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	03/12/2024

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: 03/12/24 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 72 at the time of this survey. Quality Review completed on 03/14/24	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: 03/12/24 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
Jodie Stanley	Health Facility Administrator	03/27/2024

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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	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(III) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 78 and had a census of 72 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 03/14/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60	K 0211	**1 Immediate action(s) taken for the resident(s) found to have been affected include:** The PPE cart was replaced with a PPE cart that had wheels on March 12, 2024. **1 Identification of other residents having the potential to be affected was**	04/05/2024

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	in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects at least 6 residents in the vicinity of room 169. Findings include: Based on observation during a tour of the facility with the Director of Maintenance (MD) on 03/12/24 at 2:00 p.m., a Personal Protective Equipment (PPE) cart was in use in the corridor by room 169 but was not equipped with wheels allowing the cart to be moved out of the hall during an emergency. Based on an interview at the time of observation, the MD agreed the PPE cart in the corridor by room 169 was not equipped with wheels and would need to be replaced with a PPE cart with wheels. The finding was reviewed with the Director of Nursing and the Maintenance Director during the exit conference. 3.1-19(b)		**accomplished by:** The facility has determined that all residents have the potential to be affected. All PPE carts in healthcare have been inspected to ensure that they are wheeled carts. **1 Actions taken/systems put into place to reduce the risk of future occurrence includes:** All nursing staff will be in-serviced regarding the facility policy for Means of Egress to ensure that only carts on wheels be used for PPE storage. PPE storage containers without wheels were discarded so that they are not inadvertently put into use. **1 How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON will complete random weekly audits for four (4) consecutive weeks and then monthly for three (3) months to ensure PPE is stored only in wheeled carts in the hallways. QA audits will be reviewed by the administrator upon the completion of each audit. QA records will be reviewed by the Quality Assurance Committee for review and recommendations.	
K 0511 SS=D	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect at least 2 residents. Findings include: Based on observation with the Director of Maintenance (DM) on 03/12/24 at 02:05 p.m. when the GFCI receptacle located within 6 feet feet from the sink by room 164 was tested with a GFCI tester the electric receptacle did not trip. Based on interview at the time of observation, the DM agreed the GFCI electric receptacle within 6 feet of the sink by room 164 did not trip when tested. This finding was reviewed with the Director of Nursing and the DM during the exit conference. 3.1-19(b)	K 0511	**1 Immediate action(s) taken for the resident(s) found to have been affected include:** The GFCI located by room 164, near the sink, was replaced on March 13, 2024, by maintenance staff. The new GFCI was confirmed to be in working order (Attachments A, B, C) **1 Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents and staff have the potential to be affected. All other GFCI receptacles have been inspected by the maintenance department and were found to be in working order. **1 Actions taken/systems put into place to reduce the risk of future occurrence includes:** All maintenance staff were in-serviced regarding the facility policy for Electrical Safety and the importance of replacing any faulty GFCI receptacles immediately. **1 How the corrective action(s) will be monitored to ensure the practice will not recur:**	04/05/2024

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			The Director of Maintenance or designee will complete random checks of 5 GFCI receptacles for proper function each week for four (4) weeks and then monthly for three (3) months. If any receptacles are identified as being faulty, they will be immediately replaced. QA audits will be reviewed by the administrator upon the completion of each audit. QA records will be reviewed by the Quality Assurance Committee for review and recommendations.	
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 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			

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	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 records review and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff outside the rear of the facility at the picnic table. Findings include: Based on record review with the Director of Maintenance (DM) on 03/12/24 at 03:00 p.m., there were three conflicting smoking policy documents found. The facility smoking policy stated that it is a smoke free facility with smoking prohibited in all areas of the facility and facility grounds. The second document was a smoking policy that the employees sign which stated that smoking by staff was permitted only in designated areas but with no locations identified. The third document was in the Environmental Safety Policy, smoking section that stated, Smoking by employees will be permitted ONLY in the employee's vehicles or designated areas but with no locations identified. Based on interview with the DM, he stated that employees smoke outside when the weather is nice in the back by the picnic table and there is an ashtray provided to dispose of their cigarette butts. The facility needs to clarify their smoking policy. This finding was reviewed with the Director of Nursing and DM at the exit conference.	K 0741	**1 Immediate action(s) taken for the resident(s) found to have been affected include:** On March 14,2024, the conflicting smoking policies were reviewed by the administrator and director of maintenance. The policies were condensed to ensure that only one (1) policy was in place. (Attachment D) **1 Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents and staff have the potential to be affected. On March 19, 2024, the smoking policy was posted at the employee entrance to ensure that all staff had immediate access to the updated policy. **1 Actions taken/systems put into place to reduce the risk of future occurrence includes:** All facility staff will be educated on the updated smoking policy. **1 How the corrective action(s) will be monitored to ensure the practice will not recur:**	04/05/2024

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	3.1-19(b)		The Director of Maintenance or designee will complete random audits for four (4) weeks and then monthly for three (3) months to ensure facility policy compliance. QA audits will be reviewed by the administrator upon the completion of each audit. QA records will be reviewed by the Quality Assurance Committee for review and recommendations.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions			

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	as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observation with the Director of Maintenance (DM) on 03/12/24 at 02:10 p.m. in the oxygen storage room there was no means to separate full liquid oxygen cylinders from empty cylinders with an empty liquid oxygen cylinder intermingled with the full cylinders. Based on interview at the time of observation, the DM agreed that an empty liquid oxygen cylinder was mixed with the full cylinders. This finding was reviewed with the Director of Nursing and DM during the exit conference. 3.1-19(b)	K 0923	**1 Immediate action(s) taken for the resident(s) found to have been affected include:** The director of maintenance marked the oxygen storage area to clearly delineate empty oxygen cylinders from full cylinders on March 13, 2024 (Attachment E) **1 Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. **1 Actions taken/systems put into place to reduce the risk of future occurrence includes:** All nursing staff and maintenance staff will be in-serviced regarding the facility policy for oxygen storage. (Attachment F) The policy was updated to	04/05/2024

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			store/place oxygen containers in the appropriate area designated for full cylinders and empty cylinders. **1 How the corrective action(s) will be monitored to ensure the practice will not recur:** The director of maintenance or designee will check the oxygen room weekly audits for four (4) consecutive weeks and then monthly for three (3) months. The audit will continue if 100% compliance is not achieved. The checks will be to confirm oxygen cylinders are appropriately placed in the designated area in the oxygen room. QA audits will be reviewed by the administrator upon the completion of each audit. QA records will be reviewed by the Quality Assurance Committee for review and recommendations.	