STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805	

(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
K010000	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). Survey Date: 04/24/14 Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Heritage Park 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. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms on the 200 hall. The	K010000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the proveder determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should lbe considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after May 16, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 180 and had a census of 161 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one shed used for the maintenance office and general storage and an additional shed used for maintenance storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/29/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 1. Based on observations and interview, the facility failed to ensure 2 of 2 single fire barrier doors were provided with the appropriate fire protection rating for the location in which they are installed. LSC 7.2.4.3.4 requires openings in fire barriers comply with LSC 8.2.3.2.3.1 which requires 3/4 hour doors in 1 hour fire barriers. This deficient practice	K010044	It is the practice of this provider to ensure fire rating requirements are met and fire doors latch securely. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:No residents were found to have been affected.How will you identify other residents having the potential to be affected	05/16/2014

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	could affect 23 residents in the 200 hall. Findings include: Based on an observation with the Administrator and the Maintenance Supervisor on 04/24/14 at 1:36 p.m., the corridor door to the 200 hall shower room and resident room 200 were 20 minute fire rated doors. After checking in the attic the Maintenance Supervisor confirmed both 20 minute fire rated doors were in a one hour fire rated wall entering the 200 hall. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 10 residents in the 600 hall.		by the same deficient practice:Residents living in the facility have the potential to be affected by the deficient practice.What changes will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:New doors have been ordered and are specificied with a 90-minute fire rating. They will be installed upon arrival.Closers were adjusted to the 600 hall doors and a new door coordinator has been purchased. The coordinator will be installed upon arrival to the facililty.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Preventative Maintenance Documentation Log will submitted/reviewed by the governing CQI Committee monthly. Any non-compliance will result in disciplinary action up to and including termination.	

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	Findings include: Based on observation with the Maintenance Supervisor on 04/24/14 at 2:36 p.m., the 600 hall fire door set failed to latch into the frame upon activation of the fire alarm system. Based on an interview with the Maintenance Supervisor at the time of observation, the self closing device needed to be slowed down to allow the doors to latch. 3.1-19(b)			
K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete	K010056	It is the practice of this provider to ensure canopies are fire resistant. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished to those residents found to have	05/16/2014

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	coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or combustible canopies exceeding 4 feet in width. This deficient practice could affect 4 residents in the Therapy gym. Findings include: Based on observation with the Administrator and the Maintenance Supervisor on 04/24/14 at 12:20 p.m., there was an unsprinklered combustible overhang that extends out 46 inches from the building with an attached canvas canopy that extends for an additional 75 feet from the building at the Therapy gym side exit. At the time of observation, the Administrator and the Maintenance Supervisor acknowledged the facility lacked documentation to confirm the canvas canopy was inherently fire resistant. 3.1-19(b)		been affected by the deficient practice:This provider is providing documentation reflecting the canopy is fire resistant as indicated on the "Outdoor Canopy Fire Resistance Documentation". No residents were affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:This provider is providing documentation reflecting the canopy is fire resistant as indicated on the "Outdoor Canopy Fire Resistance Documentation".Residents do not have the potential to be affected by the same deficient practice.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:Any additional canopies purchased and installed at this facility will require the manufacturer provide fire resistant documentation at the time of purchase prior to installation.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The facility will require proof of fire resistance at time of purchase prior to installation	
K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility			

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	wherein 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, 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 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect 30 residents in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 04/24/14 at 1:40 p.m., the mechanical ventilation in the oxygen transfilling/storage room which contained at least four large stationary containers of liquid oxygen was not working. The Maintenance Supervisor confirmed the mechanical vent was not working at the time of observation. 3.1-19(b)	K010143	It is the practice of this provider to ensure oxygen storage areas have appropriate ventilation. However, based on the alleged deficient practice the following has been implemented:The motor in the oxygen exhaust fan in the oxygen storage room has been replacedWhat corrective action(s) will be accomplished to those resident found ot have been affected by the deficient practice:No residents were affected by the deficient practiceHow will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:Residents living in the facility had the potential to be affected by the deficient practice- but no other residents were affected.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The motor in the oxygen exhaust fan	05/16/2014

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			in the oxygen storage room has been replacedHow the corrective action(s) will be monitored to ensure the deficient practice will not recur:The Preventative Maintenence Manual includes an audit to be completed monthly. Results will be presented to the governing CQI committee. Non-compliance will result in disciplinary action.	