

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	<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: 03/22/12</p> <p>Facility Number: 000117 Provider Number: 155210 AIM Number: 100266460</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage House of Greensburg 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and single station smoke detection in all resident sleeping rooms except the</p>	K0000	Heritage House of Greensburg respectfully requests acceptance of this required Plan of Correction submitted as our Allegation of Compliance. Completion of the following corrective measures by this facility ensures compliance on April 21, 2012.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>unoccupied Station 3 Hall and unoccupied Residential Hall. The facility has a capacity of 87 and had a census of 72 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/29/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 9 of 184 corridor doors would resist the passage of smoke. This deficient practice could affect any residents using the Main Hall, 10 residents on the L Hall, and 34 residents on the Long Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/22/12 during a tour of the facility from 11:00 a.m. to 3:25 p.m. with the interim maintenance supervisor, the resident break room, resident room 94, resident room 91, resident room 79, the laundry folding room, the certified nursing assistant classroom, the in service director office, the housekeeping supervisor office, and the therapy room each had between a one</p>	K0018	K0018 This facility is dedicated to support fire prevention and safety awareness at all times. No residents with the potential for harm were found to be affected by this deficiency. The corrective action will address those residents who reside on the main, L, and long halls. The 9 corridors doors listed in the findings were found to have gaps along the latching side and top edge when the doors are in the closed position. Foam weather stripping has been applied to each of these doors to eliminate gaps to prevent the passage of of smoke. All other interior corridor doors are also being checked for gaps within the facility. Maintenance is responsible to check doors and will continue to monitor during routine facility rounds and will make modifications as needed.	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>half inch to one inch gap along the latching side and top of each door with the doors in the closed position. This was verified by the interim maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>		<p>Completion Date for the above corrective action: 04/20/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K0025 SS=E	<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 observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers in the Main Hall were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any resident who use the Main Hall.</p> <p>Findings include:</p> <p>Based on observations with the interim maintenance supervisor on 03/22/11 during a tour of the Main Hall from 11:00 a.m. to 12:10 p.m., the following ceiling smoker barriers were not fire stopped;</p> <p>a. The kitchen mop room ceiling had a one inch gap around an 8 inch metal duct penetration with no fire stopping material.</p> <p>b. The kitchen attic access panel room had a four inch gap around the attic access</p>	K0025	<p>K 0025 Smoke Barriers It is the policy of this facility to provide a safe environment for all residents, staff, and visitors. No residents who use the main hall were affected by this finding. The corrective actions will address those who have the potential to be affected by this deficiency. The ceiling smoke barriers are deemed to be fire stopped upon completion of the following repairs: a. The kitchen mop room ceiling has been sealed with fire caulk to fill the penetration of a one inch gap around the duct with fire stopping material. b. The attic access opening inside the kitchen panel room has been reconstructed and replaced with appropriate fire resistive material to assure the attic entrance seals properly to eliminate any gaps. c. The ceiling on the north wall inside the kitchen attic ccess panel room has been repaired to seal the 1 1/2 inch gap along the 17 foot wall/ceiling juncture where</p>	04/20/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>panel where the self closing device did not seal the door to the drywall ceiling.</p> <p>c. The kitchen attic access panel room north wall had a one half inch gap along the seventeen foot wall/ceiling juncture where the drywall was separating with no fire stopping material used to seal the penetration.</p> <p>The kitchen mop room ceiling gap around the duct penetration, kitchen attic access panel north wall gap, and kitchen attic access panel not being tight fitting to the ceiling were verified by the interim maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>		<p>the dry wall was separated and is now tight fitting. Maintenance will monitor during routine daily rounds to maintain and assure compliance with the requirement for continuous smoke barriers to provide fire resistance ratings. If a gap is identified Maintenance will repair/reseal with an appropriate fire rated product. Completion Date for the above corrective actions: 04/20/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0027 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 10 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC Section 19.3.7.6 requires 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 8 residents who reside on the Main Hall.</p> <p>Findings include:</p> <p>Based on observations with the interim maintenance supervisor on 03/22/12 during a tour of the facility from 11:00 a.m. to 3:25 p.m., the Main Hall set of smoke barrier doors by resident room 91 had a one inch gap where the astragal did</p>	K0027	<p>K0027 It is the intent of this facility to provide a safe environment for residents, staff, and visitors. None of the 8 residents who reside on the main hall were affected by this deficiency. The corrective action will protect those residents who had the potential to be affected. The set of smoke barrier doors near resident room 91 have been modified to allow for proper closing with minimum clearance to restrict the passage of smoke. The second set of smoke barrier doors on the unoccupied station 3 hall have been repaired to allow for proper closure to restrict the movement of smoke. The remainder of smoke barrier doors were also checked and will be observed at least monthly for proper closure during fire drill procedures. Maintenance is responsible to implement modifications when necessary. Completion Date for the above corrective actions: 04/20/2012</p>	04/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>not meet the door, and the unoccupied Station 3 Hall set of smoke barrier doors had a one foot gap where the west smoke barrier door dragged and was propped open on the concrete floor. This was verified by the interim maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor doors to 4 of 5 Residential Hall storage rooms and 6 of 6 Station 3 Hall storage rooms, which were hazardous areas due to combustibile storage in rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect any residents who reside on the Station 2 Hall and Main Hall which are adjacent to the unoccupied Station 3 Hall and Residential Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/22/12 during a tour of the unoccupied Station 3 Hall and Residential Hall from 1:50 p.m. to 3:25 p.m. with the interim maintenance supervisor, the Station 3 Hall's six rooms</p>	K0029	<p>K 029 1. It is the practice of this facility to provide a safe environment for all residents, staff, and visitors. No one was affected by this finding. The corrective action will address those who have the potential to be affected by this deficiency. Storage areas in the non-licensed hall of Station 3 and residential halls are being consolidated to reduce the number of hazardous areas and eliminate the need for as much combustibile storage space. Any corridor doors defined as a combustibile storage room will have a self closing device installed to protect such areas. Necessary adjustments were made to self closing devices on all other storage room doors as needed. Maintenance will monitor during routine facility rounds to ensure compliance that all designated storage areas are equipped with a self closing door device. 2. The main dining room in the</p>	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>on the west side of the Station 3 Hall corridor measured two hundred sixty square feet each, and Residential Hall rooms 2, 3, 5 and the residential conference room measured two hundred sixty square feet each, had combustible storage consisting of cardboard boxes of resident clothing, wooden tables, and mattresses stored in each room and each storage room door lacked self closing devices. This was verified by the interim maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 5 Residential Hall hazardous areas, such as a combustible storage room over 50 square feet, was separated from other spaces by smoke resistant partitions and a door. This deficient practice could affect any residents who reside on the Station 2 Hall and Main Hall, which are adjacent to the unoccupied Station 3 Hall and Residential Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/22/12 at 2:50 p.m. with the interim maintenance</p>		<p>unoccupied Residential Hall has been completely cleaned out and is now empty of any combustible storage. Staff will be informed and reminded with a posted sign stating this is not a designated storage area for any purpose. This area is non-licensed for patient use. Maintenance and Administrator will monitor at least weekly during routine rounds to assure the open space remains clear since this space has no smoke resistant partitions nor interior corridor door.</p> <p>Completion date for the above corrective actions: 04/20/2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>supervisor, the unoccupied Residential Hall six hundred fifty square foot main dining room, which was open to the corridor with no smoke resistant partitions or a self closing door, was used as a combustible storage room consisting of cardboard boxes, wooden tables and mattresses. This was verified by the interim maintenance supervisor at the time of observation and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K0045 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 1 of 12 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice does not affect any residents.</p> <p>Findings include:</p> <p>Based on observation on 03/22/12 at 11:40 a.m. with the interim maintenance supervisor, the exit means of egress outside the kitchen was equipped with one light fixture with only one bulb. Based on an interview with the interim maintenance supervisor on 03/22/12 at 11:45 a.m., all outside exit lights are on emergency power. The single bulb emergency light fixture located outside the kitchen exit was verified by the interim maintenance supervisor at the time of observation and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>	K0045	<p>K 0045 Illumination for means of egress The facility is dedicated to provide a safe environment for both the residents and staff. This finding does not affect residents since the kitchen exit is not part of the an emergency evacuation route. This corrective action will address those dietary employees who use the kitchen door. A new double bulb emergency light fixture will be added to this area so the exit outside the kitchen door is not left in darkness The 12 remainder exit means of egress have all been verified to assure lighting is in proper working condition and will continue to be checked at least monthly by maintenance through routine rounds. Completion date for the above corrective actions: 04/20/12</p>	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 3 of 3 shift's fire drills were held at varying times over the past year to protect 72 of 72 residents. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the "Fire Drill Reports" with the interim maintenance supervisor on 03/22/12 at 10:00 a.m., the "Fire Drill Reports" for first, second and third shifts were held at the following similar times over the past year; first shift drills 02/28/11 at 9:15 a.m., 05/24/11 at 10:15 a.m., 08/25/11 at 10:15 a.m., second shift drills 01/31/11 at 3:50 p.m., 04/28/11 at 3:20 p.m., 07/20/11 at 3:15 p.m., third shift drills 03/31/11 at 5:00 a.m., 06/05/11 at 4:15 a.m., 09/27/11 at 6:05 a.m.. The similarly timed fire drill records were acknowledged by the interim</p>	K0050	<p>K 50 Required Fire Drills To promote safety is a primary focus of this facility. No residents were affected by this finding. Corrective measures will address those residents with the potential to have been affected by this practice. It is the policy of this facility to conduct at least quarterly unexpected fire drills on each shift to assure staff is familiar with the procedures. Plans to schedule upcoming drills with less similarity of hours from this time forward will include various times and conditions for each of the three shifts. Competent employees who are qualified to exercise leadership of the unannounced drills were made aware of the expectation to select varying times and conditions on each shift. The Administrator will review the schedule and audit the monthly fire drill reports to ensure 3 of the 3 shifts are timely as required by this regulation. Completion date for the above corrective</p>	03/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>maintenance supervisor at the time of record review and confirmed by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>		measures: March 30, 2012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0062 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>1. Based on observation and interview, the facility failed to ensure 16 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect any residents using the Main Hall, the Long Hall, and the L Hall, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/22/12 during a tour of the facility with the interim maintenance supervisor from 11:00 a.m. to 3:25 p.m., the following area sprinkler escutcheons were not tight fitting to the drywall ceiling leaving between an 1/8 inch and 1/2 inch gap between the area and the attic space above; the sprinkler in the corridor outside the administrator office, the sprinkler in the corridor outside the dietary storage room, three sprinklers in resident room 82, the sprinkler in the corridor outside resident room 82, the sprinkler in resident room 70 bed above bed 1, both sprinklers in resident room 63, and the sprinkler in the activity storage room. Furthermore, the following area sprinklers were missing an</p>	K0062	<p>K 0062 Sprinkler System No one was affected by this finding. The corrective action will address those residents, staff, and visitors with the potential to have been affected. The 16 of over 300 sprinkler heads listed as mssing sprinkler excutcheons or not being tight fitting to prevent gaps have all been maintained again to ensure each one is in reliable operating condition. The remainder of sprinklers were also inspected to assure all other heads are functional. The 2 of 12 sprinkler heads in the kitchen covered with corosion are scheduled to be replaced. The remainder of the sprinkler heads in the kitchen were inspected to make certain all others are free of corrosion and also in reliable operating condition. Maintenance will continue to monitor daily, inspect annually, and implement modifications as needed to support fire prevention and safety. Routine sprinkler system inspection is scheduled with Safecare April 5, 2012. Completion date for above corrective actions: 04/20/2012.</p>	04/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>escutcheon; the sprinkler in the dietary office, the sprinkler in the kitchen outside the walk in cooler, the sprinkler in the dietary storage room, the sprinkler in the beauty shop, the sprinkler in resident room 68, and the sprinkler in the attic access panel room across from the receptionist office.</p> <p>The sprinkler escutcheons not being tight fitting and missing were acknowledged by the interim maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 2 of 12 sprinklers in the kitchen covered in green corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect the residents, staff and visitors who use the main dining room located adjacent to the kitchen.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Findings include:</p> <p>Based on observation during a tour of the kitchen with the interim maintenance supervisor on 03/22/12 at 11:15 a.m., the two sprinklers in the kitchen outside the walk in cooler were covered with green corrosion. This was verified by the interim maintenance supervisor at the time of the observation and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K0067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/22/12 during a tour of the facility from 10:00 a.m. to 3:30 p.m. with the interim maintenance supervisor, all rooms in the facility used the egress corridors as a return air system. This was verified by the interim maintenance supervisor at the time of observations and confirmed by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>	K0067	K 0067 Heritage House of Greensburg respectfully requests a continuing waiver be granted for this deficiency. PLEASE SEE ATTACHMENT A AND THE ANNUAL LIFE SAFETY CODE WAIVER REQUEST FORM FOR YOUR REVIEW AND CONSIDERATION.	04/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K0069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review, interview and observation; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.</p>	K0069	<p>K0069 Cooking facilities 1. This facility is dedicated to provide a safe and clean environment for residents, staff, and visitors. There was no one affected by the finding. The corrective actions will address anyone who is in the vicinity of the kitchen and has the potential to be affected by this deficiency. The certified company who cleans our kitchen exhaust system has been contacted to increase the frequency of their services from annual to at least semi-annual inspections or as needed from this time forward. Their next visit has been moved up to April 19, 2012 and again in 6 months. Timely Range Hood Suppression System Inspection Reports will remain on file and available upon request. 2. Our electrician contractor was consulted about an automatic electrical shut off switch to our one of one electric powered cooking stove that connects to the kitchen fire extinguishing system. Upon his reinspection, the electrician did verify that the cook stove is currently tied in to the Ansul System and wired to automatically shut down upon activation when tripped. This makes certain the stove shuts off when the range hood suppression system is activated. The</p>	04/20/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>Based on review of the kitchen range inspection reports on 03/22/12 at 10:30 a.m. with the interim maintenance supervisor, there was no documentation to show the kitchen range hood had been cleaned within the past six months. Furthermore, the only record available for review was a Range Hood Cleaning Report dated 06/09/11 with a block checked on the form indicating this was an annual inspection. Based on observation at 11:45 a.m. during a tour of the facility with the interim maintenance supervisor, there was a sticker on the kitchen range hood which indicated the range hood was cleaned in June 2011 with the next scheduled cleaning due in June 2012.</p> <p>This was verified by the interim maintenance supervisor at the time of observation and confirmed by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>		<p>electrician confirmed when he manually tripped and tested the system then gave his approval this requirement is met. Such breaker will be labled inside the electrical panel room near the kitchen. The Dietary Manager will monitor at least weekly to ensure ongoing compliance. Completion date for the corrective action: 04/20/2012.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>2. Based on observation, record review and interview, the facility failed to ensure 1 of 1 electrically powered cooking stove was provided with an automatic electrical shut off switch connected to the kitchen fire extinguishing system. NFPA 96 at 7-4.1 requires upon activation of any fire extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice could affect all residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on review of the Range Hood Suppression System Inspection Report dated 06/09/11, which occurred on 03/22/12 at 10:45 a.m. with the interim maintenance supervisor, the report did not indicate the kitchen electric stove was electrically wired to shut off when the range hood suppression system was activated. Based on observation on 03/22/12 at 11:15 a.m. with the interim maintenance supervisor, the range hood suppression system's stainless steel enclosure in the kitchen did not have an electrical connection wired to the kitchen electric stove nor was any type of electrical shut off switch visible near or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>behind the kitchen stove area. This was verified by the interim maintenance supervisor at the time of observation and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 57 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any residents who could use the activity room hand wash sink.</p> <p>Findings include:</p> <p>Based on observation with the interim maintenance supervisor at 1:50 p.m. on 03/22/12, the electric receptacle within one foot of the activity room hand wash</p>	K0147	<p>K 147 Electrical wiring and equipment It is the policy of this facility to practice safety at all times. The corrective action will protect those residents and staff using the activity room sink who may have the potential to be affected. No one was harmed by this finding. Installation of a ground fault circuit interrupter (GFCI) will provide safety to both the main hall electrical panel room and the one electrical receptable outlet near the activity room sink. All 57 wet locations designated as resident care areas are safe with GFCI protection against electric shock. Maintenance monitors safety of the facility through routine daily rounds and will observe for any other electrical outlets that may similarly necessitate the replacement of a standard outlet with a GFCI protected outlet. The completion date for the above corrective action: 04/20/2012.</p>	04/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>sink was not provided with a ground fault circuit interrupter. Furthermore, the Main Hall main electrical panel was checked and did not have a ground fault circuit interrupter for the activity room electrical outlet near the hand wash sink. This was verified by the interim maintenance supervisor at the time of observation and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 5 of 13 alcohol based hand rub dispensers were not over 1.2 litres in capacity. This deficient practice could affect any residents using the Main Hall, and any residents who reside on the Long Hall and Station 2 Hall.</p> <p>Findings include:</p> <p>Based on observations on 03/22/12 during the tour of the facility from 11:00 a.m. to 3:25 p.m. with the interim maintenance supervisor, kitchen alcohol hand sanitizers located near the exit door to the corridor, the lady's locker room alcohol hand sanitizer located near the hand wash</p>	K0211	<p>K 0211 Alcohol Based Hand Rub (ABHR) Dispensers This facility is dedicated to provide quality of care in a safe and sanitary environment. No residents were found to be affected by this finding. The corrective measures will address those residents using the main, long, and Station 2 halls with the potential to have been affected by this practice. Each of the 5 alcohol based hand rub dispensers found to be oversized have been removed and replaced with containers no greater than 1.2 liters in capacity. The remainder 8 of 13 ABHR containers were also verified to be at or less than 1.2 liters in capacity. The nursing supply clerk will monitor through weekly inventory, and the Administrator</p>	03/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155210	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PARK RD GREENSBURG, IN 47240
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>sink, the Long Hall alcohol hand sanitizer located at the nurses station, the Long Hall alcohol hand sanitizer mounted on the treatment cart and the Station 2 alcohol hand sanitizer located in the corridor outside the classroom were each 1.6 litre sized containers, which was written on the side of each container. This was verified by the interim maintenance supervisor at the time of observations and acknowledged by the Director of Nursing at the 3:30 p.m. exit conference on 03/22/12.</p> <p>3.1-19(b)</p>		<p>will verify to make certain future orders placed for alcohol based hand rub refills and dispensers are not greater than the maximum capacity allowed by this requirement. Completion Date for the above corrective measures: 03/27/2012</p>	