| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155402 | A. BUILDING -- B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906 |

| (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<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/05/24<br><br>Facility Number: 000271<br>Provider Number: 155402<br>AIM Number: 100291260<br><br>At this Emergency Preparedness survey, Heritage Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 127 certified beds. At the time of the survey, the census was 76.<br><br>Quality Review completed on 08/07/24 | E 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. | |
| K 0000<br><br>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).<br><br>Survey Date: 08/05/24<br><br>Facility Number: 000271<br>Provider Number: 155402<br>AIM Number: 100291260 | K 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Heritage Healthcare agrees with the allegations and citations listed. Heritage Healthcare maintains that the alleged deficiencies do not jeopardize the health and safety of the residents | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joshua Davis | Executive Director | 08/22/2024 |

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 |
|---|---|---|---|
| | 155402 | A. BUILDING 01<br>B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD<br>WEST LAFAYETTE, IN 47906 |

| (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 |
|---|---|---|---|---|
| | At this Life Safety Code survey, Heritage Healthcare 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.<br><br>This one-story facility consists of the original building of Type II (000) construction and the 1989 addition of a north wing and extension to an east wing of Type V (111) construction. Since the buildings were all constructed prior to July 5th, 2016, they were surveyed as one building of Type V (000). The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered detectors in all resident sleeping rooms. The facility has a capacity of 127 and had a census of 76 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one equipment storage pod and one detached storage garage located in the rear of the facility.<br><br>Quality Review completed on 08/07/24 | | nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155402 | A. BUILDING 01<br>B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD<br>WEST LAFAYETTE, IN 47906 |

| (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 |
|---|---|---|---|---|
| | Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |
| | Based on observation, and interview; the facility failed to ensure 1 of 4 sprinkler heads on Stuart Hall was replaced in accordance with NFPA 25.<br>NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical Damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5) Loading<br>(6) Painting unless painted by the sprinkler manufacturer.<br>In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.<br>This deficient practice could affect as many as 14 residents, 2 staff and 1 visitor in the facility. | K 0353 | **K353**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**The sprinkler head located on Stuart Hall outside of resident room #29 was replaced.<br>**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.**Any residents on that hall had the potential to be affected however, none were affected. A walk through of the entire facility was performed by the ED and director of maintenance to ensure no other sprinkler heads had paint on them. All presented appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**The Maintenance Director was | 08/22/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155402 | A. BUILDING 01<br>B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD<br>WEST LAFAYETTE, IN 47906 |

| (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 |
|---|---|---|---|---|
| | Findings include:<br><br>Based on observations made with the Director of Maintenance during a tour of the facility on 08/05/24 at 12:50 a.m., the sprinkler head located on Stuart Hall outside resident room #29 had paint on the frame. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned sprinkler had paint on the frame adding that he would contact his vendor and have the sprinkler head replaced as soon as he was able to do so.<br><br>This finding was reviewed again with the Administrator and the Director of Maintenance at the exit conference held on 08/05/24 at 2:15 p.m.<br><br>3.1-19(b) | | educated on proper sprinkler head presentation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**The Executive Director/designee will audit the sprinkler heads to ensure they are not painted.5x per week for 1 month,Then 1 x per week for 5 monthThen monthly for 6 monthsOutcome of the audit will be presented to the QAPI team monthly to ensure compliance. We respectfully request a desk review for this citation | |
| K 0753 SS=E Bldg. 01 | NFPA 101<br>Combustible Decorations<br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met:<br>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.<br>o Decorations meet NFPA 701.<br>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.<br>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155402 | A. BUILDING 01<br>B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD<br>WEST LAFAYETTE, IN 47906 |

| (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 |
|---|---|---|---|---|
| | Based on observation and interview, the facility failed to ensure 1 of 1 Medical Records room corridor door contain decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met:<br>(1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.<br>(2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.<br>(3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source.<br>(4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:<br>(a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).<br>(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.<br>(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7.<br>(d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding | K 0753 | **K753**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**The paper located on the Medical Directors door was removed. **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.**Any residents on that hall had the potential to be affected however, none were affected. A walk through of the entire facility was performed by the ED and director of maintenance to ensure no other doors had papers on them that covered more than 20% on them. All presented appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**The Maintenance Director was educated on having combustible materials on doors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**The Executive Director/designee will audit the doors in the facility to ensure they do not have combustible materials covering more than 20% of them.5x per week for 1 | 08/22/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155402 | A. BUILDING 01<br>B. WING | 08/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HERITAGE HEALTHCARE | 3401 SOLDIERS HOME RD<br>WEST LAFAYETTE, IN 47906 |

| (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 |
|---|---|---|---|---|
| | four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.<br>This deficient practice could affect 20 residents in one smoke compartment.<br><br>Findings include:<br><br>Based on observations made with the Director of Maintenance during a tour of the facility on 08/05/24 at 12:50 a.m., the corridor door to the Medical Records office contained a wrapping paper decoration that covered 100% of the door. Based on interview at the time of the observation, the Director of Maintenance agreed the corridor door was covered with a combustible decoration, stated that the door was 100% covered, and agreed that he could not provide a flame spread rating document for the aforementioned door covering as of the time of this survey.<br><br>This finding was reviewed again with the Administrator and the Director of Maintenance at the exit conference held on 08/05/24 at 2:15 p.m.<br><br>3.1-19(b) | | month,Then 1 x per week for 5 monthThen monthly for 6 monthsOutcome of the audit will be presented to the QAPI team monthly to ensure compliance. We respectfully request a desk review on this citation | |