STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING -- B. WING	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/08/18 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 At this Emergency Preparedness survey, Heritage House of Richmond was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 87 certified beds. At the time of the survey, the census was 71. Quality Review completed on 02/14/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 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 is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for your consideration for paper compliance.	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to	E 0015	It has been and will continue to be the policy of this facility to provide the subsistence needs for staff and patients in times of emergency. All people had the	02/26/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all residents in the facility. Findings include: Based on record review on 02/08/18 at 9:20 a.m. with the administrator, the Emergency Operations Plan dated 11/2017 lacked documentation of subsistence needs for residents in the event the facility shelters in place during an emergency. Based on an interview at the time of record review, the administrator indicated the facility has about a three day supply of emergency water and food on hand in the food storage room but the Emergency Operations Plan does not document the emergency water and food supply. This was confirmed by the administrator at the time of record review and interview.		potential to be affected, but nobody was affected by this practice. The facility contracted with a company who specializes in disaster planning prior to the implementation of the emergency management requirement. The facility took substantial financial steps to ensure that the facility had all requirements of the disaster manual prior to implementation. When facility administrator was interviewed, by surveyor in training, in regards to the Emergency Operations Plan(EOP) administrator explained the facility always kept at least a 3 day supply of emergency food on hand per CMS regulations in addition to water. When asked why the list of items were not in the EOP, the administrator explained that those items changed and rotated as needed. When asked how would staff know what was on	

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			hand, the administrator explained that dietary kept an inventory of what was on hand and that the policies had already been established for keeping enough food on hand in case of emergency. The facility already had on page 8 of the EOP (attachment 1) that the facility maintains the essential supplies as required by federal regulations. That a listing of items would be maintained by the respective departments. The facility will additionally place more explicit policies into the manual for the emergency food (attachment 2) and the water supply (attachment 3), these policies were already listed in the facility operations manual. Any updates to the facility policies on subsistence needs will be signed off by the administrator and be added to the facility EOP and reviewed no less than annually.	
E 0018 SS=C Bldg. --				

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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on record review on 02/08/18 at 9:20 a.m. with the administrator, the Emergency Operations Plan dated 11/2017 lacked documentation of a tracking system for the staff and residents in the event the facility had to evacuate during an emergency. Based on an interview at the time of record review, the administrator indicated the facility is currently working on a tracking system to include in the Emergency Operations Plan but it is not yet finished. This was confirmed by the administrator at the time of record review and interview.	E 0018	It has been and will continue to the policy of this facility to track our staff and patients in times of emergency. All people had the potential to be affected, but nobody was affected by this practice. The facility contracted with a company who specializes in disaster planning prior to the implementation of the emergency management requirement. The facility took substantial financial steps to ensure that the facility had all requirements of the disaster manual prior to implementation. When facility administrator was interviewed, by surveyor in training, in regards to the Emergency Operations Plan(EOP) administrator explained the facility already had processes in place to	02/26/2018

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			track the employees and residents and this was already listed on page 6 of the EOP (attachment 4). The administrator explained that it would depend on which facility the resident went that would determine what system to use, but that the facility had computer systems to facilitate tracking. In the event that the computer systems were not able to be used that the facility keeps emergency packets at the nurses (attachment 5). This form will be place in the EOP for ease of use, in addition to being kept at the nurses' station. Daily staffing logs are kept by each respective department, in addition to the time-clock system in place. The facility policy is to use its own existing buildings first in case of emergency when possible, part of the reason for this is the ease of existing information amongst the buildings. In case of emergency the buildings also	

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			have agreements, already in place, with two other buildings in the area who use the same nursing documentation system, in addition to pharmacy. (attachment 6 & 7) The administrator explained, in the event we need to send someone to a facility not using our electronic records, paper documentation will be used and the location of all transfers and the specific name will be documented. It was explained that the system used would depend on where they were going. The federal regulations specify, “we are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses and electronic database, hard copy documentation, or some other method.” Any updates to the facility policies on tracking	

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			will be signed off by the administrator and added to the facility EOP and reviewed no less than annually.	
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: 02/08/18 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 At this Life Safety Code survey, Heritage House of Richmond 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 (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 87 and had a census of 71 at the time of this visit. All areas where residents have customary access	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 is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for your consideration for paper compliance.	

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	were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which are not sprinkled. Quality Review completed on 02/14/18 - DA			
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 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)			

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	g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 11 hazardous areas, such as a combustible storage room over 50 square feet, was provided with a self-closing devices which would cause the door to automatically close and latch into the door frame, This deficient practice could affect 34 residents who reside on the East Hall. Findings include: Based on observations on 02/08/18 during a tour of the facility with the maintenance supervisor at 11:15 a.m., the East Hall housekeeping storage room, which measured one hundred square feet and stored six shelves of combustible paper supplies in cardboard boxes, lacked a self closing device on the door. This was confirmed by the maintenance supervisor at the time of observation. 3.1-19(b)	K 0321	It has been and will continue to be the policy of this facility to ensure all hazardous areas have self-closing or automatic closers on the door. The residents on the east side had the potential to be affected, but nobody was affected by this practice. The maintenance supervisor put a closer on the door to the housekeeping storage room (attachment 8). All other rooms were audited to ensure the proper closers were on the door. Prior to changing any doors or removing any closers, administrator or maintenance director will approve that the right door closer is on the door. Any issues will be fixed and ongoing issues brought to quarterly QA for review and all recommendations followed.	02/26/2018

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 3 of 7 attic smoke barriers had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. 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 34 residents who reside on East Hall. Findings include: Based on observations on 02/08/17 during a tour of the attic smoke barriers from 12:00 p.m. to 12:30 p.m. with the maintenance supervisor, the following attic smoke barriers had penetrations not fire stopped: a. The East Hall attic smoke barrier wall had a twelve inch circular area of drywall missing on the	K 0372	It has been and will continue to be the policy of this facility that all smoke barriers are complete and have a ½ hour protection as required. The residents on the east side had the potential to be affected, but nobody was affected by this practice. The holes in question were caused when the fire suppression contract company replaced a section of sprinkler	02/26/2018

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	each end of the smoke barrier wall. b. The Southeast Hall attic smoke barrier wall had a three inch open electrical conduit not fire stopped on both sides of the smoke barrier wall. c. The Northeast Hall attic smoke barrier wall had a one inch open electrical conduit not fire stopped on both sides of the smoke barrier wall. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)		piping. The holes were fire caulked by maintenance and an audit was done of the attic to ensure no other holes existed. (attachments 9) Maintenance supervisor or designee will do a round weekly for six months of the building to ensure there are no fire penetrations that need to be fixed. (attachment 10) Staff was inserviced on the importance of notifying maintenance if they see a penetration in the fire/smoke barriers. (attachment 11) Any issues will be fixed and ongoing issues will be brought to quarterly QA for review and all recommendations followed.	
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 3 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 could affect 19 residents who reside on the Northeast Hall and 14 residents who reside on the Southeast Hall. Findings include: Based on observations on 02/08/18 during a tour of the facility from 9:10 a.m. to 12:30 p.m. with the maintenance supervisor, the Northeast Hall set of smoke barrier doors had two, one eight inch circular holes in the door on the nurses station side and forty, one sixteen inch circular holes in the door on the resident room side. Furthermore, the Southeast Hall set of smoke barrier doors had a two and a quarter inch circular hole in the door near the top of the door on the exit door side. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)	K 0374	It has been and will continue to be the policy of this that doors have the ability to resist fire for 20 minutes. The residents on the east side had the potential to be affected, but nobody was affected by this practice. The holes in question were caulked and all other fire doors audited by maintenance to ensure no holes existed. (attachment 12) Prior to removing anything from the door or screwing anything into the door administrator or maintenance will ensure that the integrity of the door isn't compromised. Any issues will	02/26/2018

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			be fixed and ongoing issues will be brought to quarterly QA for review and all recommendations followed.	