STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155692	A. BUILDING -- B. WING	05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF HUNTINGTON	1180 WEST 500 NORTH HUNTINGTON, IN 46750

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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: 05/11/23 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 At this Emergency Preparedness survey, Heritage Pointe of Huntington was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 78 and had a census of 63 at the time of this survey. Quality Review completed on 05/15/23	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: 05/11/2023 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 At this Life Safety Code survey, Heritage Pointe of Huntington was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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 battery operated smoke detectors in the two Communication rooms. The facility has a capacity of 78 and had a census of 63 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/15/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure all battery backup emergency lights were tested annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0291	No residents were found to be impacted by the identified finding. No additional residents were identified to be affected by the finding. Please note that after the surveyor left the building, the maintenance director was able to find that the backup emergency lights were indeed tested for 90 minutes on	05/22/2023

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	jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Director of Maintenance (DM) on 05/11/23 at 11:15 a.m., annual testing for the battery backup emergency lights was unavailable. Based on interview at the time of records review, the DM stated the annual 90 minute testing for the battery backup emergency lights has not been conducted in the past 12 months. This finding was reviewed with the Assistant Administrator and DM at the exit conference. 3.1-19(b)		1/27/23 (Attachment A). They were tested again for 90 minutes on 5/15/23 and all were working for a 90 minute duration period and were logged on a 90 Minute Exit Light Test form (Exhibit B).Battery-Operated Emergency Lights and that all battery backup emergency lights are to be tested functionally monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds (Attachment C). In addition, functional testing will be conducted annually for a minimum of 90 minutes if the emergency lighting system is battery powered. Written records of visual inspections and tests will be kept for inspection as needed. Emergency and Exit Light Testing form will be used by maintenance staff when conducting QA audits monthly for 12 months. The audits will be monitored by the Executive Director for 100% compliance. The form will also be reviewed by the QAPI committee for content and recommendations (Attachment D).	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the			

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	Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Assistant Administrator and Director of	K 0353	No residents were found to be impacted by the identified finding. No other residents were identified to be affected by the finding. The extra sprinkler heads that did not fit into the sprinkler boxes were removed from the area on 5/11/23. All Maintenance Riser rooms were inspected to ensure that all sprinkler heads were stored properly in cabinets per NFPA 25, Section 5.4.1.4 (Attachment E). All maintenance employees were in-serviced on the sprinkler service policy and proper storage of sprinkler heads not in use Attachment F). Audits will be conducted in maintenance Riser rooms to	05/22/2023

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	Maintenance (DM) on 05/11/2023 at 1:10 p.m., there was a spare sprinkler cabinet in the riser room that included 6 spare sprinklers; 4 of which were not in their own protected slot in the sprinkler box. Based on interview at the time of the observation, the DM agreed the spare sprinkler cabinet had 4 spare sprinklers not in protected slots. At the time of observation the DM put the loose sprinkler heads in protective slots. This finding was reviewed with the Assistant Administrator and DM at the time of discovery and again at the exit conference. 3.1-19(b)		ensure all sprinkler heads are stored properly, weekly for 4 weeks then monthly for 6 months. Audit records will be reviewed by the Executive Director and the QAPI committee for compliance and recommendations (Attachment G).	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke	K 0374	No residents were found to be impacted by the identified finding. No other residents were identified to be affected by the finding.	05/22/2023

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	barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 20 residents in two smoke compartments Finding include: Based on observation during a tour of the facility with the Assistant Administrator and Director of Maintenance (DM) on 05/11/23 at 2:00 p.m. the smoke barrier doors by the Dining Room and room 133 had a 1/2 inch gap between the doors because it would not fully close due to hitting the door frame. Based on an interview at the time of observation, the DM agreed there was a gap larger than 1/8 inch between the smoke doors when it attempted to close. This finding was reviewed with the Assistant Administrator and DM at the exit conference. 3.1-19(b)		The smoke barrier door was adjusted on 5/15/23 to ensure that self-closing fire doors at the healthcare dining room were in proper working condition (Attachment K). All smoke doors were inspected with all doors in compliance per LSC 8.5.4.1. Maintenance staff were in-serviced on the Fire & Smoke door policy (Attachment L). Inspections of all smoke barrier doors will be conducted by maintenance staff to ensure they close properly, weekly for 4 weeks then monthly for 6 months (Attachment M).	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure all fuel fired water heaters and boilers had current inspection certificates to ensure the water heaters and boilers were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed	K 0500	No residents were found to be impacted by the identified finding. No other residents were identified to be affected by the finding.	05/22/2023

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	constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents in the facility. Findings include: Based on observation during a tour of the facility with the Assistant Administrator and Director of Maintenance (DM) on 05/11/23 at 12:22 p.m. and 1:25 p.m., the fuel fired water heaters and boilers in the main furnace room did not have current boiler permits. Based on interview at the time of the observation, the DM stated the current inspection for the boilers and water heaters could not be found and agreed the boilers and hot water heaters needed to be inspected. This finding was reviewed with the Assistant Administrator and DM at the exit conference. 3.1-19(b)		The facility insurance company was contacted and scheduled to complete all boiler and hot water heater inspections. This inspection was completed on May 22, 2023 by The Hartford Steam Boiler Inspection and Insurance Company and can be seen as pending on the DHS permits website (Attachment N). Maintenance staff was in-serviced on the Maintenance Inspection policy (Attachment O) and a documentation checklist for Life Safety Code Surveys was reviewed to ensure that all Life Safety Standards are being followed. A work order has been placed in the TELS maintenance program that will prompt the maintenance staff to set up boiler inspections timely. The Boiler inspections were also added to the Life Safety Code Documentation Checklist to ensure the inspections are completed in a timely manner (Attachment P). The Life Safety Code Documentation list will be completed weekly for 4 weeks then monthly for 5 months. The Executive Director will review each checklist and present findings to the QAPI committee for recommendations (Attachment Q).	

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