STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(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	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: 05/01/12 Facility Number: 000035 Provider Number: 155089 AIM Number: 100266250 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Heritage House of New Castle 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. There were no smoke detectors in resident sleeping rooms.	K0000	Preparation and/or execution of This Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Heritage House of New Castle of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws. Heritage House desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 7, 2012	

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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	The facility has a capacity of 95 and had a census of 68 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/04/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	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 Based on observation and interview, the facility failed to ensure the corridor doors to 4 of 8 storage rooms used for storage of combustible items and measuring 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 using the therapy room, any residents using the main dining room located adjacent to the kitchen, and 24 residents who reside on the Southeast Hall. Findings include: Based on observations on 05/01/12 during a tour of the facility from 9:00 a.m. to 12:00 p.m. with the administrator and maintenance supervisor, the door to each of the following rooms lacked a self closing device: the therapy storage room	K0029	K 029 1. The corridor doors of the therapy storage room, No. hall housekeeping closet, kitchen food storage, and So. Biohazard storage room all have had a self closing device installed, these doors automatically close and latch into the door frame. There were no residents affected. 2. There are no other residents at risk as all rooms used for storage of combustible items and measuring over 50 sq. ft. in size are provided with self closing devices which cause the doors to automatically close and latch into the frame. 3. All rooms used for storage of combustible items and measuring over 50 sq. ft. in size are provided with self closing devices which cause the doors to automatically close and latch into the frame. The maintenance supervisor will monitor all combustible storage rooms to ensure that automatic closers remain in place.	05/02/2012

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	which measured one hundred twenty square feet, the North Hall housekeeping supply room which measured one hundred twenty square feet in size, the kitchen food storage room which measured four hundred square feet, and the Southeast Hall biohazard storage room which measured one hundred twenty square feet, each had combustible storage consisting of cardboard boxes of resident clothing, cardboard boxes of paper and plastic supplies, wooden tables, mattresses, and cardboard boxes of food stored in each room. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)		4. The maintenance supervisor will quarterly check all combustible storage rooms to ensure that automatic closers remain in place. He will report his findings to the QA Committee quarterly for 6 mo. semi-annually for 6 mos. Any recommendations will be followed. Completed 5/2/2012.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K0144	K144 1. The maintenance supervisor will inspect the generator weekly and exercise under load for 30 min. per month. There were no resident affected negatively by this issue. 2. All residents had the potential to be affected by this practice but none were negatively affected by this issue. The maintenance supervisor will inspect the generator weekly and exercise under load for 30 min. per month. 3. The maintenance supervisor will inspect the generator weekly and exercise under load for 30 min. per month and keep a written record of such. See attachment #1. 4. The maintenance supervisor will inspect the generator weekly and exercise under load for 30 min. per month and keep a written record of such. He will report to the QA Committee quarterly for 6 mo. and semi-annually for 6 months of his findings. Any recommendations will be followed. Completed by5/7/2012.	05/07/2012

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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF NEW CASTLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1023 N 20TH ST NEW CASTLE, IN 47362	

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	Based on record review with the maintenance supervisor and administrator on 05/01/12 at 9:00 a.m., there was no record of weekly storage battery inspections and weekly inspections of the generator set for the first week of May 2011, the last week of June 2011, and the months of July 2011, August 2011, September 2011, October 2011, November 2011, December 2011, January 2012, February 2012, March 2012, and April 2012. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify the missed weekly inspections of the generator and storage battery were conducted. 3.1-19(b)			