DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155228 | A. BUILDING -- <br> B. WING | 04/05/2023 |

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

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| E 0000 <br><br> Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. <br><br> Survey Date: 04/05/23 <br><br> Facility Number: 000133 <br> Provider Number: 155228 <br> AIM Number: 100266080 <br><br> At this Emergency Preparedness survey, Heritage House of Richmond was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. <br><br> The facility has 87 certified beds. At the time of the survey, the census was 46. <br><br> Quality Review completed on 04/11/23 | 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. <br><br> Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask our consideration for paper compliance. | |
| K 0000 <br><br> 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). <br><br> Survey Date: 04/05/23 <br><br> Facility Number: 000133 <br> Provider Number: 155228 <br> AIM Number: 100266080 <br><br> At this Life Safety Code survey, Heritage House of Richmond was found not in compliance with | K 0000 | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. <br><br> Please accept this | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>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 46 at the time of this visit.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.<br><br>Quality Review completed on 04/11/23 | | Plan of Correction as Credible Allegations of Compliance. We respectfully ask our consideration for paper compliance. | |
| K 0222<br>SS=F<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the | | | |

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

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| | accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | Based on observation and interview, the facility failed to ensure the means of egress through all exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all visitors and residents if needing to exit the facility.<br><br>Findings include:<br><br>Based on an observation and interview during a tour of the facility with the Maintenance Director on 04/05/23 between 1:00 p.m. and 3:10 p.m., 6 of 6 exit doors, marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code was not posted in a manner that would not require special knowledge to locate and understand the code.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present.<br><br>3.1-19(b) | K 0222 | It has and will continue to be the practice of this facility to ensure the means of egress through all exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures.<br>Although this deficient practice could affect all visitors and residents if needing to exit the facility, no one was directly affected by this.<br>Maintenance Director reprinted code stickers on all locked exterior doors to reflect that special knowledge is not required to exit (Attachment 1).<br>Maintenance Director or Designee will check to make sure code stickers are still on exterior doors 2 X a week for 1 month and then monthly thereafter (Attachment 2 ).<br>Any ongoing issues will be brought to morning IDT meeting and appropriate measures put in place. | 04/13/2023 |
| K 0324<br>SS=E | NFPA 101<br>Cooking Facilities | | | |

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| Bldg. 01 | Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | | | |
| | Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 15 residents in the dining room.<br><br>Findings include:<br><br>Based on an observation and interview during a tour of the facility with the Maintenance Director on 04/05/23 between 1:00 p.m. and 3:10 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. | K 0324 | It has and will continue to be the practice of this facility that cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking and Operations.<br>Although this deficient practice could possibly affect staff in the kitchen and 15 residents in the dining room, know one was directly affected by this.<br>Kitchen staff was re educated on proper manual operation of the ANSUL system (Attachment 3 ). All new hires will be educated upon orientation and | 04/12/2023 |

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| | Based on interview, the "lunch and dinner cook" (1 of 1) at the appliance was asked; what is the correct response if there was a grease fire underneath the hood. The employee pointed to the red ABC extinguisher. When asked, "do you know where your hood suppression pull station is located?" The employee failed to identify the location and believed the lever which activated the hood suppression system was an alarm. The Maintenance Director acknowledged the response and stated additional training would be necessary.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present.<br><br>3.1-19(b) | | continuing education will be done yearly by dietary manager or designee for all kitchen staff (Attachment 4 ).<br>Any ongoing issues will be brought to morning IDT meeting and appropriate measures will be put in place. | |
| K 0353<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____________________<br>b) Who provided system test<br>____________________________<br>c) Water system supply source<br>__________________________<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |

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| | Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 2 staff.<br><br>Findings include:<br><br>Based on an observation and interview during a tour of the facility with the Maintenance Director on 04/05/23 between 1:00 p.m. and 3:10 p.m., in the Business Records room, 2 of 2 sprinkler heads had dropped through the ceiling creating unsealed gaps around the sprinkler heads. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director stated there were unsealed gaps in the ceiling caused by the sprinkler heads being temporary and custom heads need to be made to correct the problem, stating the temporary sprinklers are not the correct size and length.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present.<br><br>3.1-19(b) | K 0353 | It has and will continue to be the practice of this facility to ensure that maintenance and testing automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing, and Maintaining of Water-based fire protection systems.<br>Although this deficient practice could possibly have affected 2 staff members, no one was directly affected by this.<br>Safecare has ordered 2 replacement pendent sprinklers. Safecare will install when they have been received (Attachment 5).<br>Maintenance Director has checked every pendent sprinkler head and no other issues noted (Attachment 6).<br>Sprinkler head inspections will be done weekly X 1 month by Maintenance Director or designee (Attachment 7) and Safecare will continue to inspect every 3 months.<br>Any ongoing issues will be brought to morning IDT meeting and appropriate measures put in place. | 06/02/2023 |
| K 0361<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridors - Areas Open to Corridor<br>Corridors - Areas Open to Corridor<br>Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), | | | |

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| | waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>18.3.6.1, 19.3.6.1 | | | |
| | Based on observation and interview, the facility failed to ensure 1 of 1 Activities area with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met:<br>(1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2).<br>(2) The openings are installed at or below half the distance from the floor to the room ceiling.<br>This deficient practice could affect staff and up to 20 residents in one smoke compartments.<br><br>Findings include:<br><br>Based on an observation and interview during a tour of the facility with the Maintenance Director on 04/05/23 between 1:00 p.m. and 3:10 p.m., the Activities office had a pass-through window into the Activities Area. The office has supervised | K 0361 | It has and will continue to be the practice of this facility to ensure that all areas open to corridor spaces (other than patient sleeping rooms, treatment rooms and hazardous areas ), waiting areas, nurses' stations, gift shops, and cooking facilities , open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.<br>Although this deficient practice could had affected staff and up to 20 residents, no one was directly affected by this.<br>Safecare has been to facility and have hard wired 2 smoked detectors in the facility's activity room (Attachment 8 ).<br>Maintenance Director with Safecare did a complete audit of facility where any additional hard wire smoke detectors would be needed when performing the smoke detector sensitivity test (Attachment 9). No additional hard wire smoke detectors needed at this time. Safecare will continue to monitor every 6 months thereafter.<br>Any ongoing issues will be brought to morning IDT meeting and appropriate measures put in place. | 04/25/2023 |

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| | smoke detection however, the Activities Area Room opposite the sliding glass window was not protected by an electrically supervised automatic smoke detecting device. Instead, a battery-operated smoke detector was provided in that location. Based on interview at the time of observation, the Maintenance Director agreed the window was greater than 20 square inches and the Activities Room was not provided with electrically supervised automatic smoke detection.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present.<br><br>3.1-19(b) | | | |
| K 0920<br>SS=E<br>Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>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 | | | |

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| | 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.<br>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 power strips in 1 location met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 2 residents.<br><br>Findings include:<br><br>Based on an observation and interview during a tour of the facility with the Maintenance Director on 04/05/23 between 1:00 p.m. and 3:10 p.m., resident room 34 was using a power strip inside the patient care vicinity for resident's personal electrical equipment items including an electronic picture display that lacked a UL rating of 1363A or 60601-1 label on each power strip.<br><br>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present.<br><br>3.1-19(b) | K 0920 | It has and will continue to be the practice of this facility that 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.<br>Resident room 34's power strip was immediately removed (Attachment 11 ).<br>Although this deficient practice effects 2 residents, there was no one directly affected by this practice. All resident rooms have been inspected by Maintenance Director and any non-compliant rooms were corrected (Attachment 12 ).<br>All staff educated on not using power strips/extension cords (Attachment 13). Families notified by text-em all system (Attachment 14 ). Residents notified by maintenance director (Attachment 15). Maintenance Director or designee will audit 1 X weekly for a month and ongoing monthly after that (Attachment 16).<br>Any ongoing issues will be brought to morning IDT meeting | 04/19/2023 |

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| | | | and appropriate measures will be put in place. | |