STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING -- B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF WARREN	801 N HUNTINGTON AVE WARREN, IN 46792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/13/23 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 At this Emergency Preparedness survey, Heritage Pointe of Warren 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 182 and had a census of 83 at the time of this survey. Quality Review completed on 03/14/23	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: 03/13/2023 Facility Number: 000542 Provider Number: 155705 AIM Number: 100267380 At this Life Safety Code survey, Heritage Pointe of Warren was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Johns	HFA	03/18/2023

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 two story facility was determined to be of Type II (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 in the resident rooms. The facility has a capacity of 182 and had a census of 83 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 03/14/23			
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 1 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	- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All hallways inspected. - What corrective action(s) will be accomplished for those	04/05/2023

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	155705	A. BUILDING 01 B. WING	03/13/2023

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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 all residents and staff in the area of resident room 161. Findings include: Based on an observation during a tour of the facility with the Maintenance Director 03/13/23 at 1:15 p.m., in the resident hall by resident room 161, a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the carts to be moved out of the halls during an emergency. Based on an interview at the time of observations, the Administrator stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		residents found to have been affected by the deficient practice; No residents were noted to be affected by the alleged deficient practice. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Wheels installed on all isolation carts. Maintenance personnel re-educated on utilizing correct isolation carts with wheels. Attachment: D - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Maintenance personnel will inspect corridors weekly for 8	

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			weeks then monthly for 4 months. Any issues will be corrected immediately. If 100% compliance is not obtained additional interventions including audits will be extended per the QA committees recommendations.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 1 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 2 smoke compartments. Findings include: Based on observations during a tour of the facility with the Administrator and Maintenance Director on 03/13/23 at 1:15 p.m., the 1 ½ hour rated fire door set located by resident room 166 was used as a horizontal exit and as a smoke barrier. When tested the doors failed to close and latch into the	K 0226	- How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Inspections completed on all fire doors - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All corridor fire doors were inspected on 03/13/2023 with no further doors noted to be deficient. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	04/05/2023

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	frame due to a latch malfunction. Based on interview at the time of observation, the Maintenance Director stated the fire door set was not latching into the frame. This deficiency was corrected prior to the end of the survey, This finding was reviewed during the exit conference with the Administrator and Maintenance Director. 3.1-19(b)		Unit recently had remodeling completed. Facility believes painting and new flooring contributed to the poor closure. Fire doors were immediately adjusted to ensure effective door closure as per regulation. Facility currently conducts monthly door checks on all fire doors. Inspections to continue monthly with an additional check post any remodeling/painting/flooring projects potentially affecting fire doors. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Audits will be conducted to ensure all fire doors are securely latching weekly for 8 weeks then monthly	

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			for 4 months. If 100% compliance is not obtained additional interventions including audits will be extended per the QA committees recommendations.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power	K 0920	- How other residents having the potential to be affected by the same deficient practice will be	04/05/2023

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	equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect 1 resident in room 205 . Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 03/13/23 at 2:05 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the resident room 205. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could effect the resident in room 116. Findings include: Based on observation with the Maintenance Director on 03/13/23 at 2:30 p.m., in resident room 116, a power strip used to power equipment, was not secured, and was dangling from the outlet on		identified and what corrective action(s) will be taken; Room inspections completed to identify all refrigerators. Rooms inspected to ensure no further unsecured power strips. - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Refrigerator taken out of service and family consulted. Power strip taken out of service as there were available outlets not in use and family notified. - What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; New policy developed for resident refrigerators. Attachment: A pages 1-2 Quarterly environmental safety inspection form modified to include inspecting for improper power strip usage (not dangling or utilized with high voltage items such as refrigerators). Attachment: B Maintenance, nursing, housekeeping and social services personnel to complete in-service	

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	the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling and not secured. These findings were reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		on new refrigerator policy. Attachment: C pages 1-4 - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Audits will be conducted to ensure all refrigerators are plugged directly into wall outlet weekly for 8 weeks then monthly for 4 months. Audits will be conducted to ensure there are no power strips in poor condition, inappropriately used or utilized (dangling) weekly for 8 weeks the monthly for 4 months. If 100% compliance is not obtained additional interventions including audits will be extended per the QA committees recommendations.	