STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING -- B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE PARK	2001 HOBSON RD FORT WAYNE, IN 46805

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/19/24 Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830 At this Emergency Preparedness survey, Heritage Park was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 180 certified beds. At the time of the survey, the census was 137. Quality Review completed on 03/20/24	E 0000		
K 0000 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). Survey Date: 03/19/24 Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830 At this Life Safety Code survey, Heritage Park was found not in compliance with Requirements	K 0000	**K 000** Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Hughes	Executive Director	03/28/2024

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.

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	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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the 12 resident rooms on the 200 hall. The remaining 84 resident rooms have battery operated smoke detectors. The facility has a capacity of 180 and had a census of 137 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one shed used for the maintenance office and general storage and an additional shed used for maintenance storage. Quality Review completed on 03/20/24		any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests paper compliance in lieu of a post survey review on or after March 29, 2024.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or			

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 8 hazardous rooms that contained fuel fired equipment was separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 03/19/24 at 12:10 p.m., in the laundry mechanical room which contained fuel fired hot water heaters had a 4" x 5" hole in the ceiling. Based on an interview at the time of the observation, the Maintenance Director agreed there was an unsealed hole in the mechanical room which contained fuel fired equipment.	K 0321	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The 4” by 5” hole in the ceiling in laundry mechanical room was repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents had the potential to be affected prior to the ceiling repair.	03/29/2024

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	The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** After any remodel, ceiling leaks or other changes in structure the Maintenance Director will audit area to assure hazardous rooms remain separated from other areas by smoke resistant partitions. **How the corrective action will be monitored to ensure the deficient practice will not recur (ie QA program put into place):** The Maintenance Director or designee will complete an audit anytime remodeling or construction work is done to assure smoke detectors are place appropriately. The results of the audits will be shared with the QAPI committee monthly if remodeling or construction has been done. If 100% is not achieved an action plan will be developed. The administrator and Maintenance Director will discontinue this audit after six months if the facility is 100% compliant and the QAPI committee agrees the audit is no longer needed. **By what date the systemic changes for each deficiency will be completed: March 29, 2024**	

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K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 unit manger office with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LSC 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 40 residents in one smoke compartment. Findings include:	K 0361	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Smoke detector ordered and will be installed in the moving forward kitchenette. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents in the north end of the building have been identified as having the potential to be affected. Smoke detector being installed in the kitchenette. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** The maintenance director or designee will review smoke detector placement after any remodel, ceiling leaks or other changes in structure to assure	03/29/2024

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	Based on observation with the Maintenance Director on 03/19/24 at 12:23 p.m., the moving forward kitchenette was open to the corridor. The room had a corridor service opening of 1720 square inches and the kitchenette was not protected by an electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Director agreed the kitchenette pass through was greater than 20 square inches, open to the corridor and, did not contain electrically supervised automatic smoke detection. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		smoke detectors are placed appropriately. **How the corrective action will be monitored to ensure the deficient practice will not recur (ie QA program put into place):** The Maintenance Director of designee will complete smoke detector operability tool weekly for 4 weeks and monthly for 6 months. The results of the audits will be shared with the QAPI committee monthly. If 100% is not achieved an action plan will be developed. The Administrator and Director of Nursing will discontinue this audit after 6 months if the facility is 100% compliant and the QAPI committee agrees that the audit is no longer needed. **By what date the systemic changes for each deficiency will be completed: March 29, 2024**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be			

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	posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview; the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect 25 clients that use exit door 11 in the 200-hall. Findings include: Based on records review with the Maintenance Director on 03/19/24 at 10:00 a.m., the smoking policy stated "All facility campuses are designated non-smoking campuses, smoking is not permitted on any of the campus grounds. Employees must leave the campus area to smoke." Based on observation at 12:17 p.m., two staff were smoking right outside door 11 on the 200-hall. Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property due to	K 0741	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Smoking policy for Heritage Park has been revised. Staff will not smoke in any undesignated areas on premises. Designated smoking area is more than 20 feet from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to have been affected by the deficient practice observed. Staff are being	03/29/2024

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	staff smoking by exit door 11. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		educated about the new smoking policy and will be disciplined upon failure to comply. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** The Maintenance Director or designee will be conducting audit of building premises to ensure staff are smoking in approved area only. **How the corrective action will be monitored to ensure the deficient practice will not recur (ie QA program put into place):** The Maintenance Director of designee will complete smoking area audit tool weekly for 4 weeks and monthly for 6 months. The results of the audits will be shared with the QAPI committee monthly. If 100% is not achieved an action plan will be developed. The Administrator and Maintenance Director will discontinue this audit after 6 months if the facility is 100% compliant and the QAPI committee agrees that the audit is no longer needed. **By what date the systemic changes for each deficiency will be completed: March 29, 2024**	

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