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	02/13/2025

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: 02/13/25 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Emergency Preparedness survey, Heritage House Rehbilitation & 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 84. Quality Review completed on 02/17/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/13/25 Facility Number: 000225 Provider Number: 155332 AIM Number: 100267670 At this Life Safety Code survey, Heritage House	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Ware	Executive Director	02/28/2025

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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	Rehbilitation & 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 84. 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 02/17/25			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 19 portable fire extinguishers had the date of 6-year maintenance documented on the extinguisher in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1	K 0355	/p> 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 02/28/2025. /p> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	02/28/2025

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	through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Conference Room by the west nurse's station. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 02/13/25, the wall mounted ABC type portable fire extinguisher located in the Conference Room by the west nurse's station was manufactured in 2017 and had no 6-year maintenance collar affixed to the container. The fire extinguisher inspection contractor had affixed a 6-year maintenance sticker on the back of the extinguisher documenting 6-year maintenance was performed in August 2023. The fire extinguisher inspection contractor had also affixed a maintenance tag to the fire extinguisher documenting annual maintenance was performed in March 2024. The facility had documented monthly inspections on the extinguisher for the most recent twelve month period. Based on interview at the time of the observations, the Maintenance Director stated he had requested the fire extinguisher inspection contractor to replace		No residents were identified as being affected by the alleged deficient practice. The fire extinguisher was replaced. **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 residents have the potential to be affected by the alleged deficient practice. The fire extinguisher was replaced and appropriately tagged on 2/19/25. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director will inspect all fire extinguishers monthly to ensure proper documentation and the 6-year maintenance collar is affixed and dated correctly. The maintenance director will add this task to his preventative maintenance program. **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:** The maintenance director will monitor fire extinguishers monthly to ensure the properly dated documentation/material is affixed to each extinguisher. The	

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	the fire extinguisher with current inspection and testing documentation but agreed the aforementioned portable fire extinguisher did not have 6-year maintenance properly documented on the extinguisher. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b)		maintenance director will submit documentation of observations to monthly QAPI to ensure compliance. Once 100 % compliance has been achieved for three months, QAPI may discontinue from review, but monitoring by the maintenance director will continue monthly. **By what date the systemic changes will be completed:** Completion Date: 02/28/2025	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor door set by Room 101. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 02/13/25, an eight inch in diameter hole was noted in the attic smoke barrier wall above the corridor door set by resident sleeping Room 101. The hole in the wall was just under the peak of the roof line in the attic and was not firestopped to maintain the fire resistance rating of the attic smoke barrier wall. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned	K 0372	/p> 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 02/28/2025. /p> 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 8-inch diameter hole in the attic smoke barrier wall above the corridor door by room 101 on the memory care unit was filled with appropriate fire caulking. **How other residents having the potential to be affected by the same deficient practice will be**	02/28/2025

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	opening in the attic smoke barrier wall was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b)		**identified and what corrective action(s) will be taken:** This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor door set by Room 101. The 8-inch diameter hole in the attic smoke barrier wall above the corridor door by room 101 on the memory care unit was filled with appropriate fire caulking on 2/19/25. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Smoke barrier walls will be inspected monthly by the maintenance director and their integrity logged and discussed with the Executive Director. **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:** The maintenance director or designee will complete the Preventative Maintenance Audit weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed during the bi-monthly QAPI meetings. Alternate months where there is no meeting, QAPI tool will be reviewed with Executive Director for follow-up as needed.	

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