

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2016
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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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: 03/28/16</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>At this Life Safety Code survey, Harcourt Terrace Nursing and Rehabilitation 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 with a partial basement was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident</p>	K 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation or regulation This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW.	

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 0025 SS=D Bldg. 01	<p>sleeping rooms. The facility has a capacity of 110 and had a census of 73 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 04/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers were protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 5 staff and</p>	K 0025	<p>K 0025 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The one half inch space surrounding a one foot wide by eighteen inch long grease trap in the floor of the kitchen and an eight inch by twelve inch hole for the passage of two three inch diameter PVC pipes next to the grease trap have all been filled with 3M Fire Barrier Sealant capable of maintaining smoke resistance. 2. How many</p>	04/15/2016

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K 0027 SS=E Bldg. 01	<p>visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, the one half inch space surrounding a one foot wide by eighteen inch long grease trap in the floor of the kitchen was filled with foam. In addition, an eight inch by twelve inch hole for the passage of two three inch in diameter PVC pipes next to the grease trap was also filled with foam. The aforementioned use of foam to fire stop the openings was observed from below in the basement and was noted in the basement ceiling smoke barrier. Based on interview at the time of observation, the Maintenance Supervisor stated he was unaware of the fire resistance rating of the foam used to fill the openings and acknowledged the aforementioned openings in the basement ceiling did not maintain the fire resistance rating of the basement ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood</p>		<p>other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents and staff in the vicinity of the kitchen have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will assure that is no open space around the grease trap and if there is ever any further noted space around the grease trap, he will fill it with a material capable of maintaining smoke resistance. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be done monthly x 3, then quarterly x 2 or until substantial compliance is maintained. Results will be reviewed in quarterly QA meetings overseen by the ED.</p>		

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	<p>core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 50 residents, staff and visitors in the vicinity of the smoke barrier door set by Room 48.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, the set of smoke barrier doors by Room 48 swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed five times which did not</p>	K 0027	<p>K 0027 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The door closing coordinator on the set of smoke barrier doors near Room 48 was immediately adjusted by the maintenance Director and closes properly.</p> <p>2. How many other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents and visitors in the vicinity of Room 48 have the potential to be affected by this practice.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director will assure this set of smoke barrier doors closes properly when doing preventative maintenance checks or he will adjust the door closing coordinator to make sure it functions correctly to form a smoke barrier.</p> <p>4. How the</p>	04/15/2016

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K 0038 SS=D Bldg. 01	<p>ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned smoke barrier door set did not close because the door closing coordinator did not function and was prevented from closing and forming a smoke resistant barrier.</p> <p>3.1-19(b)</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 provide 1 of over 100 corridor doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient</p>	K 0038	<p>corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted monthly x 3, then quarterly x 2 or until substantial compliance is maintained. Results will be reviewed in quarterly QA meetings overseen by the ED.</p> <p>K 0038 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The Maintenance Director removed the lock that required a key and replaced it with a flat plate on the corridor door to the Customer Care Office. 2. How many other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident, staff member or visitor in the Customer Care Office have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes will be made to</p>	04/15/2016

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K 0048 SS=C Bldg. 01	<p>practice could affect 2 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, the corridor door to the Customer Care Coordinator Office has two locks on the door and required a key to unlock the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire</p>	K 0048	<p>ensure that the deficient practice does not recur? The Maintenance Director will assure that no additional locks are added to this office door that already contains a lock and will remove any additional ones if found. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted quarterly x 2 or until substantial compliance is maintained. Results of audits will be reviewed in quarterly QA meetings overseen by the ED.</p> <p>K 0048 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The Maintenance Director added a symbol that is in the shape of an "M" to represent the location of smoke barrier doors and fire doors on the Fire Safety Plan. 2. How many other residents having the potential to be affected by the same deficient</p>	04/15/2016			

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	<p>(5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action Plan" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:40 a.m. on 03/28/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. "Section C Evacuation Procedures" states "...evacuating the residents into another area or the nursing unit behind the fire doors." In addition, Section C also stated to "see Diagram for Evacuation Procedure in Section A" but no diagram was noted in Section A or elsewhere in the written fire safety plan. "Section E General Action Fire Plan" states during an evacuation to "Continue moving in sequence all persons in the area until all are past the fire doors." Based on interview at the time of record review, the Maintenance Supervisor</p>		<p>practice will be identified and what corrective actions will be taken? All residents, staff and visitors have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Fire Safety Plan has been updated with the change to indicate where smoke barrier doors and fire doors are located. The Maintenance Director will assure that all copies of the Fire Safety Plan contain the added corrections. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted monthly x 3, then quarterly x2 or until substantial compliance is maintained. Results of audits will be reviewed in quarterly QA meetings overseen by the ED.</p>	

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K 0062 SS=E Bldg. 01	<p>acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan for the facility for evacuation purposes.</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>1. Based on observation and interview, the facility failed to replace 7 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of</p>	K 0062	<p>K 0062 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The white paint on both the deflector for the pendent sprinkler in the closet of Room 11 and on the deflector for the pendent sprinkler in the Willow Bend nurse's station supply closet has been removed. The lint noted on the three pendent sprinklers installed behind the dryers in laundry was immediately removed. The decorative paper party ball that was hung on a string attached to the deflector on the pendent sprinkler in Cedar Bay nurse's station office was immediately taken down. The pendent sprinkler in the housekeeping room in the kitchen will be replaced by P.I.P.E. on 4/26 /16. The</p>	04/26/2016

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	<p>the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, the following was noted:</p> <p>a. white paint was on the deflector for the pendent sprinkler in the closet for Room 11 and white paint was also on the deflector for the pendent sprinkler in the Willow Bend nurse's station Nursing Supply closet.</p> <p>b. three pendent sprinklers installed behind the dryers in the Laundry were covered with lint.</p> <p>c. a decorative paper party ball was hung on a string attached to the deflector on the pendent sprinkler in the Cedar Bay nurse's station office.</p> <p>d. the pendent sprinkler in the Housekeeping Room in the kitchen was green with corrosion.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned sprinkler locations had foreign materials attached or had become green with corrosion.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a</p>		<p>missing escutcheon plate located on the automatic sprinkler on the exterior canopy of Memory care was immediately replaced. 2. How many other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents, staff & visitors have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director on preventative rounds will visualize pendent sprinklers and escutcheon plates to assure that there are no foreign materials attached or have become green with corrosion and clean/ replace any pendent sprinklers or escutcheon plates as necessary. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted monthly x 3, then quarterly x 2 until substantial compliance is maintained. Results of audits will be reviewed in quarterly QA meetings overseen by the ED.</p>	

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K 0147 SS=E Bldg. 01	<p>listed sprinkler assembly. This deficient practice could affect 15 residents, staff and visitors if needing to exit the facility from Memory Care.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, the escutcheon plate was missing for the automatic sprinkler located on the exterior canopy at the Memory Care exit. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the escutcheon plate was missing for the aforementioned automatic sprinkler location.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 20 residents, staff</p>	K 0147	<p>K 0147 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice? The power strip in Room 35 was immediately removed and the oxygen concentrator and refrigerator were plugged into fixed wiring.</p> <p>2. How many other residents having the potential to be</p>	04/26/2016			

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	<p>and visitors in the vicinity of Room 35.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/16, an oxygen concentrator medical device and a refrigerator were plugged into a power strip in Room 35. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p>		<p>affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident, staff or visitor near Room 35 have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance Director on preventative rounds will check in rooms for power strips being used as a substitute for fixed wiring and remove them. An inservice will be completed with all staff regarding use of power strips and extension cords</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Audits will be conducted monthly x 3, then quarterly x 2 until substantial compliance is maintained. Results of audits will be reviewed in quarterly QA meetings overseen by the ED.</p>	