						PRIN'	TED:	11/30/2022
DEPARTMENT	T OF HEALTH AND HU	MAN SERVICES				FOI	RM APP	PROVED
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0	938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED	
		155332	B. WI	NG		10/26/	/2022	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
				281 S C	COUNTY ROAD 200 EAST			
HERITAG	GE HOUSE REHA	BILITATION & HEALTH CARE CEN	1TEI	CONNE	ERSVILLE, IN 47331			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMI	PLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D.	ATE
E 0000			1					
Bldg								
2.49.	An Emergency Pre	paredness Survey was	E 00	000				
		ndiana Department of Health in		<i>,</i>				
	accordance with 42	•						
	accordance with 42	2 CFR 403./3.						
	G D 10/2	(122						
	Survey Date: 10/2	6/22						
	I		ı		ĺ		I	

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.

Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670

The facility has 98 certified beds. At the time of the survey, the census was 91.

Quality Review completed on 10/31/22

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).

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

[(c) The [facility must develop and maintain an emergency preparedness communication

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7KIK21 Facility ID: 000225 Page 1 of 9 If continuation sheet

	K MEDICAKE & MEDIC						WID NO. 0938-039		
			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED		
		155332	B. V	VING		10/2	10/26/2022		
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	FROVIDER OR SUPPLIER			281 S C	COUNTY ROAD 200 EAST				
HERITA	GE HOUSE REHAB	ILITATION & HEALTH CARE CE	NTEI	CONNE	ERSVILLE, IN 47331				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	011111111111111111111111111111111111111	DATE		
	plan that complies	with Federal, State and							
	local laws and mu	st be reviewed and updated							
	at least every 2 ye	ears [annually for LTC							
	facilities]. The cor	mmunication plan must							
	include all of the fo	ollowing:]							
	(1) Nomes and	ntant information for the							
	(1) Names and co following:	ntact information for the							
	(i) Staff.								
	` '	ng services under							
	arrangement.								
	(iii) Patients' physi	icians							
	(iv) Other [facilities								
	(v) Volunteers.	-1.							
	(1) 101411100101								
	*[For Hospitals at	§482.15(c) and CAHs at							
		communication plan must							
	include all of the fo								
		ntact information for the							
	following:								
	(i) Staff.								
	` '	ng services under							
	arrangement.	-							
	(iii) Patients' physi	icians							
	(iv) Other [hospita								
	(v) Volunteers.	-							
	*[For RNHCIs at §								
	1	an must include all of the							
	following:								
		ntact information for the							
	following:								
	(i) Staff.								
	(ii) Entities providi	ng services under							
	arrangement.								
	, ,	ardian, or custodian.							
	(iv) Other RNHCIs	S.							
	(v) Volunteers.								

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

*[For ASCs at §416.45(c):] The

Event ID:

7KIK21

Facility ID: 000225

If continuation sheet

Page 2 of 9

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 10/26/2022					
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTH CARE CENT		NTEI	281 S C	ODDRESS, CITY, STATE, ZIP COD COUNTY ROAD 200 EAST CRSVILLE, IN 47331	•		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	IATE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IATE	DATE
	communication plate following: (1) Names and confollowing: (i) Staff. (ii) Entities providing arrangement. (iii) Patients' physical (iv) Volunteers. *[For Hospices at communication plate following: (1) Names and confollowing: (i) Hospice employing Entities providing arrangement. (iii) Patients' physical communication plate following: (i) Hospice employing Entities providing arrangement. (iii) Patients' physical communication plate following: (iiii) Patients' physical communication plate following: (iiiiiii) Patients' physical communication plate following: (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	an must include all of the ntact information for the ng services under cians. §418.113(c):] The an must include all of the ntact information for the ntact information for the yees. ng services under cians.			CROSS-REFERENCED TO THE APPROPR	ATE	
	following: (1) Names and co following: (i) Staff. (ii) Entities providi arrangement. (iii) Patients' physi (iv) Volunteers. *[For OPOs at §48 communication pla following:	34.102(c):] The an must include all of the intact information for the ing services under cians. 36.360(c):] The an must include all of the intact information for the					

PRINTED: 11/30/2022

EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO								
ENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	COMPLETED				
	155332	B. WI	NG	10/26/2022				
NAME OF BROWINGS OR CURRISE			STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF PROVIDER OR SUPPLIER			281 S COUNTY ROAD 200 EAST					
HERITAGE HOUSE REHAB	ILITATION & HEALTH CARE CEN	TEI	CONNERSVILLE. IN 47331					

(X4) ID SUMMARY STATEMENT OF DEFICIENCIE				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	(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	E 0030	E 030 Names and Contact	11/19/2022
	to review and update (EPP) Communication Plan		Information	
	at least annually in accordance with 42 CFR		What corrective action(s) will be	
	483.73(a). The communication plan must include		accomplished for those residents	
	all of the following:		found to have been affected by the	
			deficient practice:	
	(1) Names and contact information for the		No residents were identified	
	following:		as being affected by the alleged	
	(i) Staff.		deficient practice.	
	(ii) Entities providing services under arrangement.		· The EEP contact	
	(iii) Patients' physicians		information was immediately	
	(iv) Other [facilities].		updated and is current.	
	(v) Volunteers.		How other residents having the	
			potential to be affected by the	
	This deficient practice could affect all occupants.		same deficient practice will be	
			identified and what corrective	
	Findings include:		action(s) will be taken:	
			· All residents have the	
	Based on records review and interview with the		potential to be affected by the	
	Executive Director and Maintenance Director on		alleged deficient practice.	
	10/26/21 between 9:45 a.m. and 11:45: a.m., the		· The names and phone	
	EEP's contact information for staff was blank on		numbers of staff was immediately	
	some pages and not current where completed on a		added/updated to the EEP contact	
	different page within the provided APP		information page.	
	Communication and Contact Section.		What measures will be put into	
	Based on an interview during records review, the		place or what systemic	
	Executive Director stated the EEP Communication		changes will be made to	
	Plan had not been updated since she began at the		ensure that the deficient	
	facility in July of 2022.		practice does not recur:	
			· The EEP contact	
	This finding was acknowledged by the Executive		information will be reviewed	
	Director and Maintenance Director at the time of		regularly for updates/changes and	
	discovery and again at the exit conference with		again annually.	
	the Executive Director and Maintenance Director		1	
	present.		How the corrective action(s)	
			will be monitored to ensure the	

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

Event ID:

7KIK21

Facility ID: 000225

If continuation sheet

Page 4 of 9

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

PRINTED: 11/30/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155332	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/26/2022
	PROVIDER OR SUPPLIEF	ILITATION & HEALTH CARE CEI	281 5	ET ADDRESS, CITY, STATE, ZIP COD S COUNTY ROAD 200 EAST NERSVILLE, IN 47331	
(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)	(X5) COMPLETION DATE
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/26 Facility Number: 0 Provider Number: 100 At this Life Safety of Rehabilitation & He not in compliance w Participation in Me Subpart 483.90(a), 2012 Edition of the Association (NFPA)	00225 155332	K 0000	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 committed overseen by the ED. By what date the systemic changes will be completed: Completion Date: 11/19/2022 This provider respectfully required that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Compliand requests a desk review in of a post survey review on or 111/19/2022	ce: e i i ueee

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCT		ONSTRUCTION	(V2) DATE	CLIDVEV			
		ľ í				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			<u>01</u>		
		155332	B. W	ING		10/26	/2022
	PROVIDER OR SUPPLIER	ILITATION & HEALTH CARE CE	NTFI	281 S (ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 200 EAST ERSVILLE, IN 47331		
112111710	SETTO GOET RETURNE	MEIT (TION & FIE KEITT OF THE OF		CONTR	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0271 SS=E Bldg. 01	This one-story facil Type V (111) const The facility has a fi detection in the cor- the corridor. The fa hard wired to the fir resident sleeping ro capacity of 98 and a All areas where res were sprinklered. A services were sprink detached garage wh Quality Review cor- NFPA 101 Discharge from E: Exit discharge is a 7.7, provides a lev the provisions of 7 changes in elevat free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure 1 of walking surface, we constructed of hard surface in accordan Certification Letter	ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to acility has smoke detectors re alarm system installed in all oms. The facility has a a census of 91. idents have customary access All areas providing facility klered. The facility has one nich was not sprinklered.	K 0	271	K 271 Discharge from Exits What corrective action(s) will accomplished for those reside found to have been affected be deficient practice: No residents were ident as being affected by the alleg deficient practice.	ents by the ified	11/19/2022
	Findings include: Based on a facility	tour and interview with the			The exit discharge on the effected hall was corrected by attaching a ramp to the concrete to eliminate the drop.	<i>'</i>	
	-	tor on 10/26/21 between 11:45:			How other residents having	the	

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

Event ID:

7KIK21

Facility ID: 000225

5

If continuation sheet

Page 6 of 9

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

PRINTED: 11/30/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155332		LDING	nstruction 01	(X3) DATE SI COMPLE 10/26/2	TED
	PROVIDER OR SUPPLIEF GE HOUSE REHAB	ILITATION & HEALTH CARE CEN	TEI	281 S C	DDRESS, CITY, STATE, ZIP COD COUNTY ROAD 200 EAST CRSVILLE, IN 47331		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF a.m. and 1:30 p.m.,	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION the exit discharge from the 200	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) potential to be affected by the	e	(X5) COMPLETION DATE
	immediately outside at the time of obser Director acknowled in need of repair to surface leading to the Maintenance Direct exit discharge paths occurred, had recent waiting on a contract This finding was ac Maintenance Direct again at the exit contract of the surface of the s	tely a 3-4 inch drop off e the door. Based on interview vation, the Maintenance ged that the exit discharge was have a complete level walking ne common way. The or stated that several other , where this similar condition tly been corrected and he was ctor to complete the project. knowledged by the or at the time of discovery and afterence with the Executive enance Director present.			same deficient practice will to 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 the concrete to eliminate the consumer of the consumer that the deficient practice does not recur: Maintenance Director/designee will check a exits and egress sidewalks regularly for broken concrete a 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 resuluil be reviewed by the CQI committee overseen by the Etchanges will be completed: Completion Date: 11/19/2022	to drop ato	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7KIK21 Facility ID: 000225 If continuation sheet Page 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> CO			COMPLETED	
		155332	B. WI	NG		10/26	10/26/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				COUNTY ROAD 200 EAST			
HERITAG	SE HOUSE REHAB	ILITATION & HEALTH CARE CEN	TEI		ERSVILLE, IN 47331			
(X4) ID	SUMMARY S	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	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.0	DATE	
K 0511	NFPA 101							
SS=E	Utilities - Gas and	Electric						
Bldg. 01	Utilities - Gas and	Electric						
	Equipment using g	gas or related gas piping						
	complies with NFF	PA 54, National Fuel Gas						
	Code, electrical wi	iring and equipment						
	complies with NFF	PA 70, National Electric						
	Code. Existing ins	tallations can continue in						
	service provided n							
	18.5.1.1, 19.5.1.1,	9.1.1, 9.1.2						
	Based on observation	on and interview, the facility	K 0:	511	K 511 Utilities – Gas and		11/19/2022	
	failed to ensure elec-	trical outlets were protected in			Electric			
	the Soiled Utility ar	ea according to 19.5.1. NFPA			What corrective action(s) will be	эе		
	70, 2011 Edition, A	rticle 406.6, Receptacle			accomplished for those reside	nts		
	Faceplates (Cover P	Plates), requires receptacle			found to have been affected b	y the		
	faceplates shall be in	nstalled so as to completely			deficient practice:			
	cover the opening a	nd seat against the mounting			 No residents were identi 	fied		
	surface. This deficie	ent practice could affect 3 staff			as being affected by the allege	ed		
	on the 100 hall.				deficient practice.			
					 An outlet cover was place 	ed		
	Findings include:				over the abandoned/disconne	cted		
					electrical outlet to cover the			
		tour and interview with the			exposed wiring.			
		or on 10/26/21 between 11:45:			How other residents having	the		
	-	the Soiled Utility closet on the			potential to be affected by th			
		let cover missing from the			same deficient practice will b			
		was not covering the			identified and what correctiv	е		
	receptacle revealing				action(s) will be taken:			
	This finding was ac				· No residents have the			
		or at the time of discovery and			potential to be affected by the			
		ference with the Executive			alleged deficient practice.			
	Director and Mainte	enance Director present.			An outlet cover was place.			
					over the abandoned/disconne	cted		
	3.1-19(b)				electrical outlet to cover the			
					exposed wiring on 10/26/22.			
					All outlets were checked			
					ensure all cover plates were ir			
					good repair by the maintenand	се		
					director.			
					What measures will be put in	ıto		

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

Event ID:

7KIK21

Facility ID: 000225

If continuation sheet Page 8 of 9

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

PRINTED: 11/30/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155332	(X2) MULTIF A. BUILDIN B. WING	PLE CONSTRUCTION NG 01	(X3) DATE COMPI 10/26	
	PROVIDER OR SUPPLIE	ER BILITATION & HEALTH CARE CE	28	REET ADDRESS, CITY, STATE, ZIP COD 1 S COUNTY ROAD 200 EAST DNNERSVILLE, IN 47331	I	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ION D BE OPRIATE	(X5) COMPLETION DATE
				place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/designee will inspective facility regularly for damage and/or missing receptacle/electrical covered How the corrective action will be monitored to ensure deficient practice will no recur, what quality assure program will be put into Maintenance director/designee to compoutlet Covers QAPI weeks weeks, then monthly x5 m The results will be reviewed CQI committee overseen ED. By what date the system changes will be complete Completion Date: 11/19/2	pect ged ss. n(s) ure the t ance place: lete ly x 4 onths. ed by the by the ic ed:	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7KIK21 Facility ID: 000225 If continuation sheet Page 9 of 9