PRINTED: 08/23/2024

An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/05/24 Earlity Number: 000271 Provider Number: 155402 AIM Number: 100291260 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 The facility has 127 certified beds. At the time of the survey, the census was 76. Quality Review completed on 08/07/24 E 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana 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 agrees with the allegad 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 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. C 0000 Bidg. 01 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	DEPARTMENT	Γ OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Survey Date: 08/05/24

Facility Number: 000271

Provider Number: 155402

AIM Number: 100291260

TITLE

(X6) DATE

Heritage Healthcare agrees with

deficiencies do not jeopardize the

health and safety of the residents

the allegations and citations listed. Heritage Healthcare

maintains that the alleged

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ENM921 Facility ID: 000271 If continuation sheet Page 1 of 6

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

PRINTED: 08/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155402		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2024		
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING DEFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ENM921 Facility ID: 000271

If continuation sheet Page 2 of 6

PRINTED: 08/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				` ′	ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER					COMPLETED	
		155402	B. W	ING		08/05/	2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY 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)		DATE	
IAU	Records of system inspection and test secure location and a) Date sprinkler. b) Who provided. c) Water system. Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure 1 of Hall was replaced in NFPA 25, Standard and Maintenance of Systems, 2011 Editis sprinklers shall not be free of corrosion physical damage; and correct orientation (sidewall). Furtherm that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in the element (5) Loading (6) Painting unless promote and in the element (5) Loading (6) Painting unless promote and in the element (5) Loading (6) Painting unless promote and in the element (5) Loading (6) Painting unless promote and in the element (5) Loading (6) Painting unless promote and in the element (7) Loading (8) Painting unless promote and in the element (9) Loading (10) Painting unless promote and in the element (11) Leakage (12) Loading (13) Physical Damag (14) Loss of fluid in the element (15) Loading (16) Painting unless promote and in the element (17) Loading (18) Loading (19) L	n design, maintenance, sting are maintained in a and readily available. system last checked system test supply source RKS information on non-required or partial er system. and NFPA 25 on, and interview; the facility of 4 sprinkler heads on Stuart in accordance with NFPA 25. for the Inspection, Testing, of Water-Based Fire Protection ion, Section 5.2.1.1.1 states show signs of leakage; shall in, foreign materials, paint, and and shall be installed in the feeg., up-right, pendent, or sore, at 5.2.1.1.2 any sprinkler any of the following shall be	K 0		K353 What corrective action(s) wibe accomplished for those residents found to have been affected by the deficient practice? The sprinkler head located on Stuart Hall outside resident room #29 was replace. How other residents having the potential to be affected by the same deficient practice who identified and what corrective action(s) will be taken. Any residents on that had the potential to be affected walk through of the entire facil was performed by the ED and director of maintenance to ensino other sprinkler heads had pon them. All presented appropriately. What measures will be put into place or what systemic changes will be mat to ensure that the deficient practice does not recurThe	of ed. y vill A ity sure paint	08/22/2024	
	residents, 2 staff and	a i visitor in the facility.	1		Maintenance Director was			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155402	B. WING			08/05/2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0752	Findings include: 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. 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. 3.1-19(b)				educated on proper sprinkler in presentation. How the correct action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo placeThe Executive Director/designee will audit the sprinkler heads to ensure they not painted.5x per week for 1 month, Then 1 x per week for 5 monthThen monthly for 6 monthsOutcome of the audit where the presented to the QAPI team monthly to ensure compliance. We respectfully request a desireview for this citation	tive ty ut are fill n	
K 0753 SS=E Bldg. 01	unless one of the office of Flame retardation of Flame retardation of Flame retardation of Flame retardation of Poecorations of Decorations of The Secondaries of The	orations rations shall be prohibited					

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Event ID:

ENM921 Facility ID: 000271

If continuation sheet

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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. BUILDING <u>01</u>		01	COMPLETED	
		155402	B. W	ING		08/05/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					OLDIERS HOME RD		
HERITAGE HEALTHCARE					LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation and interview, the facility		K 0	753	K753		08/22/2024
		of 1 Medical Records room			What corrective action(s) w	/ill	
		in decorations that did not			be accomplished for those		
		of the door. LSC 18.7.5.6 states			residents found to have bee	n	
		ations shall be prohibited in			affected by the deficient		
	1	supancy, unless one of the			practice?The paper located	on	
	following criteria i				the Medical Directors door wa	as	
		-retardant or are treated with			removed. How other reside	nts	
		dant coating that is listed and			having the potential to be		
		tion to the material to which it is			affected by the same deficie		
	applied.				practice will be identified an		
		s meet the requirements of			what corrective action(s) wi	II	
	· · · · · · · · · · · · · · · · · · ·	rd Methods of Fire Tests for			be taken. Any residents on th	at	
		of Textiles and Films.			hall had the potential to be		
	` '	s exhibit a heat release rate not			affected however, none were		
	exceeding 100 kW	when tested in accordance with			affected. A walk through of th	ie	
	· ·	rd Method of Fire Test for			entire facility was performed	by	
	Individual Fuel Page	ckages, using the 20 kW			the ED and director of		
	ignition source.				maintenance to ensure no otl	her	
	1 1	s, such as photographs,			doors had papers on them the	at	
		r art, are attached directly to			covered more than 20% on the	nem.	
	_	and non-fire-rated doors in			All presented appropriately. V	What	
	accordance with th				measures will be put into pl		
	1 1	non-fire-rated doors do not			or what systemic changes v	vill	
		peration or any required			be made to ensure that the		
		r and do not exceed the area			deficient practice does not		
	limitations of 18.7.				recurThe Maintenance Direct	tor	
	` '	not exceed 20 percent of the			was educated on having		
		oor areas inside any room or			combustible materials on		
	_	ompartment that is not			doors. How the corrective		
	protected throughout by an approved automatic				action(s) will be monitored to		
	sprinkler system in accordance with Section 9.7.				ensure the deficient practice		
	(c) Decorations do not exceed 30 percent of the				will not recur, i.e., what qua	-	
	wall, ceiling, and door areas inside any room or				assurance program will be p	put	
	space of a smoke compartment that is protected				into placeThe Executive		
	throughout by an approved supervised automatic				Director/designee will audit the		
		accordance with Section 9.7.			doors in the facility to ensure		
		not exceed 50 percent of the			do not have combustible mat	erials	
	_	oor areas inside patient			covering more than 20% of		
sleeping rooms having a capacity not exceeding				them.5x per week for 1			

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155402		155402	B. WING		08/05/	2024	
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COD 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIPED IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	NTE	COMPLETION	
TAG			TAG	DEFICIENCY)		DATE	
IAU	four persons, in a sr protected throughou automatic sprinkler Section 9.7. This deficient pract one smoke compart Findings include: Based on observation Maintenance during 08/05/24 at 12:50 at Medical Records of paper decoration the Based on interview the Director of Maintenance during door was covered we stated that the door agreed that he could rating document for covering as of the time. This finding was read administrator and to the exit conference	noke compartment that is at by an approved, supervised system in accordance with size could affect 20 residents in ment. Ons made with the Director of g a tour of the facility on a.m., the corridor door to the fice contained a wrapping at covered 100% of the door. at the time of the observation, intenance agreed the corridor with a combustible decoration, was 100% covered, and a not provide a flame spread the aforementioned door	TAG	month,Then 1 x per week for 5 monthThen monthly for 6 monthsOutcome of the audit where the presented to the QAPI team monthly to ensure compliance. We respectfully request a describing on this citation.	vill n	DATE	
	3.1-19(b)						

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