

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  06/10/2015
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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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K 0000  Bldg. 01	<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: 06/10/15</p> <p>Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310</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. 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</p>	K 0000	<p>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.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June 17, 2015.</p>	

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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K 0038 SS=E Bldg. 01	<p>a capacity of 110 and had a census of 104 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <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 observation and interview, the facility failed to ensure 1 of 6 exit accesses was provided with a handrail. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 22 residents, staff and visitors if needing to exit the facility using the southwest exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:25 p.m.</p>	K 0038	<p><b>K038 life safety code standard exit has at least one handrail</b></p> <p>It is the intent of the providerto have the most recent survey binder readily accessible to residents.</p> <p><b>1: Whatcorrective action(s) will be accomplished for those residents found to haveaffected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Handrail installedon 6/12/15 by Koombomer Company</li> </ul> <p><b>2: How other residents having the potential tobe affected by the same deficient practice will be identified and whatcorrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·All otherresidents have the potential to be affected by this alleged deficientpractice. Resident on that unit will be informed of the installationof Handrail outside of their unit.</li> <li>·All handrailwill be inspect and in place by Maintenance Director</li> </ul> <p><b>3: Whatmeasures will be put</b></p>	06/15/2015

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K 0062 SS=F Bldg. 01	<p>on 06/10/15, the southwest exit discharge ramp near Room 72 measured a two foot rise over the fifteen foot length of the ramp and was not provided with a handrail. Based on interview at the time of observation, the Maintenance Supervisor stated the handrail for the ramp was removed within the last year and acknowledged the aforementioned ramp had a slope of 1 in 7.5 and was not provided with a handrail.</p> <p>3.1-19(b)</p> <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 record review, observation and interview; the facility failed to ensure 2 of 2 private fire hydrants was continuously maintained in reliable operating condition and inspected and</p>	K 0062	<p><b>into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>The systemic changes put into place to ensure this practice does not recur are: checked weekly for first 30-days, checked by-weekly x 5 months. To ensure handrails are in place by Maintenance Director</li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>The corrective actions will be monitored via the Administration Compliance CQI audit tool, and reviewed during the monthly CQI meeting x 6 months. If the monthly threshold is &lt; 100% an action plan will be created to ensure compliance. The ED oversees the monthly CQI meeting to ensure compliance.</li> </ul> <p>Compliance Date: 6/15/15</p> <p><b>K062: NFPA 101 life safety code standard Hydrant Flow test report</b> It is the intent of this provider to maintain dignity and respect of the individuality of the residents.</p> <p><b>1: What corrective action(s) will be</b></p>	06/15/2015	

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	<p>tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of P.I.P.E.'s "Hydrant Flow Test Report" dated 12/20/13 with the Maintenance Supervisor during record from 9:00 a.m. to 10:30 a.m. on 06/10/15, documentation of facility fire hydrant inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility owned two fire hydrants, one of which is located in the front of the building and the other fire hydrant is located in the rear parking lot and acknowledged documentation of facility owned fire hydrant inspection within the most recent twelve month period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:25 p.m.</p>		<p><b>accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· Corrective action Hydrant Flow test was performed on 6/15/15 by Dalmatian Fire Company</li> <li>· Both hydrants were tested by Dalmatian Fire Company</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by this alleged deficient practice.</li> <li>· Both hydrants were inspected by Dalmatian Fire Company</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>· The systemic changes put into place to ensure this alleged deficient practice does not recur are: monthly audits of Maintenance contract book performed monthly x6 months by ED/ Maintenance supervisor.</li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· The corrective action will be monitored via CQI fire hydrant tool weekly x4 then monthly x5 months. If thresholds fall under 95% then an action plan will be garnered.</li> </ul> <p>Compliance date: 6/15/15</p>	

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	on 06/10/15, two facility owned fire hydrants were noted on the premises.  3.1-19(b)				