STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155705	A. BUILDING -- B. WING	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/01/24 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 At this Emergency Preparedness survey, Heritage Pointe of Warren was found in not compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 119 and had a census of 79 at the time of this survey. Quality Review completed on 04/03/24	E 0000	Please accepted the included Plan of Correction as credible allegation of compliance for the deficiencies cited during our annual Life Safety Code Survey conducted on April 1, 2024. We hope you will find our remedies both thorough and just in the resolution of the cited deficiencies. We would like to respectfully request paper compliance.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	Executive Director	04/22/2024

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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	155705	A. BUILDING -- B. WING	04/01/2024

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in			

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	155705	A. BUILDING -- B. WING	04/01/2024

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	the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE			

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	is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next			

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	required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)			

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	of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	The community has experienced 2 weather emergencies in 2024 where the emergency plan was activated. To ensure continued compliance, the community is working with local emergency management agencies, providers, and community stakeholders to plan a qualifying exercise tentatively scheduled for summer 2024. The annual review of the emergency preparedness plan has been completed for 2024. The QAPI committee will continue to participate in and review emergency preparedness processes and procedures.	05/03/2024

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/01/24 at 10:12 a.m., there was documentation for community drill on 4/05/23 but no documentation of an additional exercise of choice was not available for review. Based on an interview at the time of records review, the Maintenance Director stated a second drill of choice was not conducted in the last year. This finding was reviewed with the Maintenance Director during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/01/24 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380	K 0000	Please accepted the included Plan of Correction as credible allegation of compliance for the deficiencies cited during our annual Life Safety Code Survey conducted on April 1, 2024. We hope you will find our remedies both thorough and just in the resolution of the cited deficiencies. We would like to	

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	At this Life Safety Code survey, Heritage Pointe of Warren was found not in compliance with Requirements for Participation in 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 two story facility with a walk out lower level was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Hard wired smoke detector were provided in the resident rooms. The facility has a capacity of 119 and had a census of 79 at the time of this survey. All areas providing customary access were sprinklered. All areas providing facility services were sprinklered except two detached barns used for the storage of the facility bus, facility cars, trucks, mowers, snow plows and maintenance supplies and another garage used for the storage of the golf cart. Quality Review completed on 04/03/24		respectfully request paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to ensure 2 of 12 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 50 residents on in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 04/01/24 between 11:30 a.m. and 1:00 p.m., the exit corridors by the 1-A and 2-B nurses' station contained scales and a towel warmer taking up two feet of corridor width. Based on an interview at the time of observations, the Maintenance Director agreed there were items stored in the exit corridor and the items were removed. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0211	It is the policy of Heritage Pointe of Warren to ensure the exit corridors are maintained free of obstructions. 1. The obstructions were immediately removed. 2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on egress requirements for halls and corridors. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	05/03/2024
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall			

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	155705	A. BUILDING 01 B. WING	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, IN 46792

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	be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable 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 LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.			

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	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 exit doors on the hall-2A were 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 over 20 residents on hall-2a. Findings include: Based on observation with the Maintenance Director on 04/01/24 at 12:33 p.m., the exit door on hall-2A by the elevator were marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. This finding was reviewed with the Maintenance Director at the exit conference.	K 0222	It is the policy of Heritage Pointe of Warren to ensure a means of egress through all exit doors. 1. Missing codes were printed and immediately placed on doors where they were missing. 2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on egress requirements for doors with mechanical latches or locks. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	05/03/2024

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	3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals. b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 04/01/24 at 10:00 a.m., no documentation was provided regarding a visual	K 0345	It is the policy of Heritage Pointe of Warren to maintain fire alarm systems in accordance with NFPA 72. 1. The fire protection company was immediately contacted and a request was made to schedule a visual inspection that takes place 6 months prior to the annual fire alarm inspection. 2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on NFPA 72 requirements pertinent to the citation. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee	05/03/2024

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	inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 03/14/24. Based on interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 storage rooms with roof access. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states	K 0353	It is the policy of Heritage Pointe of Warren to maintain ceiling construction in all storage rooms with roof access. 1. The hatch area has been framed in.	05/03/2024

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	the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 20 residents in one smoke compartment. Findings include: 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. 3.1-19(b)		2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on NFPA 13, 2010 edition, 8.5.4.11. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 2 lounges with a large quantity of combustible storage open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states Spaces, other than patient sleeping rooms, treatment rooms, and hazardous	K 0361	It is the policy of Heritage Pointe of Warren to store combustible items in accordance with LSC 19.3.4. 1. The PPE/covid supplies were immediately removed.	05/03/2024

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	areas, shall be permitted to be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 30 residents. Findings include: Based on observation with the Maintenance Director on 04/01/24 at 12:40 p.m., the 2B lounge was open to the corridor and was being used to store combustible material such as boxes of supplies and plastic containers. The lounge was on a wing that was unlicensed but there was not a 2-hour separation from the health care occupancy. This condition does not protect the corridor from a hazardous storage area. Based on interview at the time of observation, Maintenance Director agreed the lounge was open to the corridor, there was no 2-hour separation from health care occupancies, and stated PPE/covid supplies will be removed. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on the storage of combustible materials. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,			

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	ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 staff smoking policies and ensure cigarette butt were disposed in a non-combustible container with a self-closing lid. This deficient practice could affect staff around the smoking area and 35 residents in B-wing. Findings include: Based on observations with the Maintenance Director on 04/01/24 between 11:30 a.m. and 1:30 p.m., staff are not following the proper smoke procedures due to the following: a.) In the staff smoking area there were over 15	K 0741	It is the policy of Heritage Pointe of Warren to enforce smoking policies and ensure cigarette butts are properly disposed. 1. The area was immediately cleaned by environmental staff. Campus will be non-smoking as of 7/1/2024. 2. All residents on the hall have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, maintenance staff have been in-serviced on LSC 18.7.4 & 19.7.4.	05/03/2024

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	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 actions and ensure continued compliance, the Maintenance Director, or his designee, will complete the QA tool titled "LSC POC 4.20.24" weekly for 4 weeks and as needed thereafter. The QAPI committee will review findings at scheduled meetings. 5. All systemic changes will be completed by 5/3/2024.	