STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING -- B. WING	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTEI	281 S COUNTY ROAD 200 EAST CONNERSVILLE, IN 47331

(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: 12/11/23 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Emergency Preparedness survey, Heritage House Rehabilitation & Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 98 certified beds. At the time of the survey, the census was 88. Quality Review completed on 12/13/23	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: 12/11/23 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Life Safety Code survey, Heritage House	K 0000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 12/28/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Ware	Executive Director	12/21/2023

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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	Rehabilitation & Health Care Center was found not in compliance with 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 98 and a census of 88. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has one detached garage which was not sprinklered. Quality Review completed on 12/13/23			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in			

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	accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 2 of over 50 rooms were maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic	K 0753	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. The decorations were immediately taken off the doors. **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:** Over 5 residents have the potential to be affected by the alleged deficient practice. The decorations were immediately taken off the doors. Management staff were educated 12/20/23 on door and wall decoration requirements. All other rooms were checked for door and wall decorations by the Maintenance director. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/designee will check door decorations prior to them being hung to ensure compliance with	12/28/2023

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	sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect over five staff, residents and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 12/11/23 between 1:15 p.m. and 3:00 p.m., the corridor door to (1) the Social Services office and (2) Director of Nursing Services Office was covered over 30% with Christmas themed paper decoration. Based on interview at the time of the observations, the Maintenance Director stated the fire resistance rating of the decorations was not available for review, the product was not treated with fire retardant material and agreed the surface of the doors upon which the decorations were attached was substantially more than 30%. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		fire safety regulations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** Maintenance Director/designee to complete Flame Spread/Fire Retardant Treatment Documentation weekly x 4 weeks then monthly for 6 months to monitor the holidays. The results will be reviewed by the CQI committee overseen by the ED. **By what date the systemic changes will be completed:** Completion Date: 12/28/2023	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords			

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	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 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 affect 2 staff in the Maintenance Office. Findings include: Based on observations and interview during a	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the alleged deficient practice. The power strip was immediately mounted and secured to the wall in the maintenance office. **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 residents have the	12/28/2023

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	tour of the facility with the Maintenance Director on 12/11/23 between 1:15 p.m. and 3:00 p.m., in the Maintenance office a power strip was being used to power electronic equipment and was not secured, dangling from 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 stated he had recently installed/replaced the power strip and had not gotten around to attaching it to the wall. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		potential to be affected by the alleged deficient practice. The power strip was immediately mounted and secured to the wall in the maintenance office. All other areas in facility were inspected for dangling power cords by Maintenance director. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/designee will inspect facility regularly to ensure power strips are properly mounted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** Maintenance director/designee to complete the Power Strip safety audit daily x 1 week, weekly x 4 weeks, then monthly x 5 months. The results will be reviewed by the CQI committee overseen by the ED. **By what date the systemic changes will be completed:** Completion Date: 12/28/2023	