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	03/04/2019

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: 03/04/19 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 At this Emergency Preparedness survey, Heritage House of Richmond was found in sustantial 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 67. Quality Review completed on 03/06/19 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 it is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask our consideration for paper compliance.	
E 0031 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on review of "Emergency & Disaster	E 0031	It has been and will continue to be the policy of this facility to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws. While residents did have the potential to be affected, no	03/05/2019

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

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	Preparedness Manual" documentation with the Administrator and the Director of Maintenance during the exit interview from 3:20 p.m. to 4:10 p.m. on 03/04/19, the emergency preparedness plan did not include contacting the Indiana State Department of Health (ISDH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. Based on interview at the time of the exit interview, the Administrator agreed the plan did not include the correct telephone contact information for the aforementioned emergency preparedness source of assistance.		residents were directly affected. Correct telephone contact information was updated immediately (Attachment 1). Staff educated on phone number change of incident reporting (Attachment 2). Maintenance supervisor/ designee will review and update policy annually as needed. Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
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: 03/04/19 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	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. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask our consideration for paper compliance.	

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	Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 67 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached storage sheds providing facility storage services which were each not sprinklered. Quality Review completed on 03/06/19			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to properly install exit signage in 1 of 7 smoke compartments in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit	K 0293	It has been and will continue to be the policy of this facility to ensure all exit and directional signs are displayed with continuous illumination also served by the emergency lighting system. While there was a	03/05/2019

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	or directional exit signs where the continuation of the egress path is not obvious. LSC 7.10.2.1 states a sign complying with 7.10.3, with a directional indicator showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect over 20 residents and staff outside the Main Dining Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, both directional chevrons were illuminated on the east side of the exit sign hung from the ceiling in the corridor outside the Main Dining Room. The chevron pointing north would direct residents, staff and visitors into the Main Dining Room which was open to the corridor. The Main Dining Room did not have a facility exit other than back into the corridor which it was open to. The west side of the exit sign was properly illuminated with only one chevron illuminated to direct residents, staff and visitors south to the main entrance foyer. Based on interview at the time of the observations, the Director of Maintenance stated the Main Dining Room does not have a facility exit to the public way and agreed the chevron pointing north on the east side of the exit sign should have been covered over and not illuminated. 3.1-19(b)		potential of 20 residents and staff members outside the main dining room that could have been affected, no one was directly affected. Exit signage was immediately corrected and chevron was covered over and is not illuminated (Attachment 3). There was an audit completed on all exit doors and no further signage issues were identified (Attachment 4). Staff re-educated and in serviced on making Maintenance Supervisor aware of any exit signage issues (Attachment 5). Maintenance Supervisor or designee will do an audit of exit signage 3 times a week for 4 weeks and 2 times a week for 3 months and randomly ongoing (Attachment 6). Any ongoing issues will be brought to QA quarterly meeting to determine if systematic changes need to be addressed.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	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) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 5 residents staff and visitors in the vicinity of the Maintenance Office.	K 0321	It has and will continue to be the policy of this facility to that 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 8.71.	03/19/2019

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	Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, one of three vertical openings in the Maintenance Office exposed the attic space above the room. The Maintenance Office contained one natural gas fired water heater. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned opening in the ceiling of the fuel fired heater room did not separate this hazardous area from other spaces by smoke resistant partitions. 3.1-19(b)		While there was a potential that 5 residents, staff and visitors in the vicinity of the Maintenance office that could have been affected, there was no one directly affected. The natural gas fired water heater has been removed from the Maintenance Office. The opening that exposed the attic space in the Maintenance Office have been covered with 5/8 " dry wall and painted (Attachment 7). Maintenance supervisor or designee will do a wall penetration inspection 1 X per week for 6 months (Attachment 8). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas were provided with a complete interior finish with a	K 0331	It has and will continue to be the policy of this facility to ensure that existing interior wall and ceiling	03/14/2019

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	flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect over five residents staff and visitors near the Laundry. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, exposed wood studs were noted in the wall above and behind the		finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, and columns have a flame spread rating of Class A or Class B . While there was a potential of over 5 residents, staff and visitors near the laundry that could have been affected, there was no one directly affected. Exposed wood studs in the wall above and behind the three natural gas fired dryers in the laundry were covered with 5/8 “dry wall and painted (Attachment 9). Maintenance Supervisor or designee will do a wall penetration inspection 1 X per week for 6 months (Attachment 10). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	

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	three natural gas fired dryers in the Laundry. No affixed flame spread rating documentation was printed on any of the wood studs. Based on interview at the time of the observations, the Director of Maintenance stated the wood studs were not treated with flame retardant materials and he was not aware if flame spread rating documentation for the interior finish was available for review. 3.1-19(b)			
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, 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 record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 10.5.5.1 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. Section 10.5.5.4 states an overcurrent protective device of suitable current carrying capacity and capable of	K 0345	It has been and will continue to be the policy of this facility to ensure testing and maintenance of a fire alarm system in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance, and testing are readily available. While all residents, staff and visitors did have the potential to be to be affected, no	03/20/2019

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	interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of SafeCare's "Inspection and Testing Form" documentation dated 10/03/18 with the Director of Maintenance during record review from 9:55 a.m. to 12:30 p.m. on 03/04/19, the location of the overcurrent protection protective device for the facility's fire alarm system was stated as "NA". Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the facility's fire alarm system breaker could not be located. Based on interview at the time of the observations, the Director of Maintenance agreed the facility's fire alarm system breaker could not be located. 3.1-19(b)		one was directly affected. Hill Electric will isolate circuit for the fire panel and install on its own circuit with dedicated breaker (Attachment 11). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the	K 0346	It has and will continue to be the policy of this facility if the fire	03/05/2019

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	protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Watch - Richmond" and "Fire Watch" documentation with the Director of Maintenance during record review from 9:55 a.m. to 12:30 p.m. on 03/04/19, the fire watch plans for fire alarm system impairment was incomplete. Both plans failed to include contacting the Indiana State Department of Health via the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The former plan listed the ISDH (via gateway) but did not include the secondary method and the latter plan listed contacting ISDH by telephone but did not include the primary or secondary method. Based on interview at the time of record review, the Director of Maintenance agreed the fire watch documentation for fire alarm system impairment did not state to contact the Indiana State Department of Health at incidents@isdh.in.gov should the ISDH Gateway link be nonoperational. 3.1-19(b)		alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. While there was a potential of all residents, staff and visitors being affected, no one was directly affected. Our facility policy was immediately amended to include contacting the Indiana State Department of Health at incidents @isdh.in.gov should the ISDH Gateway link be nonoperational (Attachment 12). Staff educated on updating of policy (Attachment 13). Maintenance Supervisor or designee will review and update policy yearly as needed. Any further issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved			

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	are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Watch - Richmond" and "Fire Watch" documentation with the Director of Maintenance during record review from 9:55 a.m. to 12:30 p.m. on 03/04/19, the fire watch plans for sprinkler system impairment was incomplete. Both plans failed to include contacting the Indiana State Department of Health via the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to	K 0354	It has and will continue to be the policy of this facility when the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. While there was a potential of all residents, staff and visitors being affected, no one was directly affected. Our facility policy was immediately amended to include contacting the Indiana State Department of Health at incidents @isdh.in.gov should the ISDH Gateway link be nonoperational (Attachment 14). Staff educated on updating of policy (Attachment 15).	03/05/2019

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	incidents@isdh.in.gov. The former plan listed the ISDH (via gateway) but did not include the secondary method and the latter plan listed contacting ISDH by telephone but did not include the primary or secondary method. Based on interview at the time of record review, the Director of Maintenance agreed fire watch documentation for sprinkler system impairment did not state to contact the Indiana State Department of Health at incidents@isdh.in.gov should the ISDH Gateway link be nonoperational. 3.1-19(b)		Maintenance Supervisor or designee will review and update policy yearly as needed. Any further issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient	K 0355	It has been and will continue to be the policy of this facility to select, install, inspect, and maintain portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers. There was a potential that over 20 residents, staff, and visitors could have been affected, no one was directly affected. The maintenance tag had been removed from the ABC type portable fire extinguisher located in the corridor near the main dining room. This was immediately	03/14/2019

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

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	practice could affect over 20 residents, staff and visitors near the Main Dining Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the ABC type portable fire extinguisher located in the corridor near the Main Dining Room had no affixed maintenance tag documenting the date the most recent annual maintenance was performed. Based on interview at the time of the observations, the Director of Maintenance stated Allied Safety Services performed annual fire extinguisher maintenance for all facility fire extinguishers in January 2019, but agreed they did not provide an itemized listing of the location of each fire extinguisher, someone removed the maintenance tag and agreed the aforementioned portable fire extinguisher did not have a tag or label securely attached that indicates the month and year the maintenance was performed. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly		corrected and sign was placed back on fire extinguisher that showed where monthly inspections had been done (Attachment 16). Maintenance Supervisor or designee will do an audit checking one time weekly for 6 months (Attachment 17) and randomly ongoing after that. Any ongoing issues will be brought to the QA quarterly meeting to determine if systematic changes need to be addressed.	

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	manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 20 residents, staff and visitors near the Main Dining Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the ABC type portable fire extinguisher located in the corridor near the Main Dining Room had no affixed maintenance tag documenting a monthly inspection for the most recent twelve month period. Based on interview at the time of the observations, the Director of Maintenance stated Allied Safety Services performed annual fire extinguisher maintenance for all facility fire extinguishers in January 2019, but agreed they did not provide an itemized listing of the location of each fire extinguisher, someone removed the maintenance tag and agreed the aforementioned portable fire extinguisher did not have a tag or label securely attached that indicates monthly inspections for the most recent twelve month period. 3.1-19(b)			
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	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 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			

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	devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 15 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the following was noted: a. a wedge was placed on the floor under the corridor door to the Conference Room by Room 6 to prop open the door in the fully open position which provided an impediment to closing, latching and would not resist the passage of smoke. b. the top portion of the corridor door to Room 14 which was a former Dutch door and fused to the lower portion of the door had a one half inch gap in between the edge of the door and the door stop above the door handle when the door was in the fully closed and latched position and would not resist the passage of smoke. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor doors had an impediment to closing, latching or would not resist the passage of smoke. 3.1-19(b)	K 0363	It has and will continue to be the policy of this facility that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 ¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinkled smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. While there was a potential of over 15 residents, staff and visitors that could have been affected, no one was directly affected. Staff educated and in serviced on not propping doors open and if doors fail to shut properly to notify Maintenance Supervisor (Attachment 18). Maintenance immediately removed the wedge that was placed on the floor under the corridor door to the Conference Room Door and Astrigal was added to Room 14 to cover door gap (Attachment 19).	03/05/2019

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			Maintenance Supervisor did an audit of all doors to check for proper closure. Maintenance Supervisor or designee will audit once a week for 3 months to ensure proper closure. (Attachment 20). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
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 openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier,	K 0372	It has and will continue to be the policy of this facility that smoke barriers shall be constructed to a ½ 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.	03/19/2019

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	the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 5 residents staff and visitors in the vicinity of the Maintenance Office. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, one of three vertical openings in the Maintenance Office exposed the attic space above the room and did not maintain the fire resistance rating of the ceiling smoke barrier. Insulation was placed inside a second vertical opening in the room directly above the natural gas fired water heater in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned two openings in the ceiling were not protected to maintain the fire resistance rating of the ceiling smoke barrier. 3.1-19(b)		While there was a potential for over 5 residents, staff and visitors that could have been affected, there was no one directly affected. The natural gas fired water heater has been removed from the Maintenance Office. The two openings in the ceiling in the Maintenance Office have been covered with 5/8 " dry wall and painted (Attachment 21). Maintenance supervisor or designee will do a wall penetration inspection 1 X per week for 6 months (Attachment 22). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlet boxes in 1 of 46 resident sleeping rooms was protected. NFPA 70,	K 0511	It has and will continue to be the policy of this facility to ensure that electrical wiring and equipment	03/14/2019

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	National Electric Code, 2011 Edition, Article 406.6 Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect one resident and staff in resident Room 12. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the wall mounted electrical outlet box near the floor in the corridor wall inside resident sleeping Room 12 contained four electrical receptacles. The cover plate was broken and exposed the inside of the box. Based on interview at the time of the observations, the Director of Maintenance agreed the cover plate for the aforementioned electrical outlet box was broken. 3.1-19(b)		complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. While there was a potential of one resident and staff being affected, there was no one directly affected. There was no one that resided in the room at this time. The cover plate for the wall mounted electrical box was broken and exposed the inside of the box. This was immediately replaced (Attachment 23). All cover plates were checked for cracks in wall mounted electrical boxes (Attachment 24). Staff re-educated and in serviced on making Maintenance Supervisor aware of broken cover plates (Attachment 25). Maintenance Supervisor or designee will check one wing per month for 5 months to ensure that there are no broken outlets (Attachment 26). Any ongoing issues will be brought to QA quarterly meeting to determine if systematic changes need to be addressed.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in			

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	accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 4 of 7 smoke compartments. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the HVAC system for all resident sleeping rooms contained a supply and return vent. The HVAC system for the corridors were also provided with supply vents but the air returns in the corridor outside resident sleeping Rooms 12, 17, 21, 27, 30, 43 and 48 had been disconnected, covered over inside the ductwork and were not in use. Observations in the attic revealed the aforementioned air returns were disconnected from HVAC units and had been filled in with insulation materials. Records of an acceptance test per NFPA 90A, Section 7.1.1. was not available for review at the time of the survey. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned areas were using resident	K 0521	It has been and will continue to be the policy of this facility that heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. While 50 residents, staff and visitors did have the potential to be affected, no one was directly affected. Wallace Heating and Cooling will be reconnecting the cold air return vents in all corridors (Attachment 27). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	03/21/2019

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	sleeping rooms as a return air system. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 3 of 3 natural gas fired dryers in the Laundry were provided with combustion air taken directly from the outside. This deficient practice could affect over five residents staff and visitors near the Laundry. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, each of three natural gas fired dryers in the Laundry were in operation and were not continually provided with combustion air supply taken directly from the outside when in operation. Based on interview at the time of the observations, the Director of Maintenance agreed the natural gas fired dryers were not continually provided with combustion air supply taken directly from the outside when in operation.	K 0522	It has and will continue to be the policy of the facility to ensure that any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. While there was a potential of over 5 residents staff and visitors near the laundry that could have been affected, there was no one directly affected. Contractors installed fresh air vents for dryers so that they are provided with combustion air supply taken directly from the	03/13/2019

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	3.1-19(b)		outside when in operation (Attachment 28). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of	K 0761	It has and will continue to be the policy of this facility to inspect and test annually fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. While there was the potential of over 20 residents, staff and visitors being affected, on one was directly affected. The facility did not specify and include doors to oxygen storage and trans filling rooms on annual fire door inspection documentation. Our facility audit was updated immediately to include this (Attachment 29). Maintenance Supervisor or designee will continue to do monthly checks of all smoke barrier doors. Any further issues will be addressed immediately and discussed in quarterly QA meeting.	03/14/2019

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	either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the west nurse's station. Findings include: Based on review of "Fire Door Checks" documentation with the Director of Maintenance during record review from 9:55 a.m. to 12:30 p.m. on 03/04/19, annual fire door inspection documentation for the facility within the most recent twelve month period did not include doors to oxygen storage and transfilling rooms. Based on interview at the time of record review, the			

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HERITAGE HOUSE OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

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	Director of Maintenance stated the aforementioned documentation was an itemized listing of a monthly inspection for each smoke barrier door set in the facility and did not include the one oxygen storage and transfilling room inside the facility and stated additional fire door inspection documentation was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, the facility has one oxygen storage and transfilling room located near the west nurse's station with two fire rated entry doors to the room. The corridor entry door to the room was affixed with a 90 minute fire resistance rating label. The entry door from the Therapy Room was also affixed with a 90 minute fire resistance rating label. The oxygen storage and transfilling room contained six liquid oxygen containers and 37 'E' type oxygen cylinders. Based on interview at the time of record review and of the observations, the Director of Maintenance agreed annual fire door inspection documentation for the facility did not include the two fire rated doors to the oxygen storage and transfilling room near the west nurse's station. 3.1-19(b)			
K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility	K 0911	It has and will continue to be the	03/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING 01 B. WING	03/04/2019

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	failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 main electrical rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, a large water softener storage tank was stored within 18 inches of the main electrical panel for the facility in the Main Electrical Room. Based on interview at the time of the observations, the Director of Maintenance agreed a large water softener storage tank was stored within three feet of the working space in front of the main electrical panel at the aforementioned location. 3.1-19(b)		policy of this facility to ensure access and working space is maintained in enclosures housing electrical apparatus. While there was a potential of all residents, staff members and visitors being affected. There was no one directly affected. A large water softener storage tank was stored within three feet of the working space in front of the main electrical panel in the Main Electrical Room. This has now been re located by Culligan to 15 feet away from the Main Electrical Panel (Attachment 30). Any ongoing issues will be addressed immediately and discussed in quarterly QA meeting.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and			

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	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 patient bed locations within the most recent twelve month period was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 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 is administered shall be tested at intervals not exceeding 12 months. Additionally, 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	K 0914	It has and will continue to be the policy of this facility to test electrical outlet receptacles that are not listed as hospital-grade receptacles at intervals not exceeding 12 months. While there was a potential of all residents being affected, no one was directly affected. All non-hospital grade electrical outlet receptacles were tested to ensure proper functioning	03/14/2019

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	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 record review with the Director of Maintenance from 9:55 a.m. to 12:30 p.m. on 03/04/19, documentation of electrical outlet receptacle testing at all patient bed locations within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed documentation of electrical outlet receptacle testing at all patient bed locations within the most recent twelve month period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 12:30 p.m. to 3:20 p.m. on 03/04/19, all resident sleeping rooms had receptacles not listed as hospital-grade at patient bed locations. Based on interview at the time of the observations, the Director of Maintenance agreed non hospital-grade receptacles were at resident bed locations. 3.1-19(b)		(Attachment 31). Maintenance Supervisor or designee will check annually to test electrical outlet receptacles (Attachment 32). Any ongoing issues will be brought to QA quarterly meeting to determine if systematic changes need to be addressed.	