STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
			î ´	JIND I RUCTION	í í	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155705	B. WING		04/01/2024	
	ROVIDER OR SUPPLIER		STREET A 801 N H WARRI			
OVA ID	CID D (A DV)	CT A TEN CENTE OF DEFICIENCE	_	ī		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000 Bldg	A., F.,		F 0000	Discourant distributed		
		paredness Survey was	E 0000	Please accepted the included		
	-	diana Department of Health in		Plan of Correction as credible		
	accordance with 42	CFR 483.73.		allegation of compliance for th	е	
	Survey Date: 04/01	/24		deficiencies cited during our annual Life Safety Code Survey conducted on April 1, 2024. We		
	Facility Number: 00	00542		hope you will find our remedie	s	
	Provider Number: 1	55705		both thorough and just in the		
	AIM Number: 1002	267380		resolution of the cited		
				deficiencies. We would like to	1	
		Preparedness survey, Heritage		respectfully request paper		
		as found in not compliance		compliance.		
		eparedness Requirements for				
	Medicare and Medi	caid Participating Providers				
	and Suppliers, 42 C	FR 483.73. The facility has a				
	capacity of 119 and	had a census of 79 at the time				
	of this survey.					
	-	npleted on 04/03/24				
	Quality Review con	mpleted on 0 1/05/21				
E 0039 SS=F	, , , ,	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),				
Bldg	. , , ,	102(d)(2), 485.625(d)(2),				
Blug	, , , ,					
	` , ` , `	727(d)(2), 485.920(d)(2),				
	. , , ,	1.12(d)(2), 494.62(d)(2)				
	EP Testing Requir					
	. , , , .	18.113(d)(2), §441.184(d)(2),				
		32.15(d)(2), §483.73(d)(2),				
	. , , , ,	484.102(d)(2), §485.68(d)(2),				
		485.727(d)(2), §485.920(d)				
	(2), §491.12(d)(2)	, §494.62(d)(2).				
	#r= 400	0.54.0005				
	-	6.54, CORFs at §485.68,				
OPO, "Organizations" under §48		<u> </u>				
	CMHCs at §485.920, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Terrence Jent Executive Director 04/22/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6B5O21 Facility ID: 000542 If continuation sheet Page 1 of 21

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155705	ILDING	NSTRUCTION	(X3) DATE COMPL 04/01/	ETED
	PROVIDER OR SUPPLIER		801 N H	DDRESS, CITY, STATE, ZIP COD IUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(2) Testing. The [t exercises to test t	facility] must conduct he emergency plan illity] must do all of the				2
	community-based (A) When a commot accessible, confunctional exercise. (B) If the [faction natural or man-materization of the exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, opeon functional exercion include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exempted by a facilitation discussion using a clinically-relevant set of problem star messages, or preto challenge an encommunity exercises, and enthe [facility's] emetals.	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed.				
	*[For Hospices at (2) Testing for ho	418.113(d):] spices that provide care in				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet Page 2 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155705	ľ í	JILDING	NSTRUCTION	COMPL 04/01/	ETED
	F PROVIDER OR SUPPLIEF AGE POINTE OF WA			801 N H	ddress, city, state, zip cod IUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emerg of the emergency exempt from engascale community-facility-based functional exercise of the emer (ii) Conduct an advears, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an er (3) Testing for hose care directly. The exercises to test to per year. The hose (i) Participate in a that is community	nunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Idditional exercise every 2 ee year the full-scale or ender paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group an narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. Ispices that provide inpatient thospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 3 of 21

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155705		JILDING	NSTRUCTION	(X3) DATE COMPI 04/01	LETED
	OF PROVIDER OR SUPPLIE TAGE POINTE OF WA		STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	accessible, condu- facility-based fund (B) If the hospice man-made emerge of the emergency exempt from enga- full-scale community-based functional exercise emergency event (ii) Conduct an arthat may include, following: (A) A second full- community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena- statements, direct questions designe emergency plan. (iii) Analyze the h maintain document exercises, and en the hospice's emergency *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community (A) When a communicessible, condu-	act an annual individual ctional exercise; or experiences a natural or pency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the escale exercise that is for a facility based e; or eter drill; or ercise or workshop led by a udes a group discussion clinically-relevant erio, and a set of problem ted messages, or prepared ed to challenge an enospice's response to and entation of all drills, tabletop ergency events and revise ergency plan, as needed. 441.184(d), Hospitals at as 48485.625(d):] PRTF, Hospital, CAH] must as to test the emergency exercise exercise exercise exercise.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet Page 4 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIEF		801 N I	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	l ' '	lospital, CAH] experiences			
		or man-made emergency			
	-	ation of the emergency			
		s exempt from engaging in			
	1	ull-scale community based			
		ty-based functional exercise			
	T	t of the emergency event.			
		an [additional] annual at may include, but is not			
	limited to the follow				
		scale exercise that is			
	community-based				
		tional exercise; or			
		ck disaster drill; or			
	, ,	exercise or workshop that			
		or and includes a group			
	discussion, using	- -			
	_	emergency scenario, and a			
	set of problem sta	tements, directed			
	messages, or pre	pared questions designed			
	to challenge an er	nergency plan.			
		ne [facility's] response to			
		ımentation of all drills,			
	· ·	, and emergency events			
		cility's] emergency plan, as			
	needed.				
	*[For PACE at §46	60.84(d):]			
	(2) Testing. The P	ACE organization must			
	conduct exercises	to test the emergency			
	plan at least annu	-			
	organization must	-			
		ın annual full-scale exercise			
	that is community				
	1 ' '	unity-based exercise is not			
		ct an annual individual,			
	facility-based fund				
	1 ' '	rperiences an actual natural			
		ergency that requires			
	activation of the e	mergency plan, the PACE			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIER GE POINTE OF WA		801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	is exempt from en full-scale community-based functional exercise of this section is of this section in this section is of this section is of this section in this section	gaging in its next required ity based or individual, tional exercise following the gency event. In additional exercise every the year the full-scale or exercise under paragraph (d)(2)(i) conducted that may include, to the following: Is cale exercise that is or individual, a facility exercise; or the dill; or exercise or workshop that is and includes a group an anarated, emergency scenario, and a tements, directed pared questions designed energency plan. In ACE's response to and externation of all drills, tabletop exercise years and revise gency plan, as needed. It is at §483.73(d):] It				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet

Page 6 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		A. BUILDING COMPLETE B. WING 04/01/202			ETED		
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
HERITA	GE POINTE OF WA	RREN			EN, IN 46792		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION lle community-based or		TAG	DEFICIENCY		DATE
		based functional exercise					
		et of the emergency event.					
	(ii) Conduct an ad	dditional annual exercise					
	_	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	I	or an individual, facility					
	based functional e	·					
	(B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is led by a facilitator includes a group						
	discussion, using						
		emergency scenario, and a					
	set of problem sta	•					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the [I	LTC facility] facility's					
	response to and n	naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	· · · -					
	` '	CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:	n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ict an annual individual,					
		ctional exercise; or.					
	-	experiences an actual					
		ade emergency that requires					
	activation of the e	mergency plan, the ICF/IID					
	is exempt from en	gaging in its next required					
		nity-based or individual,					
	,	ctional exercise following the					
	onset of the emer	gency event.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet

Page 7 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIER		801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
IAU	(ii) Conduct an ad that may include, following: (A) A second full-scommunity-based facility-based function (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or pretochallenge an erection (iii) Analyze the IC maintain documer exercises, and emaintain documer exercises to test the ICF/IID's emerity (I) Participate in a community-based (A) When a cois not accessible, individual, facility-levery 2 years; or. (B) If the HH. natural or man-material or	tional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed energency plan. EF/IID's response to and entation of all drills, tabletop ergency events, and revise engency plan, as needed. EA-102] E-HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is gor community-based exercise conduct an annual based functional exercise. A experiences an actual and emergency plan, the HHA is ging in its next required ity-based or individual, tional exercise following the			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet

Page 8 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705 AND PLAN OF CORRECTION IDENTIFICATION NUMBER B. WING			COMPLETED 04/01/2024			
	OF PROVIDER OR SUPPLIEF		801 N H	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	(A) A second community-based facility-based function (B) A mock d (C) A tableton is led by a facilitat discussion, using clinically-relevant set of problem states messages, or preto challenge an er (iii) Analyze the H maintain documer exercises, and em the HHA's emerged *[For OPOs at §48 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency problem statement prepared question emergency plan. It actual natural or not require activation opolicy exempt for required testing exercises, and emergency (ii) Analyze the Olicy maintain documer exercises, and emergency set of the emergency (iii) Analyze the Olicy maintain documer exercises, and emergency exercises, and emergency exercises, and emergency exercises.	limited to the following: full-scale exercise that is lor an individual, ctional exercise; or isaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop nergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of nts, directed messages, or ns designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet

Page 9 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ĺ	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
		155705	B. WI			04/01/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	exercises to test til RNHCI must do th (i) Conduct a pape at least annually, a group discussion i narrated, clinically scenario, and a se directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCI's emel Based on record rev failed to conduct ex plan at least twice p unannounced staff o procedures. The LT following: (i) Participate in an is community-based a. When a commun accessible, conduct facility-based funct b. If the LTC facilit or man-made emerg of the emergency pl from engaging its n community-based o full-scale functional the onset of the actu (ii) Conduct an add include, but is not li a. A second full-scal	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency er year, including drills using the exercise that d; or ity-based exercise is not an annual individual, ional exercise. The exercise an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based I exercise for 1 year following tal event. itional exercise that may timited to the following: the exercise that is or an individual, facility-based	E 00	039	The community has experience weather emergencies in 2024 where the emergency plan was activated. To ensure continue compliance, the community is working with local emergency management agencies, provide and community stakeholders to plan a qualifying exercise tentatively scheduled for summe 2024. The annual review of the emergency preparedness plan been completed for 2024. The QAPI committee will continue participate in and review emergency preparedness processes and procedures.	s ders, o mer ne n has	05/03/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet

Page 10 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIE		801 N	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	c. A tabletop exerce facilitator that inche a narrated, clinical and a set of problet messages, or prepare challenge an emergent (iii) Analyze the L'maintain document exercises, and eme LTC facility's eme accordance with 42 deficient practice of Findings include: Based on records represent to the problem of the process of the problem	TC facility's response to and tation of all drills, tabletop regency events, and revise the regency plan, as needed in 2 CFR 483.73(d)(2). This could affect all occupants. eview with the Maintenance 24 at 10:12 a.m., there was community drill on 4/05/23 but of an additional exercise of idable for review. Based on an one of records review, the event of the total stated a second drill of adducted in the last year.	TAG	DEFICIENCY	DATE	
K 0000						
Bldg. 01	Licensure Survey S	1/24 000542 155705	K 0000	Please accepted the included Plan of Correction as credible allegation of compliance for the deficiencies cited during our annual Life Safety Code Surve conducted on April 1, 2024. A hope you will find our remedies both thorough and just in the resolution of the cited deficiencies. We would like to	e ne ey We es	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet

Page 11 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		r í	JILDING	onstruction 01	(X3) DATE COMPL 04/01	ETED	
	PROVIDER OR SUPPLIER			801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	of Warren was foun Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L Care Occupancies at This two story facil was determined to be and was fully sprint alarm system with secorridors and areas wired smoke detect resident rooms. The and had a census of All areas providing sprinklered. All area were sprinklered ex for the storage of th trucks, mowers, sno	the time of this survey. 1, 42 CFR Subpart 483.90(a), and the 2012 edition of the etion Association (NFPA) 101, and 410 IAC 16.2. 1, 2, 3, 41 Color of the etion Association (NFPA) 101, and 410 IAC 16.2. 1, 2, 3, 41 Color of Type I (332) construction and the etion of Type I (332) construction and the etion of the corridors. Hard for were provided in the etion of the etion of this survey. 1, 2, 42 CFR Subpart 483.90(a), and the etion of this survey. 1, 2, 42 CFR Subpart 483.90(a), and the etion of the et			respectfully request paper compliance.		
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to emergency, unles	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means auously maintained free of full use in case of s modified by 18/19.2.2					
	emergency, unles through 18/19.2.1 18.2.1, 19.2.1, 7.1	1.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21

Facility ID: 000542

If continuation sheet

Page 12 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2024		
	PROVIDER OR SUPPLIER		80	1 N HUI	ORESS, CITY, STATE, ZIP COD NTINGTON AVE , IN 46792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on observation failed to ensure 2 of were continuously robstructions. This direction in two fresidents on in two frindings include: Based on observation Director on 04/01/2 p.m., the exit corridustation contained set taking up two feet of interview at the time Maintenance Direct stored in the exit corremoved.	on and interview, the facility C12 corridor means of egresses maintained free of eficient practice affects 50 smoke compartments. on with the Maintenance 4 between 11:30 a.m. and 1:00 ors by the 1-A and 2-B nurses' ales and a towel warmer of corridor width. Based on an e of observations, the or agreed there were items rridor and the items were	K 0211	o c c o o 1 1 ir 2 2 tt d d h re c c 4 4 a a tt d d te w tt w m n 5	is the policy of Heritage Point Warren to ensure the exit orridors are maintained free obstructions. The obstructions were mediately removed. All residents on the hall have potential to be affected by deficient practice. To ensure the deficient practice of the possible for halls and orridors. To monitor corrective action and ensure continued compliance Maintenance Director, or lesignee, will complete the Quot titled "LSC POC 4.20.24" weekly for 4 weeks and as new preedings. All systemic changes will be completed by 5/3/2024.	of ve the ctice aff ess ance, his A eded tee	05/03/2024
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security need, only one locking are required.	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: S OR SECURITY THREAT king arrangements for the leds of the patient are king device shall be door and provisions shall					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 13 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		A. B	A. BUILDING <u>01</u> B. WING		COMPLETED 04/01/2024	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP COD		
HERITA	GE POINTE OF WA	RREN			EN, IN 46792		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		apid removal of occupants					
		l of locks; keying of all					
		ied by staff at all times; or					
	other such reliable	e means available to the					
	staff at all times.						
	18.2.2.2.5.1, 18.2	.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
	· ·	king arrangements for the					
	-	e patient are used, all of					
		curity Locking requirements					
	_	addition, the locks must be					
		at fail safely so as to					
		of power to the device; the ed by a supervised					
		er system and the locked					
	· ·	by a complete smoke					
		(or is constantly monitored					
	· ·	ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
	Approved, listed d	lelayed-egress locking					
		in accordance with					
	7.2.1.6.1 shall be	•					
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2						
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies lance with 7.2.1.6.2 shall					
	be permitted.	iance with 1.2.1.0.2 Shall					
	pe permitted.						1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
155705		B. WING 04/01/2024			/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIEF	{		801 N F	HUNTINGTON AVE		
HERITAC	GE POINTE OF WA	RREN		WARR	EN, IN 46792		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	18.2.2.2.4, 19.2.2	.2.4 BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.	ood datomatic opinimo					
	18.2.2.2.4, 19.2.2	.2.4					
		on and interview, the facility	K 0	222	It is the policy of Heritage Poir	nte	05/03/2024
	failed to ensure the	means of egress through 1 of			of Warren to ensure a means		
	3 exit doors on the	hall-2A were readily accessible		egress through all exit doors			
	for residents withou	nt a clinical diagnosis requiring			1. Missing codes were printed	and	
	specialized security	measures. Doors within a			immediately placed on doors		
	required means of e	egress shall not be equipped			where they were missing.		
		that requires the use of a tool			2. All residents on the hall hav	е	
		ess side unless otherwise			the potential to be affected by	the	
		9.2.2.2.4. Door-locking			deficient practice.		
		be permitted in accordance			3. To ensure the deficient prac		
		This deficient practice could			doesn't recur, maintenance sta		
	affect over 20 resid	ents on hall-2a.			have been in-serviced on egre	ess	
	Findings include:				requirements for doors with mechanical latches or locks. 4. To monitor corrective action		
	Based on observation	on with the Maintenance			and ensure continued complia		
		44 at 12:33 p.m., the exit door on			the Maintenance Director, or h		
		ator were marked as a facility			designee, will complete the Q		
	-	ally locked, and could be			tool titled "LSC POC 4.20.24"	•	
	_	a four-digit code on the			weekly for 4 weeks and as nee	eded	
		but the code was not posted			thereafter. The QAPI committ		
	• .	n interview at the time of			will review findings at schedule		
		nintenance Director agreed the			meetings.		
		it door was not posted by the			5. All systemic changes will be	;	
	access control pad.				completed by 5/3/2024.		
	This find:	viewed with the M-inter					
	This finding was re Director at the exit	viewed with the Maintenance					
	Director at the exit	comerciac.					
			1		Ī.		ī

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155705	B. Wl	NG	04/01/	04/01/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE OF WARREN			<u> </u>	801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	3.1-19(b)						
K 0345 SS=F Bldg. 01	3.1-19(b) NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are readed and testing are readed on record reversity failed to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual insped accordance with the more often if requirily jurisdiction. Table must be visually insurance and testing devices fire alarm boxes, he etc.) d. Notification applie. Magnetic hold-op This deficient practifacility. Findings include:	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 1-19(b) FPA 101 ire Alarm System - Testing and laintenance ire Alarm System is tested and maintained accordance with an approved program omplying with the requirements of NFPA 70, ational Electric Code, and NFPA 72, ational Fire Alarm and Signaling Code. ecords of system acceptance, maintenance ind testing are readily available. 6.1.3, 9.6.1.5, NFPA 70, NFPA 72 ased on record review and interview, the facility ailed to maintain 1 of 1 fire alarm systems in ecordance with NFPA 72, as required by LSC 101 ections 19.3.4.5.1 and 9.6. NFPA 72, Section 4.3.1 states that unless otherwise permitted by 4.3.2, visual inspections shall be performed in ecordance with the schedules in Table 14.3.1, or nore often if required by the authority having arisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: Control unit trouble signals. Remote annunciators Initiating devices (e.g. duct detectors, manual re alarm boxes, heat detectors, smoke detectors, ic.) Notification appliances Magnetic hold-open devices his deficient practice affects all occupants in the		345	It is the policy of Heritage Poin of Warren to maintain fire alars systems in accordance with NFPA 72. 1. The fire protection company was immediately contacted an request was made to schedule visual inspection that takes pla 6 months prior to the annual fire alarm inspection. 2. All residents on the hall have the potential to be affected by deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance state have been in-serviced on NFP requirements pertinent to the citation. 4. To monitor corrective action and ensure continued complianthe Maintenance Director, or he designee, will complete the QA	d a e a ace re e the aff A 72 s nce, is	05/03/2024
	During records review with the Maintenance Director on 04/01/24 at 10:00 a.m., no documentation was provided regarding a visual				tool titled "LSC POC 4.20.24" weekly for 4 weeks and as nee thereafter. The QAPI committe		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 16 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIER		801 N I	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	prior to the annual f on 03/14/24. Based records review, the visual inspection of	e alarm system six months fire alarm inspection conducted on interview at the time of Maintenance Director stated a fire alarm system six annual fire alarm inspection		will review findings at schedul meetings. 5. All systemic changes will be completed by 5/3/2024.	
	This finding was red Director at the exit	viewed with the Maintenance conference.			
	3.1-19(b)				
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with North Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR	<u>.</u>			
	automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to maintain the storage rooms with trap hot air and gase cause the sprinkler to	r system.	K 0353	It is the policy of Heritage Poir of Warren to maintain ceiling construction in all storage room with roof access. 1. The hatch area has been framed in.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 17 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2024			
	PROVIDER OR SUPPLIER SE POINTE OF WA		STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI			(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION en the sprinkler deflector and	 	TAG	2. All residents on the hall have		DATE
	the ceiling above sh type of sprinkler and	nall be selected based on the did the type of construction.			the potential to be affected by deficient practice. 3. To ensure the deficient practice.	the	
	smoke compartmen Findings include:	t.			doesn't recur, maintenance staff have been in-serviced on NFPA 13, 2010 edition, 8.5.4.11.		
	Based on observation with the Maintenance Director on 04/01/24 at 12:20 p.m., in the 2-B linen room there was no hatch cover around the ladder access to the roof and was exposed to the roof hatch about seven feet above the ceiling. This condition could delay the activation of the sprinklers installed on the ceiling. Based on an interview at the time of the observations, the Maintenance Director agreed there were no covering around the ladder opening. This finding was reviewed with the Maintenance Director at the exit conference.				4. To monitor corrective action and ensure continued compliant the Maintenance Director, or high designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as neethereafter. The QAPI committe will review findings at schedule meetings. 5. All systemic changes will be completed by 5/3/2024.	nce, is A eded ee	
K 0361 SS=E Bldg. 01	treatment rooms a waiting areas, nursand cooking facilit in accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation	Open to Corridor an patient sleeping rooms, and hazardous areas), rse's stations, gift shops, ties, open to the corridor are the criteria under 18.3.6.1	K 03	361	It is the policy of Heritage Poin		05/03/2024
	quantity of combust corridor was not use 19.3.6.1(7) states Sp	f 2 lounges with a large tible storage open to the ed as hazardous storage. LSC paces, other than patient atment rooms, and hazardous			of Warren to store combustible items in accordance with LSC 19.3.4. 1. The PPE/covid supplies wer immediately removed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 18 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIER		801 N	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE	
K 0741	areas, shall be perm and unlimited in are corridors which the smoke compartmen electrically supervis system in accordance space is protected be (c) The space does a required exits. This 30 residents. Findings include: Based on observation Director on 04/01/2 was open to the correstore combustible me supplies and plastic on a wing that was a 2-hour separation for This condition does a hazardous storage the time of observation agreed the lounge was no 2-hour separation occupancies, and state the correspondence of the correspondence of the supplies and plastic on a wing that was a 2-hour separation for the correspondence of the supplies and plastic on a wing that was a 2-hour separation for the correspondence of the supplies and state of	itted to be open to the corridor a provided: (a) The space and space opens onto in the same t are protected by an aed automatic smoke detection with 19.3.4, and (b) Each y an automatic sprinklers, and not to obstruct access to deficient practice could affect on with the Maintenance 4 at 12:40 p.m., the 2B lounge ridor and was being used to naterial such as boxes of containers. The lounge was unlicensed but there was not a om the health care occupancy. not protect the corridor from area. Based on interview at ion, Maintenance Director as open to the corridor, there ration from health care ated PPE/covid supplies will wiewed with the Maintenance		2. All residents on the hall had the potential to be affected by deficient practice. 3. To ensure the deficient prodoesn't recur, maintenance is have been in-serviced on the storage of combustible mate 4. To monitor corrective action and ensure continued complete Maintenance Director, or designee, will complete the tool titled "LSC POC 4.20.24 weekly for 4 weeks and as in thereafter. The QAPI commovill review findings at schedule meetings. 5. All systemic changes will completed by 5/3/2024.	actice staff e rials. ons iance, his QA " eeded ittee
SS=E Bldg. 01	Smoking Regulation Smoking Regulation Smoking regulation shall include not lead to provisions:				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/01/2024	
	PROVIDER OR SUPPLIER		801 N I	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	liquids, combustibused or stored and location, and such signs that read NO posted with the intermediate smoking. (2) In health care a smoking is prohibit prominently place secondary signs with smoking shall not. (3) Smoking by paresponsible shall lever the pare supervision. (5) Ashtrays of no safe design shall lever smoking is (6) Metal contained devices into which shall be readily avismoking is permitting 18.7.4, 19.7.4	d at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Intent of 18.7.4(3) shall not satient is under direct attent is under direct and be provided in all areas permitted. In with self-closing cover an ashtrays can be emptied sailable to all areas where sted.	V 0741	It is the policy of Heritage Poi	nto 05/02/2024
	interview, the facili smoking policies and disposed in a non-coself-closing lid. This staff around the smooth B-wing. Findings include: Based on observation	on, records review, and ty failed to enforce 1 of 1 staff and ensure cigarette butt were combustible container with a s deficient practice could affect beking area and 35 residents in ons with the Maintenance 4 between 11:30 a.m. and 1:30	K 0741	It is the policy of Heritage Poi of Warren to enforce smoking policies and ensure cigarette are properly disposed. 1. The area was immediately cleaned by environmental sta Campus will be non-smoking 7/1/2024. 2. All residents on the hall have the potential to be affected by deficient practice. 3. To ensure the deficient pra	butts ff. as of we the
	p.m., staff are not for procedures due to the	ollowing the proper smoke		doesn't recur, maintenance st have been in-serviced on LSC 18.7.4 & 19.7.4.	aff

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6B5O21 Facility ID: 000542

If continuation sheet Page 20 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2024				
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE OF WARREN				STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792					
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION cigarette buts on the ground. b) Inside the building by the door to the smoking area there was a cigarette butt on the floor. c) Outside the 1B courtyard exit (a non-smoking area) there was a pot containing 10 cigarette butts. Based on records review at 10:20 a.m., the smoking policy stated smoking is allowed in posted smoking areas and staff shall follow all state regulations. Based on interview at the time of observation and records review, the Maintenance Director agreed there were cigarette butts on the ground and smoking was taking place in non-smoking areas. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)				4. To monitor corrective action and ensure continued complete the Maintenance Director, or designee, will be a complete to the Maintenance Director, or designee, will be a complete to the Maintenance Director, or designee, will be a complete to the Maintenance Director, or designee, will be a complete to the Maintenance Director, or designee, will be a complete to the Maintenance Director, or designee, will complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or designee, will be a complete the Maintenance Director, or desig	iance, his QA " eeded ittee			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6B5O21 Facility ID: 000542 If continuation sheet Page 21 of 21