STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155332	A. BUILDING -- B. WING	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S COUNTY ROAD 200 EAST CONNERSVILLE, IN 47331

(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: 10/26/22 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Emergency Preparedness survey, Heritage House Rehabilitation & Health Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 98 certified beds. At the time of the survey, the census was 91. Quality Review completed on 10/31/22	E 0000		
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Ware		11/19/2022

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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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The			

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	communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.			

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	(iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the failed to review and update (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Executive Director and Maintenance Director on 10/26/21 between 9:45 a.m. and 11:45: a.m., the EEP's contact information for staff was blank on some pages and not current where completed on a different page within the provided APP Communication and Contact Section. Based on an interview during records review, the Executive Director stated the EEP Communication Plan had not been updated since she began at the facility in July of 2022. This finding was acknowledged by the Executive Director and Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present.	E 0030	**E 030 Names and Contact Information** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · No residents were identified as being affected by the alleged deficient practice. · The EEP contact information was immediately updated and is current. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · The names and phone numbers of staff was immediately added/updated to the EEP contact information page. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The EEP contact information will be reviewed regularly for updates/changes and again annually. **How the corrective action(s) will be monitored to ensure the**	11/19/2022

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			deficient practice will not recur, what quality assurance program will be put into place: · Maintenance Director/designee to complete EPP Emergency Contact List QAPI weekly x 4 weeks, then monthly x5 months, then annually. The results will be reviewed by the CQI committee overseen by the ED. **By what date the systemic changes will be completed:** Completion Date: 11/19/2022	
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: 10/26/22 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Life Safety Code survey, Heritage House Rehabilitation & Health Care Center 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.	K 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 111/19/2022	

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	This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 98 and a census of 91. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has one detached garage which was not sprinklered. Quality Review completed on 10/31/22			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 15 residents and staff using the 200 Hall Exit. Findings include: Based on a facility tour and interview with the Maintenance Director on 10/26/21 between 11:45:	K 0271	**K 271 Discharge from Exits** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · No residents were identified as being affected by the alleged deficient practice. · The exit discharge on the effected hall was corrected by attaching a ramp to the concrete to eliminate the drop. **How other residents having the**	11/19/2022

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	a.m. and 1:30 p.m., the exit discharge from the 200 Hall had approximately a 3-4 inch drop off immediately outside the door. Based on interview at the time of observation, the Maintenance Director acknowledged that the exit discharge was in need of repair to have a complete level walking surface leading to the common way. The Maintenance Director stated that several other exit discharge paths, where this similar condition occurred, had recently been corrected and he was waiting on a contractor to complete the project. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · 15 residents have the potential to be affected by the alleged deficient practice. · The exit discharge was corrected by attaching a ramp to the concrete to eliminate the drop on 11/18/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Maintenance Director/designee will check all exits and egress sidewalks regularly for broken concrete and trip hazards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · Maintenance Director/designee to complete Exits Free from Trip Hazards QAPI weekly x 4 weeks, then monthly x5 months. The results will be reviewed by the CQI committee overseen by the ED. **By what date the systemic changes will be completed:** Completion Date: 11/19/2022	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlets were protected in the Soiled Utility area according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 3 staff on the 100 hall. Findings include: Based on a facility tour and interview with the Maintenance Director on 10/26/21 between 11:45: a.m. and 1:30 p.m., the Soiled Utility closet on the 100 Hall had an outlet cover missing from the electrical outlet and was not covering the receptacle revealing exposed wiring. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director present. 3.1-19(b)	K 0511	**K 511 Utilities – Gas and Electric** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · No residents were identified as being affected by the alleged deficient practice. · An outlet cover was placed over the abandoned/disconnected electrical outlet to cover the exposed wiring. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · No residents have the potential to be affected by the alleged deficient practice. · An outlet cover was placed over the abandoned/disconnected electrical outlet to cover the exposed wiring on 10/26/22. · All outlets were checked to ensure all cover plates were in good repair by the maintenance director. **What measures will be put into**	11/19/2022

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			place or what systemic changes will be made to ensure that the deficient practice does not recur: · Maintenance Director/designee will inspect facility regularly for damaged and/or missing receptacle/electrical covers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · Maintenance director/designee to complete Outlet Covers QAPI weekly x 4 weeks, then monthly x5 months. The results will be reviewed by the CQI committee overseen by the ED. **By what date the systemic changes will be completed:** Completion Date: 11/19/2022	