STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING -- B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HEALTHCARE	3401 SOLDIERS HOME RD WEST LAFAYETTE, IN 47906

(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: 05/09/23 Facility Number: 000271 Provider Number: 155402 AIM Number: 100291260 At this Emergency Preparedness survey, Heritage Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 127 certified beds. At the time of the survey, the census was 66. Quality Review completed on 05/10/23	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: 05/09/23 Facility Number: 000271 Provider Number: 155402 AIM Number: 100291260 At this Life Safety Code survey, Heritage Healthcare was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua Davis	Executive Director	05/22/2023

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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	Requirements 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 consists of the original building of Type II (000) construction and the 1989 addition of a north wing and extension to an east wing of Type V (111) construction. Since the buildings were all constructed prior to July 5th, 2016, they were surveyed as one building of Type V (000). The facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered detectors in all resident sleeping rooms. The facility has a capacity of 127 and had a census of 66 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two equipment storage pods located in the back parking lot. Quality Review completed on 05/10/23			
K 0291 SS=E 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 observation and interview, the facility failed to ensure 2 of 23 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated	K 0291	**K291** **What corrective action(s) will**	05/22/2023

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	emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect as many as 18 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility between 11:15 a.m. and 2:00 p.m. on 05/09/23 with the Maintenance Director, the following was noted: a) the battery-operated emergency light between resident rooms #59 and #60 failed to function when its respective test button was pushed five times. b) the battery-operated emergency light located in the Service Hall failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, Maintenance Director acknowledged the aforementioned battery-operated emergency lights failed to function when its respective test button were pushed. This finding was reviewed with the facility administrator and the Maintenance Director at the exit conference on 05/08/23 at 2:15 p.m. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** The battery powered emergency lights had batteries replaced in them and are now operational. **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.** Any residents on that hall had the potential to be affected however, none were affected. A walk through of the entire facility was performed by the ED and director of maintenance to ensure no other battery operated lights failed to operate. All operated appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Executive Director/designee will change the batteries in the emergency lighting annually to ensure proper function.	

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			Maintenance Director was educated on changing batteries in emergency lighting. **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** The Executive Director/designee will audit the emergency lighting to ensure proper function. 5x per week for 1 month, Then 1 x per week for 5 month Then monthly for 6 months Outcome of the audit will be presented to the QAPI team monthly to ensure compliance.	
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			

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	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 2 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 18 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility between 11:15 a.m. and 2:00 p.m. on 05/09/23 with the Maintenance Director, the following was noted: a) the smoke barrier doors nearest to resident rooms #65 and #70 failed to fully close leaving a one-inch gap when tested on three separate occasions. b) the smoke barrier doors on Ross Hall failed to fully close leaving a one-inch gap when tested on three separate occasions. Based on interview at the time of the observations, Maintenance Director acknowledged the aforementioned smoke barrier doors failed to fully close when tested adding that he would adjust them as soon as ha had time to work on them. This finding was reviewed with the facility	K 0374	**K374** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**The smoke barrier doors were serviced and repaired. **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.**Any residents on that hall had the potential to be affected however, none were affected. A walk through of the entire facility was performed by the ED and director of maintenance to ensure no other smoke barrier doors failed to operate. All operated appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**The Executive Director/designee will audit the doors monthly to ensure function. Maintenance Director was educated on proper function of smoke barrier doors. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	05/22/2023

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	administrator and the Maintenance Director at the exit conference on 05/08/23 at 2:15 p.m. 3.1-19(b)		**recur, i.e., what quality assurance program will be put into place**The Executive Director/designee will audit the smoke barrier doors to ensure proper function.5x per week for 1 month,Then 1 x per week for 5 monthThen monthly for 6 monthsOutcome of the audit will be presented to the QAPI team monthly to ensure compliance.	