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	03/27/2025

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: 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	E 0000	Please consider this Plan of Correction to be the facility's credible allegation of compliance. We respectfully request consideration for a desk review, as we have achieved substantial compliance with the applicable requirements set forth in this Plan of Correction. Please feel free to contact 260-375-2201 if you have questions or require additional information. Respectfully, Terrence Jent, HFA, Executive Director.	
E 0037 SS=C Bldg. --	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 training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect	E 0037	It is the policy of Heritage Pointe of Warren to ensure staff demonstrate understanding of emergency preparedness policy and procedure. 1. All staff will demonstrate understanding by completing the attached quiz (Attachment #1) by 5/1/2025. 2. All residents have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, staff will complete a	05/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	Administrator	04/17/2025

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	all residents in the facility. Findings include: Based on records review with the Maintenance Director and the Assistant Maintenance Director on 03/27/25 at 10:50 a.m., there was documentation of a sign-in sheet for EPP training dated 01/03/25, but there was no documentation to show if staff could demonstrate knowledge of the EPP. Based on an interview at 10:56 a.m., the Maintenance Director stated staff have been trained on the EPP, but demonstration of knowledge of the EPP was not documented. This finding was reviewed with the Administrator, the Maintenance Director, and the Assistant Maintenance Director during the exit conference at 2:30 p.m.		post-training quiz for all future emergency preparedness training sessions. 4. To monitor corrective actions and ensure continued compliance, the QAPI committee will review annual emergency preparedness training and testing upon completion. 5. All systemic changes will be completed by 5/1/2025.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements 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	E 0039	It is the policy of Heritage Pointe of Warren to conduct exercises to test the emergency plan at least twice per year. 1. The community has scheduled an onsite meeting with Huntington County EMA on 4/29/2025. At that time, the community will plan and 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 additional exercise will be	05/01/2025

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	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 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, and the Assistant Maintenance Director on 03/27/25 at 11:00 a.m., the following documentation was not available for review: a.) Documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill was not available. b.) Documentation of an additional annual exercise of choice. Based on an interview at 11:01 p.m., the Maintenance Director stated both required exercises to test the emergency plan have not been conducted within the last 12 months. This finding was reviewed with the Administrator, the Maintenance Director, and the Assistant		completed by 9/30/2025. 2. All residents have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur, the community has appointed a Disaster Preparedness Coordinator that will work with EMA, District Healthcare Coalition, and other pertinent agencies to ensure continued compliance with EPP requirements. 4. To monitor corrective actions and ensure continued compliance, the QAPI committee will review annual emergency preparedness exercises upon completion. 5. All systemic changes will be completed by 5/1/2025.	

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	Maintenance Director during the exit conference at 2:30 p.m.			
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: 03/27/25 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 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	K 0000	Please consider this Plan of Correction to be the facility's credible allegation of compliance. We respectfully request consideration for a desk review, as we have achieved substantial compliance with the applicable requirements set forth in this Plan of Correction. Please feel free to contact 260-375-2201 if you have questions or require additional information. Respectfully, Terrence Jent, HFA, Executive Director.	

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	155705	A. BUILDING 01 B. WING	03/27/2025

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	supplies and another garage used for the storage of the golf cart. Quality Review completed on 03/31/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 2 of 12 exit doors 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 35 residents on the second floor. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 03/27/25 at 12:10 p.m. and at 12:19 p.m., exit doors by rooms 264 and 255 were marked as facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pads, but the code was not posted by the access control pads. Based on an interview at 12:10 p.m. and at 12:19 p.m., the Maintenance Director agreed the code to open the exit doors were not posted by the access control pads. This finding was reviewed with the Administrator, the Maintenance Director, and the Assistant Maintenance Director during the exit conference at 2:30 p.m.	K 0222	It is the policy of Heritage Pointe of Warren to ensure the means of egress through all exit doors. 1. The codes were immediately posted on the doors. 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, the Maintenance Director has added verifying code placement as a task in the online maintenance management system. 4. To monitor corrective actions and ensure continued compliance, the 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.	05/01/2025

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	3.1-19(b)			
K 0251 SS=E Bldg. 01	NFPA 101 Dead-End Corridors and Common Path of Travel Based on observation and interview, the facility failed to ensure 2 of 2 dead-end corridors did not exceed 30 feet. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director and the Assistant Maintenance Director on 03/27/25 at 12:00 p.m. and 12:45 p.m., the first-floor corridor leading to wing 1B and the second-floor corridor leading to wing 2B ending at a set of closed magnetically locked doors without a marked exit making them dead-end corridors. The corridors measured 45 feet in length and the doors did not contain exit signs. Based on an interview at 12:00 p.m. and 12:45 p.m., the Maintenance Director provided the measurement of the corridors and stated the doors at the end of the corridors were in a path of egress and needed exit signs. This finding was reviewed with the Administrator, the Maintenance Director, and the Assistant Maintenance Director during the exit conference at 2:30 p.m.	K 0251	It is the policy of Heritage Pointe of Warren to ensure all corridors have necessary exit signs. 1. The exit signs were immediately installed. 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, the Maintenance Director added a task of verifying exit sign placement and function in the maintenance management system. 4. To monitor corrective actions and ensure continued compliance, the Maintenance Director, or his designee, will review all audits upon completion. Any irregularities will be reviewed by the QAPI committee. 5. All systemic changes will be completed by 5/1/2025.	05/01/2025
	3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 2 of 8 smoke barrier walls were protected to maintain the smoke	K 0372	It is the policy of Heritage Pointe of Warren to ensure that penetrations through smoke	05/01/2025

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	resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 50 residents in four smoke compartments. Findings include: Based on observations with the Maintenance Director and the Assistant Maintenance Director on 03/27/25 at 1:05 p.m. and at 1:10 p.m., above the drop ceilings of the 1B and 2B smoke barrier walls there were 10 unsealed screw holes through the walls. Based on an interview at 1:05 p.m. and at 1:10 p.m., the Maintenance Director agreed there were unsealed screw holes in the smoke barriers. This finding was reviewed with the Administrator, the Maintenance Director, and the Assistant Maintenance Director during the exit conference at 2:30 p.m. 3.1-19(b)		barrier walls are protected. 1. The screw holes were immediately filled. 2. All residents have the potential to be affected by the deficient practice. 3. To ensure the deficient practice doesn't recur and ensure continued compliance, the Maintenance Director will monitor and review work or modifications to smoke barrier walls to ensure protection for any new penetrations. 5. All systemic changes will be completed by 5/1/2025.	