STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155210	A. BUILDING -- B. WING	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(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: 04/12/23 Facility Number: 000117 Provider Number: 155210 AIM Number: 100266460 At this Emergency Preparedness survey, Heritage House of Greensburg was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 49. Quality Review completed on 04/17/23	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: 04/12/23 Facility Number: 000117 Provider Number: 155210 AIM Number: 100266460 At this Life Safety Code survey, Heritage House of Greensburg was found not in compliance with	K 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. We respectfully request paper	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki Mcguire	Administrator	04/28/2023

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 was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 49 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/17/23		compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 3 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 8 residents. Findings include: Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, the exit door located in the Park Manor Utility Corridor, marked as a facility exit, was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. The Maintenance Director tested the delayed egress mechanism during the survey and verified that it was functional. This finding was reviewed with the Maintenance Director and Administrator at the time of	K 0222	It has and will continue to be the policy of this facility to ensure that proper signage is placed on all doors marked as facility exit. Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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. A: While other residents have the potential, and after review, it was noted that none were adversely affected by this deficient practice. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: A sign was ordered and has been placed on the door.	04/28/2023

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	discovery and again at the exit conference. 3.1-19(b)		Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: Audits will be done monthly for six months by administrator or designee to ensure sign remains appropriately on the door.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 8 residents and staff using the Station 3 Exit. Findings include: Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, the exit discharge from the Station 3 Exit corridor had large cracks in the concrete and was uneven on the	K 0271	It has and will continue to be the policy of this facility to ensure safe and level walking areas on exit discharges that are free of obstructions and constructed of hard packed all-weather surface. Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice.	04/28/2023

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	right and left as you exit the door and begin down the ramps. Where the concrete adjoins on each side of the exit door there was uneven grade where the concrete had separated and broken apart. Based on interview at the time of observation, the Maintenance Director acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions leading to the common way. This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		Q: 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 A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: Concrete has been poured to ensure safe, smooth and level walking surface without obstruction. Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: Administrator or designee will monitor monthly x 6 months to ensure safe and level walking areas.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, the date and time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be approximately 25 minutes faster than the actual local time and the date displayed was 2 months and 13 days ahead of the actual day. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed time updated on the fire alarm control panel. This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)	K 0345	It has and will continue to be the policy of this facility to ensure time and date on fire alarm system are accurate. Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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 A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: Time and date have been reset. SafeCare has been scheduled to check/repair time and date. Q: How the corrective action will	05/12/2023

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: Time and date of fire alarm system will be audited/monitored for accuracy by the administrator or designee weekly for 26 weeks.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 alcoves with a large quantity of combustible material open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 13 residents and staff. Findings include:	K 0361	It has and will continue to be the policy of this facility to ensure safe storage areas. Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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	04/28/2023

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	Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, on the Station 3 Maintenance Hall, former dining area, there was an alcove open to the corridor. The alcove was being used as hazardous storage of 4 tables, over 20 chairs, several large bags of clothes, a dorm style refrigerator, and a reclining chair. This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: Materials mentioned in this tag have been disposed of or moved into a closed area. This area will be monitored/audited to ensure safe storage practices are being followed. Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: This will be monitored weekly for 26 weeks by administrator or designee.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

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	to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 6 staff and 2 residents. Findings include:	K 0363	It has and will continue to be the policy of this facility to ensure all corridor and resident rooms are provided with a means suitable for keeping doors closed for safety purposes. Q: What corrective action will be accomplished for those residents	05/12/2023

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	Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, the corridor door to (1) the Kitchen Storage room was propped open with a box from the storage room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door would not close unless the box was moved. And (2) the corridor door to resident room # 88 failed to latch positively into the door frame. The Maintenance Director attempted to latch the door no fewer than 3 times but was unsuccessful each time. This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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 A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected by this deficient practice. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: SafeCare has been contacted and given permission to attach the said door to the fire alarm system so it will automatically and safely close when necessary. Lock on room 88 was also repaired for proper and safe closing. Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: Kitchen door and residents' room locks will be monitored	

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			monthly for six months by administrator or designee.	
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 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 observation and interview; the facility failed to ensure 1 of 3 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing	K 0741	It has and will continue to be the policy of this facility to ensure any cigarettes or butts are disposed in a safe manner and that smoking is	04/28/2023

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	cover devices. This deficient practice could affect staff and 10 residents in the courtyard. Findings include: Based on observations and interview on 04/12/23 between 11:45 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, outside the kitchen exit door, in the gravel next to the building, there were over 25 cigarette butts disposed on the ground in and around the area immediately outside the exit door. The Maintenance Director stated that it was likely the result of staff as the residents do not generally smoke in the area where the butts were observed. This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		only done in designated area. Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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 A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: Cigarette butts were picked up and a No Smoking sign has been posted in the above mentioned area. Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: This will be monitored weekly for 26 weeks by administrator or	

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	155210	A. BUILDING 01 B. WING	04/12/2023

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			designee. Anyone found smoking or disposing of cigarette butts in that area will be addressed with disciplinary action.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section	K 0914	It has and will continue to be the policy of this facility to ensure electrical outlet receptacles are tested annually and when the need arises.	05/12/2023

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	6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on records review and interview with the Maintenance Director and Administrator on 04/12/23 between 10:10 a.m. and 11:45 a.m., an itemized listing of inspection and testing electrical outlet receptacles in the facility for the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated electrical receptacle testing had not been completed in the past 12 months. Provided documentation showed the last receptacle testing was done during the months of June and July of calendar year 2020 .		Q: What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A: No residents experienced adverse effects due to this deficient practice. Q: 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 A: Other residents have the potential to be affected by this deficient practice, but after review, no other residents were affected. Q: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. A: All receptacles are being tested and will continue to be tested annually or as needed to ensure all are working properly and safely. Q: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A: This will be monitored monthly for six months by administrator or designee. Will be	

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	This finding was reviewed with the Maintenance Director and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		discussed at QAPI meetings to ensure any attention needed is directed toward properly tested and working receptacles.	