STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155729	A. BUILDING -- B. WING	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ADAMS HERITAGE	12011 WHITTERN RD MONROEVILLE, IN 46773

(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: 12/06/2022 Facility Number: 002549 Provider Number: 155729 AIM Number: 200289420 At this Emergency Preparedness survey, Adams Heritage 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 61 and had a census of 40 at the time of this survey. Quality Review completed on 12/12/22	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: 12/06/22 Facility Number: 002549 Provider Number: 155729 AIM Number: 200289420 At this Life Safety Code survey, Adams Heritage was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natasha Graves	Administrator	12/23/2022

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	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 hard wired smoke detectors in the resident rooms. The facility has a capacity of 61 and had a census of 40 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 12/12/22		executed solely because is required by the provisions of federal and state law. Adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of December 23, 2022.	

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			Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it the requirements of participation or that corrective action was necessary.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the			

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	approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms in the large Activity room with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 30 residents in the large Activity room. Findings include: Based on observation during a tour of the facility with the Lead Maintenance Mechanic (LMM) on 12/06/22 at 1:00 p.m., the large Activity room	K 0321	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? The facility cleaned out the storage room and added the automatic door closer to the door. See pictures in attachments A, B,	12/21/2022

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	storage room contained over 20 feet of storage racks five feet tall of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the LMM agreed the storage room contained a large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the LMM during the exit conference. 3.1-19(b)		and C. 2. 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? No other residents were identified that could be affected by the same alleged deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The activity department will monitor the storage monthly to ensure the storage area does not exceed 20 feet of storage.	

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			4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? This will be an indicator added to our QAPI program. The activity director will monitor This indicator will be on QAPI for one year.	
K 0353 SS=D 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 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	K 0353	1. What corrective action will be accomplished for	12/06/2022

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	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 Lead Maintenance Mechanic (LMM) on 12/06/22 at 1:05 pm. there were 7 spare sprinkler heads in the spare sprinkler head cabinet; 6 of which were in their own protected slot. Furthermore, inside the cabinet 1 sprinkler head was stored loose in the cabinet and not secured in a holder. Based on interview at the time of the observation, the LMM agreed the spare sprinkler cabinet had one spare sprinkler not in protected slot. This finding was reviewed with the LMM and the Administrator at the exit conference.		those residents found to have been affected by this alleged deficient practice? The one sprinkler head was placed in the secure holder, now all spare sprinkler heads are in the secure holder. See pictures in attachment D. 2. 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? No other residents were identified that could be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	

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			Maintenance was educated on the deficiency that spare sprinkler heads must be inside the red cabinet in its own secured slot. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? This will be an indicator added to our QAPI program. Maintenance will monitor to ensure all spare sprinkler heads are in the secured slot. This indicator will be on QAPI for one year.	
K 0711 SS=E Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available			

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	with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) 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 inches. (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	K 0711	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? It is the facility policy for all wheeled equipment to be stored off the corridor in the shower rooms I.e., med carts, treatment carts, vital machines, etc. Nursing associates may have wheeled equipment on the corridor while in use, however, it should never be stored on the corridor. 2. 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?	12/22/2022

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	This deficient practice could affect all occupants. Findings include: Based on records review with the Lead Maintenance Mechanic (LMM) and Administrator at 11:25 a.m. on 12/06/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation when entering the facility, patient lifts and med-carts were in the corridors throughout the building. Based on interview at the time of records review and observations, the LMM and Administrator acknowledged there was patient wheeled equipment in the halls and the Administrator stated the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. 3.1-19(b)		No other residents were identified that could be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing associates educated that it is the nurse in charge of each corridor to make sure wheeled equipment (if in use during an emergency) is moved in the event of an emergency. Education provided, see attachment F. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? This will be an indicator added to our QAPI program. The DON will monitor to ensure all wheeled	

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			equipment is stored in the shower rooms. This indicator will be on QAPI for three months.	
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 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)			

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	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. NFPA 99, Section11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states, empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observations with the Lead Maintenance Mechanic (LMM) on 12/06/22 at 12:50 p.m., the oxygen storage room contained two racks that did separate full cylinders from empty cylinders. Based on interview at the time of observation, the LMM stated there were full and empty cylinders in the racks but were not identified as full or empty. There was no full or empty cylinder signage. The findings were reviewed with the Administrator and the LMM during the exit conference.	K 0923	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice? The oxygen tanks are identified as full if they have the white cap in place. Once oxygen tanks are empty, or in use, the white cap is removed. Signs are now placed where full tanks can be found and where empty tanks can be placed. See picture on attachment E. 2. 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?	12/15/2022

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	3.1-19(b)		No other residents were identified that could be affected by the same deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing re-educated on placement of empty and full oxygen tanks. See attachment F. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? This will be an indicator added to our QAPI program. The administrator will monitor to ensure empty and full oxygen	

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			tanks are stored in the correct areas of the oxygen room. This indicator will be on QAPI for three months.	