

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2013
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NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/22/13</p> <p>Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Harrison Terrace was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered except for the Boiler room and Main Housekeeping room. The facility has a fire alarm system with smoke detection in the corridors, areas</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>open to the corridor and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 103 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has a housekeeping room, boiler room and one detached building all providing facility services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 corridor doors serving hazardous areas such as a laundry room was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect approximately 4 residents adjacent to the laundry room observed in the Therapy room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 04/22/13 at 1:05 p.m. with the Maintenance Supervisor, the laundry room door was held open by a magnetic device which would not allow the door to close automatically upon activation of the fire</p>	K010021	<p>Corrective action was to place the proper closing device on the door tied to the fire alarm system, allowing the door to close upon fire alarm. All other doors opening to a corridor have been checked for proper closures. Systemic changes made will be to observe each door opening into a corridor to be in proper working order at each fire drill. Correction made May 3rd, 2013.</p>	05/03/2013			

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	<p>alarm system. Based on interview on 04/22/13 at 1:07 p.m., it was acknowledged by the Maintenance Supervisor the laundry room corridor door was held open with a magnetic device which did not release automatically with the fire alarm system, but rather had to be manually pulled to disengage the magnet so the door could be closed.</p> <p>3.1-19(b)</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 smoke barrier walls was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 24 residents on Northwest hall as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 12:50 p.m. with the Maintenance</p>	K010025	Appropriate fire rated material was placed into the gap to seal the area in question. All other smoke barriers were observed for similar problems, with no problems noted. After any contracted work in the attic, Maintenance will ensure all areas requiring sealing will have appropriate fire-rated sealant applied as appropriate.	05/03/2013			

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	<p>Supervisor, the Northwest smoke barrier wall had a four inch diameter hole located at the bottom center of the wall with nine wires penetrating the smoke barrier and was not sealed with a fire rated material. Based on interview on 04/22/13 at 12:59 p.m. with the Maintenance Supervisor, it was acknowledged the Northwest smoke barrier wall had an unprotected opening which was not sealed with a fire rated material.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observations and interview, the facility failed to ensure exit access was arranged so 2 of 3 exit access doors on Service hall were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 states means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 4 to 5 staff members as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 1:33 p.m. with the Maintenance Supervisor, the east and west Kitchen corridor doors had a door knob lock and a deadbolt lock on each door leading out the Kitchen.</p> <p>Based on interview on 04/22/13 at 1:34 p.m., it was acknowledged by the Maintenance Supervisor there were two locking devices on the east and west Kitchen corridor doors.</p> <p>3.1-19(b)</p>	K010038	The dead bolt locking mechanism for both doors identified have been removed. No residents have the potential to be affected as no residents are in this area. No further measure need to be taken to ensure this practice does not continue. No QA program needs to be put into effect as the resolution is permanent.	05/03/2013	

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 21 rooms on Northwest hall were provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 24 residents as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 11:20 p.m. and 12: 45 p.m. with the Maintenance Supervisor, the Main Supply room on Northwest hall had one sprinkler head in the ceiling by the east wall which was behind a two and one half foot bulkhead which prevented sprinkler access to a three foot by ten foot area next to the west wall which left the area</p>	K010056	Contracted company has been contacted to make necessary changes. No other areas like this exist in the building requiring additional sprinkler support. Further measures are not necessary as the correction will be permanent. No CQI necessary.	05/20/2013			

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	<p>unprotected. Furthermore, the Boiler room on Northwest hall had a sprinkler head which was positioned next to a one and one half inch diameter metal pipe which blocked the sprinkler head and prevented providing complete protection for the nine foot by nine foot room. Based on interview on 04/22/13 concurrent with the observations, it was acknowledge by the Maintenance Supervisor the two aforementioned rooms would have insufficient sprinkler coverage and further acknowledged an extra sprinkler head in each room would be needed to provide complete sprinkler coverage to both areas.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents as well as staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 11:45 a.m. with the Maintenance Supervisor, there was only one upright</p>	K010062	Upright sprinkler heads have been replaced in the cabinet where they are stored. No residents were affected by this practice. Preventative maintenance through monthly checks will reveal if the proper number of sprinkler heads are available as monitored by the Maintenance Director.	05/03/2013			

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	<p>sprinkler head in the spare sprinkler head cabinet. There were upright sprinkler heads observed during the tour throughout the facility. Based on interview on 04/22/13 at 11:50 p.m. it was acknowledged by the Maintenance Supervisor, only one upright sprinkler head was available in the sprinkler head cabinet.</p> <p>3.1-19(b)</p>			

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 8 areas where smoking was permitted. This deficient practice could affect 24 residents on Northwest hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 11:15 a.m. with the Maintenance Supervisor, over 100 extinguished</p>	K010066	No residents were affected by this practice as the building is brick and the exit door is steel. Neither residents nor visitors are ever in the described area. ED held an inservice and spoke about proper disposal of smoking material and to use the proper ashcans as provided. ED will observe the described area weekly for compliance. Any non-compliance could result in being a non-smoking property.	05/03/2013			

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	<p>cigarette butts were observed strewn about on the ground outside the Northwest exit. Based on review of the smoking policy on 04/22/13 at 2:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 04/22/13 at 11:17 a.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts on the ground instead of in an approved container.</p> <p>3.1-19(b)</p>			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire resistive enclosure. This deficient practice could affect 4 residents in the Therapy room on Service hall as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 at 10:23 a.m. with the Maintenance Supervisor, the door to the Oxygen transfer room on Service hall did not have a manufacturer's tag which could identify it as a forty five minute fire rated door. Based on interview on 04/22/13 at 10:25</p>	K010143	No residents were affected by this practice as the described door is not near the Therapy area nor the Service hall. A proper fire-rated door was installed. As this was permanent, no further changes or monitoring are necessary.	05/02/2013	

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	a.m., it was acknowledged by the Maintenance Supervisor oxygen transfer occurs in the Oxygen storage room and the fire rating for the corridor door to the oxygen transfer room was unknown and could not be determined. 3.1-19(b)			