STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			OVA) MAIL TUDE TO THE	ONGTRUCTION	OVA) DATE CHRYESY
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155104	B. WING		04/03/2024
	ROVIDER OR SUPPLIER	2	1201 V	ADDRESS, CITY, STATE, ZIP COD W BUENA VISTA RD	
HERITAG	GE CENTER		EVAIN	SVILLE, IN 47710	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
E 0000	0000				
E 0000 Bldg E 0041 SS=F Bldg	conducted by the In accordance with 42 Survey Date: 04/03 Facility Number: 0 Provider Number: 1002 At this Emergency I Center was found not Emergency Prepare Medicare and Medicand Suppliers, 42 Comparison of the survey, the censurvey, the censurvey, the censurvey, the censurvey of the requirement at MET as evidenced I 482.15(e), 483.73 Hospital CAH and §482.15(e) Condition (e) Emergency and The hospital must standby power system ergency plan sethis section and in	290960 Preparedness survey, Heritage of in compliance with dness Requirements for caid Participating Providers FR 483.73. Certified beds. At the time of the was 126. Impleted on 04/05/24 42 CFR, Subpart 483.73 is NOT by: (e), 485.625(e) LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraphs (b)(1)	E 0000	Submission of the plan of correction is not an admission guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like the formally request paper compliance.	he
	§483.73(e), §485. (e) Emergency an	625(e) d standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Adam Strickland Administrator 04/19/2024

Any defiency statement 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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155104		A. BUILDING B. WING			COMPLETED 04/03/2024			
		PROVIDER OR SUPPLIER	t		1201 W	ADDRESS, CITY, STATE, ZIP COD BUENA VISTA RD VILLE, IN 47710		
PR	4) ID EFIX ΓAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
		implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co. Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements foun Facilities Code, NIC Code. 482.15(e)(3), §483 Emergency gener and LTC facilities] source to power end the power systems open emergency, unles *[For hospitals at §483.73(g), and Can the standards incomplement the eminspection of the power systems open emergency, unles	3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must rergency power system g, and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs of that maintain an onsite fuel remergency generators must aw it will keep emergency perational during the					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155104		UILDING	NSTRUCTION	(X3) DATE COMPI 04/03,	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1201 W BUENA VISTA RD EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Federal Register is 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Reconstruction (NARA). For information this material at NA go to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the charance (1) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (viii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to NI 11, 2011. (ix) TIA 12-2 to NI 30, 2012.	n accordance with 5 U.S.C. part 51. You may obtain the sources listed below. a copy at the CMS urce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to inges. Protection Association, 1 k, p, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, iFPA 99, issued March 3, fe Safety Code, 2012						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155104		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/03/2024		
		ROVIDER OR SUPPLIER SE CENTER		1201 \	ADDRESS, CITY, STATE, ZIP COD W BUENA VISTA RD SVILLE, IN 47710	
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
	TAG		LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		(xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to o	FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,	me		
		failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). Based on record reversal failed to provide contesting of 3 of 3 Em. Systems in accordate for Emergency and Section 8.4.9, as record Facilities Code, Section 8.4.9 states Power Systems share every three years (3) assigned class is grup permitted to terminal NFPA 99 Section 6. Type 2 essential eles shall be classified a generator sets. This affect all building of Findings include: Based on record reversal mand 10:45 a.m. Supervisor present, provide documentate three emergency the past 36 month process.	riew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 riew and interview, the facility implete documentation for the tergency Power Standby ince with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care that all Level 1 Emergency Il be tested at least once within 6 months). Where the teater than 4 hours, it shall be tate the test after 4 hours. 1.4.1.1.6.1 states that Type 1 and terrical system power sources to Type 10, Class X, Level 1 to deficient practice could coupants. 1.5. 1.6. 1.6. 1.7. 1.	E 0041	Heritage Center Life Safety Plan of Correction 4-3-2024 Submission of the plan of correction is not an admission guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like the formally request paper compliance. E 041 Hospital CAH and LTC Emergency Power What corrective action(s) with accomplished for those residents found to have been affected by the deficient practice; No residents were affected. The facility has completed a 4-hour load test on 3 of 3 Emergency Power System Generators. How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken; All residents have the potential be affected by the alleged definited and through	the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPLETED
		155104	B. WI	NG	_	04/03/2024
NAME OF P	PROVIDER OR SUPPLIE	ER.			ADDRESS, CITY, STATE, ZIP COD	
LIEDITAC	OF OFNITED				/ BUENA VISTA RD	
HERITAC	GE CENTER			EVANS	SVILLE, IN 47710	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	review.				audits/assessments, alteration	
					processes and in servicing the	
	_	eviewed with the Administrator Supervisor during the exit			facility will ensure correct action	ons
	conference.	supervisor during the exit			will be taken to accurately	, ,
	contenence.				complete a 4-hour load test or of 3 Emergency Power System	
					Generators every 3 years (36	
					months).	
					monard).	
					What measures will be put in	nto
					place and what systematic	
					changes will be made to ens	sure
					the deficient practice does n	not
					recur;	
					Maintenance has been in-serv	viced
					and a 4-hour load test on	
					Emergency Power System	
					Generators every 3 year (36	
					months) has been added to th	ne
					maintenance schedule.	
					How the corrective action w	ill
					be monitored to ensure the	
					deficient practice will not red	cur,
					i.e., what quality assurance	
					program will be put into place	ce;
					Maintenance/Designee(s) will	
					monitor the maintenance	
					calendar/schedule to ensure a	a
					4-hour load test on 3 of 3	
					Emergency Power System	
					Generators is completed ever	·
					years (36 months) with results	
					compliance being forwarded to committee for review and furth	
					suggestions/comments.	ICI
					auggestions/comments.	
					By what date the systematic	,
					changes for each deficiency	
					be completed;	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155104		ì í	UILDING	DNSTRUCTION		ESURVEY LETED B/2024	
	PROVIDER OR SUPPLIER GE CENTER			1201 W	ADDRESS, CITY, STATE, ZIP COD / BUENA VISTA RD SVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
					Completion Date 4-17-2024	4	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 04/0 Facility Number: 0 Provider Number: 1000 At this Life Safety 0 was found not in co for Participation in Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existin 410 IAC 16.2. This one story facility one sto	200043 155104 290960 Code survey, Heritage Center mpliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors, corridors, and all resident the facility has a capacity of 172 126 at the time of this survey. Idents have customary access and all areas providing facility storage and one	K 0	000	Submission of the plan of correction is not an admiss guilt by the facility related to alleged deficiencies noted in 2567. The facility would like formally request paper compliance.	o the in the	

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G9GD21 Facility ID: 000043

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155104		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2024		
	PROVIDER OR SUPPLIER		1201 V	ADDRESS, CITY, STATE, ZIP COD V BUENA VISTA RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ppleted on 04/05/24	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cookin appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer p conditions under 1 Cooking facilities with 30 or fewer p conditions under 1 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure the stove/ovens in the fi switch when not in within a smoke corr commercial cooking prepare meals for 30 permitted, provided complies with all th (1) The space conta is not a sleeping roo (2) The space conta	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small is microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. orotected according to 3 are not required to be redous areas, but shall not ridor. 1.18.3.2.5.4, 19.3.2.5.1 1.5, 9.2.3, TIA 12-2 1.5 on and interview, the facility cook top for 3 of 3 accility were shut off at the use. LSC 19.3.2.5.4 states apartment, residential or grequipment that is used to 0 or fewer persons shall be that the cooking facility to following conditions: ining the cooking equipment	K 0324	Heritage Center Life Safety Plan of Correction 4-3-2024 Submission of the plan of correction is not an admission guilt by the facility related to the alleged deficiencies noted in a 2567. The facility would like the formally request paper compliance.	he the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155104	B. W	ING		04/03/	2024
				CENTER	ADDRESS STEW STATE SID COD		
NAME OF F	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
LIEDITA	OF OFNITED				/ BUENA VISTA RD		
HERITAG	GE CENTER			EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	complying with 19.	3.6.2 through 19.3.6.5.			K 324 Cooking Facilities		
	(3) The requirement	ts of 19.3.2.5.3(1) through (10)					
	and (13) are met.				What corrective action(s) will	l be	
	19.3.2.5.3(9) states	A switch meeting all the			accomplished for those		
	following is provide	ed:			residents found to have been	า	
	(a) A locked switch	, or a switch located in a			affected by the deficient		
	restricted location, i	is provided within the cooking			practice;		
	facility that deactive	ates the cooktop or range.			No residents were affected. The	ne	
	(b) The switch is us	sed to deactivate the cooktop			facility has installed power shu	ıt off	
	or range whenever t	the kitchen is not under staff			switches for 3 of 3 oven/stove	tops	
	supervision.				and ensured the power is swit	ched	
	This deficient practice could affect at least 10		off when not in use.				
	resident, staff and visitors while in the Activity						
	Pavilion, Hearthside Breakroom, and Physical				How other residents having	the	
	Therapy Gym.				potential to be affected by th	e	
					same deficient practice will l	ре	
	Findings include:				identified and what correctiv	e	
					action will be taken;		
		ons on 04/03/24 between 10:45			All residents have the potentia	l to	
	_	during a tour of the facility with			be affected by the alleged defi	cient	
		pervisor, there were cooktop			practice and through		
		Activity Pavilion, Hearthside			audits/assessments, alteration		
		hysical Therapy Gym. The			processes and in servicing the		
		e areas were not being used at			facility will ensure correct action		
		servation and the power to			will be taken related to power		
		s on. Based on interview at			off switches being installed for		
		servation, the Maintenance			3 oven/stove tops and ensurin	•	
		ed the cooktop stove/ovens			power is switched off when no	t in	
	were not deactivate	d when not in use.			use.		
		viewed with the Administrator			What measures will be put in	ito	
		upervisor during the exit			place and what systematic		
	conference.				changes will be made to ens		
	2 1 10/h				the deficient practice does n	ot	
	3.1-19(b)				recur;		
					Staff have been in-serviced or	-	
					power shut off switches being		
					installed for 3 of 3 oven/stove	iops	
					and ensuring the power is		
					switched off when not in use.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/23/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155104	l í	JILDING	ONSTRUCTION 01	(X3) DATE S COMPL 04/03/	ETED
	PROVIDER OR SUPPLIER GE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP COD 1201 W BUENA VISTA RD EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, esting are maintained in a and readily available. system last checked			How the corrective action windle monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. Maintenance/Designee(s) will monitor 3 oven/stove tops to ensure the power is switched when not in use x 5 days a wear for 4 weeks, then 3 x a week for weeks, then weekly for four months with results of compliate being forwarded to QA commit quarterly thereafter for review further suggestions/comments. By what date the systematic changes for each deficiency be completed; Completion Date 4-17-2024	cur, ce; off eek for 4 ance ttee and s.	
	b) Who provided	<u> </u>					
	c) Water system	supply source	I		Í.		

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Provide in REMARKS information on

Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155104		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/03/2024		
	ROVIDER OR SUPPLIER			1201 W	DDRESS, CITY, STATE, ZIP COD BUENA VISTA RD VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure sprincompartments partial was replaced. NFP sprinklers shall not be free of corrosion physical damage; at correct orientation (sidewall). Furthern that shows signs of replaced: (1) Leaka Damage (4) Loss of responsive element unless painted by the	and NFPA 25 on and interview, the facility inkler heads in 1 of 12 smoke ally covered with corrosion A 25, 2011 edition, at 5.2.1.1.1 show signs of leakage; shall is, foreign materials, paint, and and shall be installed in the e.g., up-right, pendent, or hore, at 5.2.1.1.2 any sprinkler any of the following shall be e.ge (2) Corrosion (3) Physical if fluid in the glass bulb heat (5) Loading (6) Painting e sprinkler manufacturer. ince could affect at least 20	K 03	53	Heritage Center Life Safety Plan of Correction 4-3-2024 Submission of the plan of correction is not an admission guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance. K 353 Sprinkler System – Maintenance and Testing	ne he	04/17/2024
	a.m. and 1:00 p.m. of the Maintenance Su sprinkler head in the rooms 114 and 115 corrosion. Based or observation, the Mathe sprinkler head in rooms 114 and 115 green corrosion and This finding was re-	ons on 04/03/24 between 10:45 during a tour of the facility with pervisor, there was one e corridor outside resident partially covered with green in interview at the time of intenance Supervisor agreed in the corridor outside resident was partially covered with should be replaced. Viewed with the Administrator apervisor during the exit			What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice; No residents were affected. The facility has replaced the sprink head that was partially covere with corrosion. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents have the potential be affected by the alleged defipractice and through audits/assessments, alteration processes and in servicing the facility will ensure correct action.	nnekler d the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155104		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2024		
	PROVIDER OR SUPPLIER		1201 \	ADDRESS, CITY, STATE, ZIP COD W BUENA VISTA RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
mo	KEGGEZHIGKI GA	THE INCIDENTIAL	will be taken related to and has replaced any sprinkler head covered with corrosion.		
				What measures will be put in place and what systematic changes will be made to entitle deficient practice does recur; Maintenance has been in-ser to ensure sprinkler heads cowith corrosion are replaced. How the corrective action who be monitored to ensure the deficient practice will not refice, what quality assurance program will be put into plate Maintenance/Designee(s) will monitor sprinkler heads 2 time year during the semi-annual inspection to ensure corroded sprinkler heads are replaced results of compliance being forwarded to QA committee for review and further suggestions/comments. By what date the systematic changes for each deficiency be completed; Completion Date 4-17-2024	sure not viced vered vill ecur, ce; l es a fire d with or
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the			

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 $G9GD21 \quad \ \ \text{Facility ID:} \quad \ 000043$

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED			
		155104	B. WING	<u> </u>	04/03/2024			
NAME OF F	PROVIDER OR SUPPLIER	t	STREET ADDRESS, CITY, STATE, ZIP COD					
				/ BUENA VISTA RD				
HERITAC	GE CENTER		EVANS	EVANSVILLE, IN 47710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION			
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			
	10-second criterio	n is not met during the						
		ocess shall be provided to						
		his capability for the life						
	I	branches. Maintenance						
	· -	generator and transfer						
	_	ormed in accordance with						
	NFPA 110.							
	Generator sets are	e inspected weekly,						
		pad 30 minutes 12 times a						
		intervals, and exercised						
	1 -	nths for 4 continuous hours.						
		der load conditions include						
	a complete simula							
	automatic or manual transfer of all EES loads, and are conducted by competent							
		nance and testing of stored						
	I	rces (Type 3 EES) are in						
	1	NFPA 111. Main and feeder						
		re inspected annually, and a						
		dically exercising the						
	1	tablished according to						
	1	uirements. Written records						
	I	nd testing are maintained						
		ble. EES electrical panels						
		arked, readily identifiable,						
		n normal power circuits.						
		ssibility of damage of the						
		source is a design						
	consideration for r	<u> </u>						
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
		view and interview, the facility	K 0918	Heritage Center	04/17/2024			
		mplete documentation for the	1.0710	Annual Recertification and	0 7/1 //2027			
	_	nergency Power Standby		Licensure Survey				
	_	nce with NFPA 110, Standard		Plan of Correction				
		Standby Power Systems,		4-3-2024				
		quired by NFPA 99 Health Care						
		etion 6.4.1.1.6.1. NFPA 110		Submission of the plan of				
		that all Level 1 Emergency		correction is not an admission	of			
		Il be tested at least once within		guilt by the facility related to the				
	1 - 5 Ci - y bicilib bila	01100 17 111111	1	I game by the racinty related to th	, o			

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Event ID:

G9GD21

Facility ID: 000043

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPLETED		
		155104	B. WING			04/03/2024		
				CTREET	ADDRESS SITU STATE ZIR SOD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
LIEDITA	OF OFNITED		1201 W BUENA VISTA RD					
HERITAG	GE CENTER			EVANSVILLE, IN 47710				
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DEAN OF CODDECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				DEFICIENCY)	.16	DATE	
	every three years (36 months). Where the				alleged deficiencies noted in t	he		
	assigned class is greater than 4 hours, it shall be			2567. The facility would formally request paper compliance.				
	permitted to terminate the test after 4 hours.							
	NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and							
	Type 2 essential electrical system power sources							
	shall be classified at Type 10, Class X, Level 1				K 918 Electrical Systems –			
	generator sets. This deficient practice could				Essential Electrical Systems			
	affect all building occupants.				Essential Electrical Cysterns			
	affect an building occupants.				What corrective action(s) wi	II he		
Findings include:					accomplished for those	" DC		
	i manigs merade.				residents found to have been	,		
	Deced on record review on 04/02/24 hetween 0.1				affected by the deficient	"		
	Based on record review on 04/03/24 between 9:15				_			
	a.m. and 10:45 a.m. with the Maintenance				practice; No residents were affected. T	ha		
	Supervisor present, the facility was unable to provide documentation of a four hour load test of							
	_				facility has completed a 4-hou			
		y generators conducted within			load test on 3 of 3 Emergency	′		
	the past 36 month period. This was confirmed by				Power System Generators.			
	the Maintenance Supervisor at the time of record				l			
	review.				How other residents having the			
					potential to be affected by the			
	_	ding was reviewed with the Administrator			same deficient practice will			
	and Maintenance Supervisor during the				identified and what corrective	⁄e		
	conference.				action will be taken;			
					All residents have the potentia			
	3.1-19(b)				be affected by the alleged def	icient		
					practice and through			
					audits/assessments, alteration			
					processes and in servicing the	Э .		
					facility will ensure correct action	ons		
					will be taken to accurately			
					complete a 4-hour load test or	า 3		
					of 3 Emergency Power Syster	n		
					Generators every 3 years (36			
					months).			
					What measures will be put in	nto		
					place and what systematic			
					changes will be made to ens	euro		
					the deficient practice does n	iot		
					recur;			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/03/2024			
NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1201 W BUENA VISTA RD EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		ATE	(X5) COMPLETION DATE		
					Maintenance has been in-ser and a 4-hour load test on Emergency Power System Generators every 3 year (36 months) has been added to the maintenance calendar/schedute. How the corrective action with the maintenance calendar/schedute. How the corrective action with the monitored to ensure the deficient practice will not resisted. When the monitored to ensure the deficient practice will not resisted. When the maintenance program will be put into place Maintenance/Designee(s) will monitor the maintenance calendar/schedule to ensure a 4-hour load test on 3 of 3 Emergency Power System Generators is completed ever years (36 months) with results compliance being forwarded to compliance being forwarded to compliance for review and furth suggestions/comments. By what date the systematic changes for each deficiency be completed; Completion Date 4-17-2024	ne ule. ill cur, ce; a y 3 s of o QA ner			

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