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	05/12/2025

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 03/27/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/12/25 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 At this PSR 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 05/13/25	E 0000	Please consider this Directed 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 Directed 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 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	E 0039	/p1. The facility will ensure at least two emergency preparedness exercises utilizing the emergency preparedness plan are conducted by 6/1/2025 and going forward, on an annual basis. The facility will maintain documentation of the exercises and subsequent analysis. Ongoing, the Administrator or designee will monitor and maintain documentation for the purposes of surveyor verification to ensure continued compliance. Results of	06/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terrence Jent	Administrator	05/27/2025

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.

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	05/12/2025

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
	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 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 05/12/25 at 1:30 p.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 1:30 p.m., the Maintenance Director stated both required exercises to test the emergency have been scheduled and will be completed in the next few		the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. The community-involved exercise was completed 5.27.25 with corresponding documentation attached (Attachment #1). Exercise two involves an active COVID outbreak. All pertinent information will be submitted upon completion and prior to 6.1.25 per the Directed Plan of Correction.	

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	05/12/2025

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
	weeks. This finding was reviewed with the Maintenance Director and the Assistant Maintenance Director during the exit conference at 1:50 p.m. This deficiency was cited on 03/27/25. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/27/25 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 05/12/25 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 At this PSR survey, Heritage Pointe of Warren was found 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	K 0000	Please consider this Directed 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 Directed 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 01 B. WING	05/12/2025

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
	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 05/13/25			