PRINTED: 04/23/2025

CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/27/2025	
		801 N	HUNTINGTON AVE		
GE POINTE OF WA	ARREN	WARR	EN, IN 46792		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	(X5) OMPLETION DATE
conducted by the Irraccordance with 42 Survey Date: 03/27 Facility Number: 00 Provider Number: 1002 At this Emergency Pointe of Warren w with Emergency Pr Medicare and Mediand Suppliers, 42 C capacity of 119 and of this survey.	diana Department of Health in CFR 483.73. 7/25 00542 155705 267380 Preparedness survey, Heritage ras found in not compliance eparedness Requirements for icaid Participating Providers FR 483.73. The facility has a land a census of 79 at the time	E 0000	We respectfully request consideration for a desk review we have achieved substantial compliance with the applicable requirements set forth in this F of Correction. Please feel free contact 260-375-2201 if you h questions or require additional information. Respectfully,	w, as Plan e to ave	
Based on record rev failed to conduct an Emergency Prepare facility must do all training in emergen procedures to all ne individuals providin and volunteers, con roles; (ii) Provide e	view and interview, the facility mual training for the edness Program (EPP). The LTC of the following: (i) Initial acy preparedness policies and ex and existing staff, ag services under arrangement, sistent with their expected mergency preparedness	E 0037	of Warren to ensure staff demonstrate understanding of emergency preparedness poli and procedure. 1. All staff will demonstrate understanding by completing tattached quiz (Attachment #1) 5/1/2025.	cy the	5/01/2025
	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER GE POINTE OF WA SUMMARY (EACH DEFICIEN REGULATORY OF An Emergency Prepare conducted by the Irraccordance with 42 Survey Date: 03/22 Facility Number: 10/2 At this Emergency Provider Number: 10/2 At this Emergency Provider of Warren was with Emergency Provider and Medicare and Medicare and Medicare and Medicare and Suppliers, 42 Capacity of 119 and of this survey. Quality Review con 403.748(d)(1), 410 EP Training Program Based on record regalled to conduct are Emergency Prepare facility must do all training in emergen procedures to all negative individuals providing and volunteers, con roles; (ii) Provide expenses to the survey of the survey o	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA 155705 155705 155705 200 201 202 203 204 205 205 206 207 208 20	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155705 R. BUILDING B. WING PROVIDER OR SUPPLIER GE POINTE OF WARREN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/27/25 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 03/31/25 403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness	REMEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155705 IDENTIFICATION NUMBER 155705 STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

emergency procedures in accordance with 42 CFR

483.73(d) (1). This deficient practice could affect

training; (iv) Demonstrate staff knowledge of

(X6) DATE

Terrence Jent Administrator 04/17/2025

practice.

3. To ensure the deficient practice

doesn't recur, staff will complete a

TITLE

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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PRINTED: 04/23/2025 FORM APPROVED

JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155705	B. WING		03/27/2025
	PROVIDER OR SUPPLIER		801 N I	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	all residents in the f Findings include: Based on records re Director and the As on 03/27/25 at 10:50 of a sign-in sheet fo but there was no do could demonstrate k on an interview at 1 Director stated staff but demonstration of not documented.		TAU	post-training quiz for all future emergency preparedness train sessions. 4. To monitor corrective action and ensure continued compliate the QAPI committee will review annual emergency preparedness training and testing upon completion. 5. All systemic changes will be completed by 5/1/2025.	ning ns nnce, w ess
E 0039 SS=F Bldg	Maintenance Direct at 2:30 p.m. 403.748(d)(2), 416 EP Testing Requint Based on record reversities failed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based functions in the LTC facility or man-made emergency please from engaging its new form.	or during the exit conference 5.54(d)(2), 418.113(d)(rements riew and interview, the facility ercises to test the emergency er year, including drills using the emergency C facility must do the annual full-scale exercise that l; or ity-based exercise is not an annual individual,	E 0039	It is the policy of Heritage Poir of Warren to conduct exercise test the emergency plan at leastwice per year. 1. The community has schedu an onsite meeting with Hunting County EMA on 4/29/2025. At that time, the community will pand coordinate a full-scale exercise that is community based. The exercise will be completed by 5/30/2025. Additionally, the community will also plan and coordinate an additional exercise that meets regulatory requirements. This	s to est eled gton t blan

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full-scale functional exercise for 1 year following

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additional exercise will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155705		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G	COMPLET	(X3) DATE SURVEY COMPLETED 03/27/2025	
	PROVIDER OR SUPPLIER		801	EET ADDRESS, CITY, STATE, ZIP CO N HUNTINGTON AVE RREN, IN 46792	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR the onset of the actu		ID PREFIX TAG	completed by 9/30/2025	ULD BE PROPRIATE	(X5) COMPLETION DATE
	include, but is not li a. A second full-sca community-based o functional exercise. b. A mock disaster c. A tabletop exerci facilitator that inclu a narrated, clinically and a set of problen messages, or prepar challenge an emerg (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer accordance with 42	drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, a statements, directed ed questions designed to		2. All residents have the to be affected by the def practice. 3. To ensure the deficier doesn't recur, the comm appointed a Disaster Preparedness Coordinat work with EMA, District Healthcare Coalition, an pertinent agencies to en continued compliance w requirements. 4. To monitor corrective and ensure continued cothe QAPI committee will annual emergency preparexercises upon completi 5. All systemic changes completed by 5/1/2025.	nt practice unity has tor that will d other sure ith EPP actions ompliance, review aredness ion.	
	Director, and the As on 03/27/25 at 11:0 documentation was a.) Documentation exercise, an actual remergency, or an arfunctional exercise available. b.) Documentation exercise of choice. Based on an interviewaintenance Direct exercises to test the been conducted with	view with the Maintenance sistant Maintenance Director 0 a.m., the following not available for review: of a community based annual natural or man-made anual individual facility-based if a community drill was not of an additional annual ew at 11:01 p.m., the or stated both required emergency plan have not hin the last 12 months.				

, ´		r í				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155705	B. W	B. WING			03/27/2025	
	ROVIDER OR SUPPLIER			801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Maintenance Direct at 2:30 p.m.	or during the exit conference						
K 0000								
Bldg. 01								
-	A Life Safety Code	Recertification and State	K 0	000	Please consider this Plan of			
	-	urvey was conducted by the			Correction to be the facility's			
	_	of Health in accordance with			credible allegation of compliar	ice.		
	42 CFR 483.90(a).				We respectfully request			
	G D 02/27	U05			consideration for a desk review			
	Survey Date: 03/27	7/23			we have achieved substantial compliance with the applicable			
	Facility Number: 00	00542			requirements set forth in this F			
	Provider Number: 1				of Correction. Please feel free			
	AIM Number: 1002	67380			contact 260-375-2201 if you h			
					questions or require additiona	I		
	_	Code survey, Heritage Pointe			information. Respectfully,			
		d not in compliance with			Terrence Jent, HFA, Executive	Э		
	Requirements for Pa	-			Director.			
		, 42 CFR Subpart 483.90(a),						
	_	re and the 2012 edition of the etion Association (NFPA) 101,						
		SC) Chapter 19 Existing Health						
	Care Occupancies a							
	1							
	This two story facili	ity with a walk out lower level						
		be of Type I (332) construction						
	• •	clered. The facility has a fire						
	-	moke detection in the						
		open to the corridors. Hard						
		or were provided in the e facility has a capacity of 119						
		79 at the time of this survey.						
	and mad a consus of	, at the time of this survey.						
	All areas providing	customary access were						
	sprinklered. All area	as providing facility services						
	_	cept two detached barns used						
	_	e facility bus, facility cars,						
	trucks, mowers, sno	w plows and maintenance						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155705	B. WING			03/27	/2025
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE OF WARREN		•	801 N F	ADDRESS, CITY, STATE, ZIP COD HUNTINGTON AVE EN, IN 46792			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	supplies and anothe of the golf cart.	r garage used for the storage					
	Quality Review con	npleted on 03/31/25					
K 0222	NFPA 101						
SS=E Bldg. 01	Egress Doors						
	failed to ensure the 12 exit doors were rewithout a clinical disecurity measures. of egress shall not be lock that requires the egress side unless of 19.2.2.2.4. Door-loopermitted in accordeficient practice consecond floor. Findings include: Based on observation Director and the Asson 03/27/25 at 12:1 doors by rooms 264 facility exits, were rebe opened by enterifaccess control pads, by the access control pads, by the	on and interview, the facility means of egress through 2 of readily accessible for residents fagnosis requiring specialized Doors within a required means be equipped with a latch or the use of a tool or key from the therwise permitted by LSC tocking arrangements shall be ance with 19.2.2.2.5.2. This bould affect 35 residents on the sistant Maintenance Director 0 p.m. and at 12:19 p.m., exit and 255 were marked as magnetically locked, and could ng a four-digit code on the but the code was not posted of pads. Based on an interview to 12:19 p.m., the Maintenance code to open the exit doors the access control pads.	K 0	222	It is the policy of Heritage Poir of Warren to ensure the mean egress through all exit doors. 1. The codes were immediate posted on the doors. 2. All residents on the hall have the potential to be affected by deficient practice. 3. To ensure the deficient practice doesn't recur, the Maintenance Director has added verifying or placement as a task in the onlimaintenance management system. 4. To monitor corrective action and ensure continued compliate Maintenance Director, or his designee, will spot check code boxes to ensure no missing codes. 5. All systemic changes will be completed by 5/1/2025.	ly ve the ctice e code ine ns ance, nis	05/01/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155705	B. W	B. WING 03/27			/2025
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			HUNTINGTON AVE		
HERITAC	GE POINTE OF WA	ARREN			EN, IN 46792		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	3.1-19(b)						
K 0251	NFPA 101						
SS=E	Dead-End Corrido	ors and Common Path of					
Bldg. 01	Travel						
	Based on observati	on and interview, the facility	K 0	251	It is the policy of Heritage Poir	nte	05/01/2025
	failed to ensure 2 o	f 2 dead-end corridors did not			of Warren to ensure all corrido		
	exceed 30 feet. Thi	s deficient practice could affect			have necessary exit signs.		
	40 residents in two	smoke compartments.			1. The exit signs were		
					immediately installed.		
	Findings include:				2. All residents on the hall hav	e	
					the potential to be affected by	the	
		on with the Maintenance			deficient practice.		
		ssistant Maintenance Director			3. To ensure the deficient prac	ctice	
		00 p.m. and 12:45 p.m., the			doesn't recur, the Maintenance		
		leading to wing 1B and the			Director added a task of verify	•	
		or leading to wing 2B ending at			exit sign placement and function		
	_	netically locked doors without			in the maintenance manageme	ent	
		ng them dead-end corridors.			system.		
		sured 45 feet in length and the			4. To monitor corrective action		
		in exit signs. Based on an			and ensure continued complia		
		p.m. and 12:45 p.m., the			the Maintenance Director, or h		
		tor provided the measurement			designee, will review all audits	;	
		I stated the doors at the end of in a path of egress and needed			upon completion. Any		
	exit signs.	in a path of egress and needed			irregularities will be reviewed the QAPI committee.	Эу	
	exit signs.						
	This finding was re	eviewed with the Administrator,			5. All systemic changes will be completed by 5/1/2025.	;	
	_	irector, and the Assistant			Completed by 5/1/2025.		
		tor during the exit conference					
	at 2:30 p.m.	tor during the exit conference					
	u. 2.30 p.m.						
	3.1-19(b)						
K 0372	NFPA 101						
SS=E		ilding Spaces - Smoke					
Bldg. 01	Barrie	- •					
	Based on observati	on and interview, the facility	K 0	372	It is the policy of Heritage Poir	nte	05/01/2025
		netrations through 2 of 8 smoke			of Warren to ensure that		
	barrier walls were protected to maintain the smoke				penetrations through smoke		

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 03/27/2025		
NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE OF WARREN			STREET ADDRESS, CITY, STATE, ZIP COD 801 N HUNTINGTON AVE WARREN, IN 46792				
	SUMMARY: (EACH DEFICIEN REGULATORY OR resistance of each s: 19.3.7.5 requires sn in accordance with a minimum ½ hour Section 8.5.2.1 requires sn continuous from an wall, from a floor to to a smoke barrier, of thereof. 8.5.6.2 requires thereof. 8.5.6.2 requires that pass the floor/ceiling assembly barrier, or through the roof/ceiling of a sm protected by a system structure of the move practice could affect compartments. Findings include: Based on observation Director and the Asson 03/27/25 at 1:05 drop ceilings of the there were 10 unseas walls. Based on an example of the system			801 N F	IUNTINGTON AVE	ntial ctice nitor ons ure	(X5) COMPLETION DATE
	This finding was re	v holes in the smoke barriers. viewed with the Administrator, rector, and the Assistant or during the exit conference					

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