STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING -- B. WING	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF HUNTINGTON	1180 WEST 500 NORTH HUNTINGTON, IN 46750

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/27/25 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 At this Emergency Preparedness survey, Heritage Pointe of Huntington was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 78 and had a census of 71 at the time of this survey. Quality Review conducted on 01/29/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/27/25 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 At this Life Safety Code survey, Heritage Pointe of Huntington was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodie Stanley	Health Facility Administrator	02/17/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 (III) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 78 and had a census of 71 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review conducted on 01/29/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress for 1 of over 5 exit doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 12 staff, residents and visitors when needing to exit the facility. Findings include: Based on observations and interview during a tour with the Administrator (AD) and Director of	K 0222	**Immediate action(s) taken for the resident(s) found to be affected include:** On 1/27/25, the correct code was posted on the exit door across from the Riser room in rehab (Exhibit A) **Identification of other residents having the potential to be affected was accomplished by:** All residents, staff and visitors have the potential to be affected by not having a code or correct code posted on keypad exit doors. **Actions taken/systems put into place to reduce the risk of future occurrences include:**	01/28/2025

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	Maintenance (DM) on 01/27/25 between 1:20 p.m. and 4:00 p.m., the exit door across from the Riser Room had a code posted which was incorrect. In other locations, the posted code was deemed too challenging to figure out in the event of an emergency as the print was very small or there was a mixture of Roman and Standard numerals. The MD stated that the former Maintenance professional had posted the codes in a form that made it challenging to decipher. This finding was acknowledged by the AD and DM at the time of observation and again at the exit conference. 3.1-19(b)		On 1/28/25, all coded exit doors were audited and any posted code that was not easy to decipher was changed to be less challenging (roman numerals removed) **How the corrective action(s) will be monitored to ensure the practice will not recur:** A log had been created listing all the egress doors operating on a keypad in the building. Each month, the Director of Maintenance or designee will complete an audit ensuring all keypads have the correct code posted on the exit. Any ill findings with the monthly audit will be presented to the Quality Assurance Committee for discussion and review. (Exhibit B)	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 stove/oven in the therapy area. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met.	K 0324	**Immediate action(s) taken for the resident(s) found to be affected include:** The Director of Maintenance immediately contacted a contractor to install a lock switch and timer on the stove in the therapy gym. The contractor visited the facility on 1/31/25 to review the project and ensure appropriate parts were ordered for the work. **Identification of other residents having the potential to be affected was accomplished by:** The deficient practice could affect	02/11/2025

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	19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could impact at least 10 residents and staff. Findings include: Based on observations and interview during a tour with the Administrator (AD) and Director of Maintenance (DM) on 01/27/25 between 1:20 p.m. and 4:00 p.m., there was a cooktop stove/oven in the therapy area. Based on interview at the time of observation, the Maintenance Director stated there was not a disconnect for the appliance. Ranges in other locations in the facility had 'timer shut-off devices' but the aforementioned location did not have such a timer shut-off device. The AD stated the range in the Therapy Area had a rehab to home type usage. This finding was acknowledged by the AD and DM at the time of observation and again at the exit conference. 3.1-19(b)		all residents, staff, and all visitors in the facility. **Actions taken/systems put into place to reduce the risk of future occurrences include:** A lock switch and timer were installed by a licensed contractor on the stove in the therapy gym on February 7, 2025. (Exhibit C and D) **How the corrective action(s) will be monitored to ensure the practice will not recur:** If additional cooktop stove/ovens are installed in the skilled nursing facility, the Director of Maintenance will ensure that they are also installed with a lock switch and timer	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility	K 0351	**Immediate action(s) taken for**	02/27/2025

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	failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 smoke compartment. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3. Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect up to 10 residents staff and visitors. Findings include: Based on observations and interview during a tour with the Administrator (AD) and Director of Maintenance (DM) on 01/27/25 between 1:20 p.m. and 4:00 p.m., the corridor in front of the main Nurses Station was equipped with quick response sprinkler heads and standard response sprinkler heads. This finding was acknowledged by the AD and DM at the time of observation and again at the exit conference. 3.1-19(b)		**the resident(s) found to be affected include:** The Director of Maintenance contacted the contractor who works on our sprinkler system to arrange for the standard response sprinklers in the smoke compartment by the main nurse's station to be switched out to quick response sprinklers. The contractor inspected the sprinklers on February 11, 2025, and will complete the replacement of the standard sprinklers to a quick response sprinklers. A proposal for the work has been signed with the contractor and the work is scheduled to be completed on 2/26/25. (Exhibit e and F) **Identification of other residents having the potential to be affected was accomplished by:** All residents, visitors and staff have the potential to be affected by the deficient practice. **Actions taken/systems put into place to reduce the risk of future occurrences include:** The Director of Maintenance and contractor did an inspection of all facility smoke compartments to ensure that only one type of sprinkler was installed throughout each smoke compartment. Thirteen additional dry pendant heads (standard sprinklers) were identified as needing to be replaced to have the same type of sprinkler head in each smoke compartment. The signed work	

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			proposal indicates the replacement of sprinklers will be completed and weather conditions are favorable (above freezing) **How the corrective action(s) will be monitored to ensure the practice will not recur:** Anytime a sprinkler head is switched out in the facility, the Director of Maintenance will communicate the type of sprinkler that must be installed and will do a visual inspection to confirm after installation that the correct sprinkler is in place. The Director of Maintenance does an ongoing monthly visual inspection of sprinkler heads, monitoring of sprinkler type will be done during the monthly inspection.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 3 of 5 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include:	K 0353	**Immediate action(s) taken for the resident(s) found to be affected include:** The contractor responsible for installing the facility sprinkler system gauges was immediately contacted regarding the outdated gauges. All five gauges in the Rehab Riser Room were replaced with updated gauges on 1/30/25. (Exhibit G - J) **Identification of other residents having the potential to be affected was accomplished by:** The deficient practice could affect all residents, staff, and all visitors	01/31/2025

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	Based on observations and interview during a tour with the Administrator (AD) and Director of Maintenance (DM) on 01/27/25 between 1:20 p.m. and 4:00 p.m., the facility has a supervised dry sprinkler system with 3 of 5 gauges in the Rehab Riser Room that were dated 2019. The remaining two gauges were dated 2020. Based on interview at the time of the observation, the MD stated he was aware of the outdated gauge and all the gauges would be scheduled to be replaced shortly. This finding was acknowledged by the AD and DM at the time of observation and again at the exit conference. 3.1-19(b)		in the facility. **Actions taken/systems put into place to reduce the risk of future occurrences include:** A log has been created by the Director of Maintenance to show each gauge in the building by number and the date in which the gauge needs to be replaced to remain compliant. (Exhibit K) **How the corrective action(s) will be monitored to ensure the practice will not recur:** Annually in November, the Director of Maintenance and Administrator will review the gauge log and determine what gauges in the facility need to be replaced by the end of the year. The Director of Maintenance will work with contractors to ensure that updated gauges are installed in the building before they are considered outdated.	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of 1 Resident Room was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 2 residents and staff. Findings include: Based on observations and interview during a tour with the Administrator (AD) and Director of Maintenance (DM) on 01/27/25 between 1:20 p.m.	K 0753	Removal of the two wicked candles and the facility policy against having candles in the room was discussed with the resident's and family member. The wicked candles were removed from the facility however the candlestick remain on display as they are sentimental to the resident (Exhibit L) **Identification of other residents having the potential to be**	02/03/2025

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	and 4:00 p.m., Resident Room #106 contained two wick burning candles near the entrance to the room positioned on a table along with Christmas cards. The AD agreed that the candles were present and the wicks were evident on the top. This finding was acknowledged by the AD and DM at the time of observation and again at the exit conference. 3.1-19(b)		**affected was accomplished by:** All residents, staff, and visitors have the potential to be affected by the deficient practice. The Environmental Service (EVS) Director inspected all resident rooms to ensure no other candles were in the building. If candles were noted, social service staff contacted the family and spoke with the residents about the facility policy against candles, and all candles have been removed from the building. (Exhibit M) **Actions taken/systems put into place to reduce the risk of future occurrences include:** The facility administrator sent an email to responsible parties informing them of the facility policy of not having candles for decoration. (Exhibit N) The facility administrator spoke with the admission staff member and asked that she emphasize the facility policy on candles when speaking with new admissions and their families. The Environmental Services Director spoke with environmental service staff members and educated then to do visual inspections in resident rooms when cleaning and if candles are noted to notify the director. The EVS director will do ongoing education with new hires in the department. (Exhibit O) **How the corrective action(s) will be monitored to ensure the**	

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			practice will not recur: A monthly audit form has been created to have an inspection of each resident room completed monthly. (Exhibit M) The Environmental Service Director or designee will complete this monthly audit. Findings will be presented to the administrator and social service staff, patterns of noncompliance will be presented to the Quality Assurance committee for discussion and review.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels	K 0921	**Immediate action(s) taken for the resident(s) found to be affected include:** The Director of Maintenance contacted a contractor that completes PCREE testing, all beds were tested and logged on February 11, 2025. (Exhibit P) The facility has also purchased a device used for PCREE testing, an Electrical Safety Analyzer, for future testing of portable patient care equipment. **Identification of other residents having the potential to be affected was accomplished by:** Any resident using portable patient care equipment has the potential to be affected by the deficient practice. **Actions taken/systems put into place to reduce the risk of**	02/11/2025

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	and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include: Based on records review, interview and facility tour with the Administrator (AD) and Director of Maintenance (DM) on 01/27/25 between 10:10 a.m. and 1:20 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The AD stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the AD and MD stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the AD and DM at the time of discovery and again at the exit conference with each present. 3.1-19(b)		**future occurrences include:** A policy has been developed for the facility on PCREE testing. Maintenance manuals have been updated with this policy (Exhibit Q) PCREE testing will be completed on any new facility acquired portable patient care equipment before putting into use or following repairs on portable patient care equipment, a log will be kept of this testing. The facility received confirmation from the vendor who supplies their respiratory equipment that they do appropriate testing on their equipment before putting it into service at the facility. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Once the baseline testing of all facility patient portable equipment is completed, the testing results will be logged. Upon any repairs to the facility owned patient portable equipment, the PCREE testing will be completed and logged before putting the equipment back into service. Any ill findings related to the PCREE testing will be presented to the Quality Assurance committee for review.	

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