The original section consisting of 1A and 1B and 2A and 2B was surveyed with Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Hard wired smoke detector were provided in the resident rooms. The</p>	K 0000	<p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Life Safety Code survey conducted by your department on October 4, 2016. Our staff would like to compliment the surveyor who performed the ISDH survey this year, for his professionalism and cooperation during the survey process. This letter and Plan of Correction serve as our allegation of compliance that by November 3, 2016 Heritage Pointe will have corrected the cited deficiencies and have all the systemic changes implemented to comply with state and federal regulations. We heartily thank you and your department for your service. Please contact us with any questions at (260) 375-2201 or <a href="mailto:dsouder@ummh.org">dsouder@ummh.org</a></p>	
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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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K 0015 SS=E Bldg. 01	<p>facility has a capacity of 186 and had a census of 130 at the time of this survey.</p> <p>All areas providing customary access were sprinklered with exception of a closet located in therapy. All areas providing facility services were sprinklered except two detached barns used for the storage of the facility bus, facility cars, trucks, mowers, snow plows and maintenance supplies and another garage used for the storage of the golf cart.</p> <p>Quality Review completed on 10/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure the interior finish for 1 of 1 service elevators has a flame spread rating of Class A, Class B or Class C finish. This deficient practice could affect 20 residents in 2 of 16 smoke compartments</p>	K 0015	<p>K-015 Elevator Carpet</p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>All elevators inspected for</p>	10/20/2016			

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 at 10:46 a.m., there was carpet on the walls of the cage service elevator measuring three feet from the bottom with an unknown flame spread rating. Based on interview at the time of observation, the Director of Maintenance was unable to provide documentation to demonstrate the carpet on the bottom third of the elevator walls met a Class A, Class B or Class C rating.</p> <p>3.1-19(b)</p>		<p>combustible products to identify potentially affected residents.</p> <p><b>What corrective action for residents found to have been affected by deficient practice were put into place.</b></p> <p>No residents were noted to be affected by the alleged deficient practice as this unit is not being occupied at this time due to a remodeling project.</p> <p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>Carpet to be removed from elevator walls.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p> <p>No combustible products to be applied to elevator walls.</p> <p>All future interior finishes applied to elevator carts will have appropriate flame spray rating.</p>		

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K 0038 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 exit discharge paths that lead through court yard was readily accessible at all times and 1 of 1 procedures on how to unlock the gate in the exit discharge path was known to all staff. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 at 1:06 p.m., each wing of the facility had at least one exit path that went through the fenced in court yard to a locked gate in order to reach the common way. The Director of Maintenance did have a key and was able to unlock the gate. Based on an interview at the time of observation, when asked if all staff had access to the key the Director of Maintenance stated the head nurse on each unit has a key to unlock the gate. At 1:13 p.m. during the interview, the surveyor had the Director of Maintenance ask the head nurse on unit 1B for the AB key, the key to the gate. The head nurse did not have an AB key. The Director of</p>	K 0038	<p>K-038 Exit Access</p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>All residents residing in the facility had the potential to be affected by the alleged deficient practice.</p> <p><b>What corrective action for residents found to have been affected by deficient practice were put into place.</b></p> <p>No residents were affected by the alleged deficient practice.</p> <p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>New lock placed on fenced courtyard exit gate. Decreased security level on lock and key access.</p> <p>Staff to complete an in-service on the appropriate procedure in order to open the gate in the courtyard during an emergency.</p>	11/03/2016			

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K 0056 SS=E Bldg. 01	<p>Maintenance asked three other employees on the unit if they had an AB key; one did but two did not. The surveyor asked the employee with the AB key how to open the gate and what key would be used; the employee with the AB key stated, " I would call the maintenance person to help me. " At 1:20 p.m. during the interview the Director of Maintenance acknowledged that staff did not know the correct procedure in order to open the gate in the court yard during and emergency.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p>		<p>Staff will receive in-service annually on procedure of opening courtyard gate during emergency/evacuation.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p> <p>Random staff interviews to be conducted on correct procedure of opening courtyard gate during an emergency/evacuation 3 times/week for 4 months. (Exhibit A)</p> <p>Any concerns will be reported to the QA Committee for review and recommendations.</p>	
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	<p>1. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 3 of 16 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect up to 50 residents in 3 of 16 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 between 11:00 a.m. and 1:00 p.m., the following smoke compartments had a mix of standard response and quick response sprinkler heads:</p> <p>a) In the second floor " T " hall smoke compartment eight sprinkler heads had standard response glass rods and 15 sprinkler heads had quick response glass rods.</p> <p>b) In the first floor " T " hall smoke compartment one sprinkler head had standard response glass rods and 22 sprinkler heads had quick response glass rods.</p> <p>c) In the second floor " 2B " dining hall smoke compartment 11 sprinkler heads</p>	K 0056	<p><b>K-056 Sprinkler Heads</b></p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>All sprinklers being audited in all areas of healthcare to identify potentially affected residents.</p> <p><b>What corrective action for residents found to have been affected by deficient practice were put into place.</b></p> <p>No residents were noted to be affected by the alleged deficient practice.</p> <p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>Inspection to be completed by Shambaugh Fire Protection Division to ensure only one type of sprinkler is utilized per smoke compartment.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p>	11/03/2016			

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	<p>had standard response glass rods and 15 sprinklers were concealed quick response heads.</p> <p>Based on an interview at the time of observations, the Director of Maintenance confirmed there was a mix of standard response and quick response in the aforementioned smoke compartments.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 outpatient therapy closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect 10 resident in outpatient therapy.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 at 12:00p.m., the closet in the outpatient therapy lacked sprinkler coverage due to no sprinkler head in the closet. Based on an interview at the time of observation, the Director of Maintenance acknowledged the closet lacked a sprinkler head.</p>		<p>Koorsens Fire Protection to complete visual audits to ensure compliance quarterly.</p> <p>Koorsens to complete facility-wide inspection annually.</p> <p>Any concerns will be reported to the QA Committee for review and recommendations.</p> <p><b>K-056 Therapy Closet</b></p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>Each unit inspected for closets with no sprinklers and no other non-sprinkled closets were identified.</p> <p><b>What corrective action for residents found to have been affected by deficient practice were put into place.</b></p> <p>No residents noted to be affected by the alleged deficient practice.</p>	

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K 0147 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords in room 118 were not used as a substitute for fixed wiring to provide power for medical equipment. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in room</p>			K 0147	<p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>Any newly constructed closets to have appropriate sprinklers installed at time of construction.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p> <p>Maintenance and Health Facility Administrator to ensure regulations pertaining to sprinklers to be followed with new construction.</p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>All resident(s) rooms were inspected to identify other residents potentially affected by the alleged deficient practice.</p> <p><b>What corrective action for residents found to have been</b></p>		11/03/2016

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K 0000  Bldg. 02	<p>118.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 at 12:40 p.m., an oxygen concentrator was supplied with electricity by standard extension cord power strip in room 118. Based on interview, this was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in</p>			K 0000	<p><b>affected by deficient practice were put into place.</b></p> <p>No residents were found to be affected by the alleged deficient practice.</p> <p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>Staff completing in-service on acceptable uses of power strip electrical cord (flexible cord).</p> <p>Weekly rounds to ensure oxygen equipment is utilizing appropriate power supply.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p> <p>Audits to be completed weekly for 3 months. (Exhibit B)</p> <p>Any concerns will be reported to the QA Committee for review and recommendations.</p> <p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Life Safety Code survey conducted by your</p>		

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	<p>accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/04/16</p> <p>Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380</p> <p>At this Life Safety Code survey, Heritage Pointe was found in not 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) and 410 IAC 16.2. The new section consisting of the Anthony and Geedy Wings was surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Hard wired smoke detector were provided in the resident rooms. The facility has a capacity of 186 and had a census of 130 at the time of this survey.</p> <p>All areas providing customary access were sprinklered.</p> <p>Quality Review completed on 10/05/16 -</p>				<p>department on October 4, 2016. Our staff would like to compliment the surveyor who performed the ISDH survey this year, for his professionalism and cooperation during the survey process. This letter and Plan of Correction serve as our allegation of compliance that by November 3, 2016 Heritage Pointe will have corrected the cited deficiencies and have all the systemic changes implemented to comply with state and federal regulations. We heartily thank you and your department for your service. Please contact us with any questions at (260) 375-2201 or <a href="mailto:dsouder@ummh.org">dsouder@ummh.org</a></p>		

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K 0038 SS=F Bldg. 02	<p>DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 exit discharge paths that lead through court yard was readily accessible at all times and 1 of 1 procedures on how to unlock the gate in the exit discharge path was known to all staff. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Maintenance on 10/04/16 at 1:06 p.m., each wing of the facility had at least one exit path that went through the fenced in court yard to a locked gate in order to reach the common way. The Director of Maintenance did have a key and was able to unlock the gate. Based on an interview at the time of observation, when asked if all staff had access to the key the Director of Maintenance stated the head nurse on each unit has a key to unlock the gate. At 1:13 p.m. during the interview, the surveyor had the Director of Maintenance ask the head nurse on unit 1B for the AB</p>	K 0038	<p>K-038 Exit Access</p> <p><b>How other residents were identified for the potential to be affected by the same deficient practice.</b></p> <p>All residents residing in the facility had the potential to be affected by the alleged deficient practice.</p> <p><b>What corrective action for residents found to have been affected by deficient practice were put into place.</b></p> <p>No residents were affected by the alleged deficient practice.</p> <p><b>Measures put into place or changes that will be made to prevent recurrence.</b></p> <p>New lock placed on fenced courtyard exit gate. Decreased security level on lock and key access.</p> <p>Staff to complete an in-service on</p>	11/03/2016

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	<p>key, the key to the gate. The head nurse did not have an AB key. The Director of Maintenance asked three other employees on the unit if they had an AB key; one did but two did not. The surveyor asked the employee with the AB key how to open the gate and what key would be used; the employee with the AB key stated, " I would call the maintenance person to help me. " At 1:20 p.m. during the interview the Director of Maintenance acknowledged that staff did not know the correct procedure in order to open the gate in the court yard during and emergency.</p> <p>3.1-19(b)</p>		<p>the appropriate procedure in order to open the gate in the courtyard during an emergency.</p> <p>Staff will receive in-service annually on procedure of opening courtyard gate during emergency/evacuation.</p> <p><b>How corrective action(s) will be monitored to prevent recurrence (QA).</b></p> <p>Random staff interviews to be conducted on correct procedure of opening courtyard gate during an emergency/evacuation 3 times/week for 4 months. (Exhibit A)</p> <p>Any concerns will be reported to the QA Committee for review and recommendations.</p>		