STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 01 B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOUSE OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

(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
K 0000 Bldg. 01	A Pre-Occupancy Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/05/22 Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760 At this Pre-Occupancy Life Safety Code survey, Heritage House of Shelbyville 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 surveyed as one building of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 60 at the time of this visit. The purpose of the survey was a request for bed additions described below: In Building A Station 2 East: ten unlicensed rooms renovated into 2-Bed comprehensive rooms, to be numbered 0, 1, 2, 3, 4, 5, 6, 7, 8, and 9 Station 4 East: six unlicensed rooms renovated	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. We respectfully request paper compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlson "David" DePrez	Administrator	12/22/2022

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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	into 2-Bed comprehensive rooms, to be numbered 78, 79, 80, 81, 82, and 83 In Building A Station 3 West: Existing Comprehensive Room # 66 renovated from 1-Bed to 2-Bed Station 3 East: Existing Comprehensive rooms #45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, and 59 renovated from 1-Bed to 2-Bed Station 4 North: Existing Comprehensive rooms #104, 105, 106, 109, 111, 112, and 113 renovated from 1-Bed to 2-Bed All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/12/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors 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: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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 staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6			

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	SPECIAL NEEDS LOCKING ARRANGEMENTS 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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised			

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	automatic fire detection system and an approved, supervised automatic sprinkler system. 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 the service hall exit 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 over 15, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Executive Director on 12/05/22 between 1:30 p.m. and 3:00 p.m., the exit door near RR 80, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. This finding was acknowledged by the Maintenance Director and Executive Director at the time of observation and again at the exit conference. 3.1-19(b)	K 0222	It has been and will continue to be the policy of this facility that all magnetically locked doors requiring codes to be posted have them. While over 15 staff and visitors had the potential to be affected, nobody was affected by this practice. It appears as though the code placed on the door keypad had been scratched off. A new code was placed on the door allowing passage if needed. All other doors in the facility were checked and any requiring codes had them. Maintenance director or designee will do biweekly walking rounds to ensure doors have the proper coding on them. Any doors missing codes will be immediately fixed and any ongoing issues will be brought to QA for review.	12/19/2022
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required			

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	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 15 staff and residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director and Executive Director on 12/05/22 between 1:30 p.m. and 3:00 p.m., the following locations had sprinkler heads which were missing escutcheons: A) Resident Room 52 B) Resident Room 48 C) Resident Room 54	K 0351	It has been and will continue to be the policy of this facility that all annular space around the sprinkler head will be protected with the appropriate device. While over 15 staff and visitors had the potential to be affected, nobody was affected by this practice. All sprinkler heads cited were fixed with the proper escutcheons. Maintenance walked the entire building looking for any other missing or improper escutcheons. Any missing or improper escutcheons were fixed or replaced. Maintenance director or designee will do biweekly walking rounds to sprinkler heads have escutcheons in place. Any sprinkler heads	12/19/2022

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	D) Resident Room 47 E) The corridor near Resident Rooms 55 & 56. This finding was acknowledged by the Maintenance Director and Executive Director at the time of observation and again at the exit conference. 3.1-19(b)		missing escutcheons or improper escutcheons will be immediately fixed and any ongoing issues will be brought to QA for review.	