STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155149	A. BUILDING -- B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/03/22 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 At this Emergency Preparedness survey, Harcourt Terrace Nursing and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 73. Quality Review completed on 11/10/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	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 the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/25/22.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony Link	Executive Director	11/28/2022

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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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load testing documentation for the facility's diesel fired emergency generator for January and February 2022 was incomplete. The "Load kW" achieved for January and February 2022 was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the load percent achieved for the January and February 2022 monthly load test was not available for review. b. Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load testing documentation for the facility's diesel fired	E 0041	**E 041 Hospital CAH and LTC emergency power** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The load test data for January and February 2022 was not recorded at the time of the test. - The transfer time data for January and February 2022 was not recorded at the time of the test. - The cool down time data for January and February 2022 was not recorded at the time of the test. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficiency. - Data from the January and February 2022 is not available. Previous maintenance director no longer works at this location. No issues noted on thoroughness of	11/25/2022

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	emergency generator for January and February 2022 was incomplete. The "Transfer Time" for January and February 2022 was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the transfer time for January and February 2022 monthly load test was not available for review. c. Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load testing documentation for the facility's diesel fired emergency generator for January and February 2022 was incomplete. The "cool down" time for January and February 2022 monthly load testing was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the cool down time for the January and February 2022 monthly load test was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.		document since arrival of new Maintenance Director. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include proper use of forms and being filled out completely after each test. - Executive Director will review weekly generator test documentation to ensure completeness in filling out. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The ED will be responsible for the completion of the E041 CQI Tool weekly for 3 months, then monthly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0000 Bldg. 01				

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	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). Survey Date: 11/03/22 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 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 483.90(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 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 sleeping rooms. The facility has a capacity of 110 and had a census of 73 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/10/22	K 0000	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 the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/25/22.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC			

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	Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation: "Detectors Test Battery Operated Smoke Detectors" for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly resident sleeping room battery operated smoke detector testing was not itemized by location. The aforementioned documentation stated "all detectors" were tested but the testing documentation did not list the location of each device tested. In addition, resident sleeping room battery operated smoke detector cleaning	K 0300	**K 300 Protection Other** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - All battery operated smoke detectors have been recorded on the TELS logbook form. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents with battery operated smoke detectors had the potential to be affected by the alleged deficiency. - All battery operated smoke detectors have been recorded on the TELS logbook form **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to	11/25/2022

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	documentation for the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Executive Director stated the facility regularly tests battery operated smoke detectors but agreed an itemized list of each device tested was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, manufacturer's documentation affixed to the First Alert Model 0827 battery operated smoke alarm installed on the ceiling in resident sleeping Room 4 stated to clean the unit monthly. Manufacturer's documentation affixed to the Universal Security Instruments (USI) Model 130505 battery operated smoke alarm installed on the ceiling in resident sleeping Room 3 stated to clean the unit annually. Based on interview at the time of the observations, the Executive Director and the Maintenance Director stated most resident sleeping rooms have the same USI battery operated smoke alarm installed in the room. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		include ensuring all battery operated smoke detectors are properly recorded on the TELS logbook form. - Executive Director will inspect the monthly testing that is to be performed on all battery operated smoke detectors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The Executive Director will be responsible for the completion of the K300 CQI Tool monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated			

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	from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 7 hazardous areas such as soiled linen and trash collection rooms exceeding 64 gallons were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry Services room near the Cedar Bay nurse's station. Findings include: Based on observations with the Executive Director and the Maintenance Director during a	K 0321	**K 321 Hazardous Areas Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - A self closing device was installed on the door from the cedar bay laundry services door to the adjoined fax room door. **How other residents having the potential to be affected by the same deficient practice will be**	11/25/2022

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	tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, the Laundry Services room near the Cedar Bay nurse's station has two entry doors to the room which was used to store 32 gallon capacity trash and soiled linen carts. The corridor door to the room was self closing or automatic closing but the door to the room from the adjoining fax room was not self closing or automatic closing. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the door to the aforementioned hazardous area from the fax room was not self closing or automatic closing. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents on the Cedar Bay Unit had the potential to be affected by the alleged deficiency. - No other laundry rooms have a door leading into an adjacent room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring all laundry rooms doors that have adjacent rooms have a self closing device installed. - Executive Director will inspect any new door installation from a laundry services room to an adjacent rooms to ensure a self closing device is in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The Maintenance Director will be	

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			responsible for the completion of the K321 CQI Tool monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - 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. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were not loaded with foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g.,	K 0353	K 353 Sprinkler System **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The 3 sprinkler heads in the area behind the dryers were cleaned and all lint was removed.	11/25/2022

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HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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	up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 2 staff and visitors in the basement laundry room. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, three of three ceiling mounted sprinklers located behind the dryers in the basement laundry room were loaded with lint. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned automatic sprinkler locations were loaded with lint. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficiency. - The 3 sprinkler heads in the area behind the dryers were cleaned and all lint was removed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring all sprinkler heads in the laundry room are thoroughly cleaned and free of lint. - Executive Director will inspect sprinkler heads in laundry room and areas behind the dryers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each**	

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	155149	A. BUILDING 01 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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			deficiency will be completed **-** The Executive Director will be responsible for the completion of the K353 CQI Tool weekly for 3 months, and then monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), 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. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). 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. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Therapy Room.	K 0361	K361 Corridors areas open to corridor **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The latching hardware for the door leading into the therapy was installed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All	11/25/2022

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	Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, the latching hardware for the corridor door to the Therapy Room was removed from the door. The door only had a thumb twist lock on the door which required a key to unlock from the corridor side of the door. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the positive latching device to latch the Therapy Room corridor door into the door frame was removed. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		residents on the therapy room hall had the potential to be affected by the alleged deficiency. - The latching hardware for the door leading into the therapy was installed . **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring the therapy room door has required functioning latching hardware. - Maintenance Director to ensure the therapy room door has required functioning latching hardware. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The Maintenance Director will be responsible for the completion of the K361 CQI Tool monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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			Date of compliance 11/25/2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, the following was noted: a. the corridor door to resident sleeping Room 38 failed to latch into the door frame when tested to close multiple times. b. the latching plate on the door frame for the corridor door to resident sleeping Room 56 was missing which caused a one inch gap in between the face of the door and the door stop on the door frame when the door was in the fully closed and latched position. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.	K 0363	K363 Corridor Doors **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The doors to room 38 was adjusted so that it latches into the frame. - The door to room room 56 had a latching plate installed, to ensure it closes correctly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficiency. - The doors to room 38 was adjusted so that it latches into the frame. - The door to room room 56 had a latching plate installed, to ensure it closes correctly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/25/2022

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	3.1-19(b)		**practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring all doors latch correctly into the frame and have latching plates. - Maintenance Director to ensure ensuring all doors latch correctly into the frame and have latching plates . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The Maintenance Director will be responsible for the completion of the K363 CQI Tool monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0541 SS=E Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive			

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	construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82			
	Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was maintained in accordance with NFPA 82. NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 2009 Edition, Section 5.2.3.2.2 states the bottom of a linen chute shall be protected by a listed automatic closing or self closing door in accordance with Section 5.2.3.1. Section 5.2.3.1.3 states openings shall be as follows: (1) 1 1/2 fire resistance rating for 2-hour rated enclosures. (2) 1-hour fire resistance rating for 1-hour rated enclosures. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the linen chute on the first floor by the main dining room. Findings include:	K 0541	K541 Rubbish Chutes, incinerators, and laundry Chutes **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The hook on the chain was removed, to allow the door to close when released by the wall mounted magnetic holding device. - The door to the chute in the linen chute room on the first floor was closed when not in use. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	11/25/2022

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	Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, the self closing chute door at bottom of the linen chute in the Laundry room in the basement was equipped with a chain and a magnet and could be held in the fully open position with a wall mounted magnetic holding device set to release the door with fire alarm system activation but a hook was inserted into the chain and placed on the door frame for the self closing door to hold the chute door in the fully open position. The use of the hook on the chain served to prop the chute door in the fully open position and override the use of the wall mounted magnetic holding device. When the hook was removed from the door frame, the chute door closed and when the door was reopened, the energized wall mounted magnetic holding device held the door in the fully open position. In addition, the chute door in the first floor linen chute room was in the fully open position. A sign was near the chute door stating "Linen chute must remain closed when not in use". Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the chute door at the bottom of the linen chute was propped open with the use of the hook on the chain and the chute door in the first floor linen chute room was in the fully open position. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficiency. - The hook on the chain was removed, to allow the door to close when released by the wall mounted magnetic holding device. - The door to the chute in the linen chute room on the first floor was closed when not in use. - **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring the self closing chute door at the bottom of the linen chute can close automatically as needed. - Maintenance Director to ensure self closing chute door at the bottom of the linen chute can close automatically as needed and the door to the chute in the linen chute room on the first floor was closed when not in use. - **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed **-** The Maintenance Director will be responsible for the completion of the K541 CQI Tool monthly for 6 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be	K 0761	K761 Maintenance inspection and testing doors **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The doors to the oxygen storage room, corridor door to the laundry chute room, and the stairwell door by the kitchen were added to the TELS logbook for section fire smoke doors annual fire smoke door inspection. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be	11/25/2022

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	performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include:		affected by the alleged deficiency. - The doors to the oxygen storage room, corridor door to the laundry chute room, and the stairwell door by the kitchen were added to the TELS logbook for section fire smoke doors annual fire smoke door inspection. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include ensuring all fire doors are logged on the TELS logbook under section fire smoke doors annual fire smoke door inspection. - Maintenance Director to ensure all fire doors are logged on the TELS logbook under section fire smoke doors annual fire smoke door inspection . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The Maintenance Director will be responsible for the completion of the K761 CQI Tool annually, with results reported to the	

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	Based on review of Direct Supply TELS Logbook Documentation: "Fire-Smoke Doors (Opening Protectives) Annual Fire/Smoke Door Inspection" documentation dated 06/28/22 with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. Doors to oxygen storage rooms were not included in the annual fire door listing of fire doors inspected by the facility on 06/28/22. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, two oxygen storage and transfilling rooms are located inside the facility. The oxygen storage and transfilling room near the main dining room had five liquid oxygen containers and seven 'E' type oxygen cylinders stored in the room. The oxygen storage and transfilling room near the nurse's station by Room 11 had three liquid oxygen containers and seven 'E' type oxygen cylinders stored in the room. The entry door to each of the two rooms had a 1-hour fire resistance rating label affixed to the hinge side of the door. In addition, the corridor door to the laundry chute room on the first floor had a 90 minute fire resistance rating label affixed to the hinge side of the door. The stairwell door at the top of the stairs by the kitchen had a 1-hour fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of record review and of the observations, the Executive Director and the Maintenance Director agreed it could not be assured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. This finding was reviewed with the Executive		Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	

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	Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(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
	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 2 months of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load	K 0918	K918 Electrical systems **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The load test data for January and February 2022 was not recorded at the time of the test. - The transfer time data for January and February 2022 was not recorded at the time of the test. - The cool down time data for January and February 2022 was not recorded at the time of the test. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficiency. - Data from the January and February 2022 is not available. Previous maintenance director no longer works at this location. No issues noted on thoroughness of document since arrival of new Maintenance Director. **What measures will be put into**	11/25/2022

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	testing documentation for the facility's diesel fired emergency generator for January and February 2022 was incomplete. The "Load kW" achieved for January and February 2022 monthly load testing was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the load percent achieved for the January and February 2022 monthly load test was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation of the transfer time to the alternate power source was within 10 seconds for monthly load tests conducted for 2 of the most recent 12 month period. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load testing documentation for the facility's diesel fired emergency generator for January and February 2022 was incomplete. The "Transfer Time" for January and February 2022 monthly load testing was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the transfer time for		**place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to include proper use of forms and being filled out completely after each test. - Executive Director will review weekly generator test documentation to ensure completeness in filling out. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The ED will be responsible for the completion of the K918 CQI Tool weekly for 3 months, then monthly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	

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	January and February 2022 monthly load test was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for 2 of 12 months. NFPA 110 8.4.5(4) requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load testing documentation for the facility's diesel fired emergency generator for January and February 2022 was incomplete. The "cool down" time for January and February 2022 monthly load testing was left blank and was not available for review. Based on interview at the time of record review, the Executive Director agreed the cool down time for January and February 2022 monthly load test was not available for review. . This finding was reviewed with the Executive Director and the Maintenance Director during the			

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	exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated			

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	from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen was properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Cedar Bay nurse's station. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, one of one oxygen cylinders was standing upright on floor at the Cedar Bay nurse's station and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed one of one oxygen cylinders at the Cedar Bay nurse's station was not properly chained or supported in a proper cylinder stand or cart and secured it to a crash cart nearby.	K 0923	K 923 Gas equipment **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The one oxygen cylinder was properly affixed and supported to the Cedar Bay crash cart. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No residents were affected by the alleged deficiency. All residents on Cedar Bay had the potential to be affected by the alleged deficiency. - The one oxygen cylinder was properly affixed and supported to the Cedar Bay crash cart. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Executive Director to provide education to Maintenance Director via in servicing. Education to	11/25/2022

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		include properly chaining or supporting all oxygen cylinders. - Maintenance Director will ensure all oxygen cylinders at nurses stations and crash carts are properly chained and or supported. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The Maintenance Direcotr will be responsible for the completion of the K923 CQI Tool weekly for 3 months, then monthly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	