PRINTED: 11/30/2022

	T OF HEALTH AND HU R MEDICARE & MEDIC						MB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATI COMF	E SURVEY PLETED 3/2022
NAME OF PROVIDER OR SUPPLIER			8181 ⊦	ADDRESS, CITY, STATE, ZIP COD			
HARCO	URT TERRACE NU	RSING AND REHABILITATION		INDIAN	NAPOLIS, IN 46260		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLIDERICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
L 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 11/02 Facility Number: (Provider Number: AIM Number: 100 At this Emergency Terrace Nursing an in compliance with Requirements for Macondance in Compliance of Macondance in Compliance of Macondance in Compliance with Requirements for Macondance in Compliance	3/22 000070 155149	E 00	000	The creation and submission this plan of correction does constitute an admission by provider of any conclusion in the statement of deficien of any violation of regulatio. This provider respectfully rethat the 2567 plan of correctionsidered the letter of creallegation and requests decreview (paper compliance) after 11/25/22.	not this set forth cies, or n. equests ction be dible sk	
	the survey, the cens	O certified beds. At the time of sus was 73. mpleted on 11/10/22 42 CFR Subpart 483.73 is NOT					
E 0041 SS=F Bldg	MET as evidenced 482.15(e), 483.73 Hospital CAH and §482.15(e) Condi (e) Emergency ar The hospital must standby power sy emergency plan s this section and ir	by: (e), 485.625(e) I LTC Emergency Power tion for Participation: ad standby power systems. I implement emergency and stems based on the set forth in paragraph (a) of					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(i) and (ii) of this section.

§483.73(e), §485.625(e)

(X6) DATE

TITLE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/03/2022	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
TAG	(e) Emergency an The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Co Interim Amendments TIA and TIA 12-4), and Structure is built of structure or building 482.15(e)(2), §483 Emergency generator the [hospital, CAI implement the eminspection, testing requirements foun Facilities Code, NIC Code. 482.15(e)(3), §483 Emergency generator and LTC facilities] source to power end LTC facilities] source to power end the power systems open emergency, unless *[For hospitals at §483.73(g), and Code the power systems open emergency, unless the standards incomplete the sta	e located in accordance with ements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, do NFPA 110, when a new or when an existing and is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. Health Care and LTC facility] must be ergency power system and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency perational during the	TAG	DEFICIENCY	DATE

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155149	B. WING		11/03/2022		
NAME OF D	PROVIDER OR SUPPLIER)	STREE	ET ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF P	ROVIDER OR SUPPLIER	X.		HARCOURT RD			
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION	INDIA	ANAPOLIS, IN 46260			
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTIO			
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP	PRIATE		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE		
	1	Director of the Office of the n accordance with 5 U.S.C.					
	_	part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	(NARA). For inform	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
	1	eference, CMS will publish a					
		ederal Register to					
	announce the cha	_					
	1 ' '	Protection Association, 1					
	Batterymarch Park Quincy, MA 02169						
	1.617.770.3000.	e, www.mpa.org,					
		th Care Facilities Code,					
		ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	• •					
		FPA 99, issued August 9,					
	2012.	-					
	(iv) TIA 12-4 to NF 2013.	FPA 99, issued March 7,					
		PA 99, issued August 1,					
	2013.						
	(vi) TIA 12-6 to NF	FPA 99, issued March 3,					
	2014.						
	. ,	fe Safety Code, 2012					
	edition, issued Au	_					
	` ′	IFPA 101, issued August					
	11, 2011.						
	` '	FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NFPA 101, issued October						

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CENTERS F	OR MEDICARE & MEDIC				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/03/2022	
	F PROVIDER OR SUPPLIE	R RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	22, 2013. (xi) TIA 12-4 to N 22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 2009 Based on record re failed to implemen inspection, testing found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all residents, Findings include: a. Based on review Generator-Weekly Log" documentation month period with Maintenance Direct 9:25 a.m. to 12:20 testing documentate emergency generat 2022 was incomple for January and Fe was not available f at the time of recor agreed the load per	Exercise/Monthly Load Test on for the most recent twelve the Executive Director and the stor during record review from p.m. on 11/03/22, monthly load ion for the facility's diesel fired for January and February etc. The "Load kW" achieved bruary 2022 was left blank and for review. Based on interview dreview, the Executive Director from the control of the January monthly load test was not	E 0041	E 041 Hospital CAH and LTC emergency power What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; The load test data for Jan and February 2022 was not recorded at the time of the test. The transfer time data for January and February 2022 v not recorded at the time of the test. The cool down time data January and February 2022 v not recorded at the time of the test. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: No residents were affected the alleged deficiency. All	the ne be ve
	Log" documentation month period with Maintenance Direct	Exercise/Monthly Load Test on for the most recent twelve the Executive Director and the stor during record review from p.m. on 11/03/22, monthly load		residents had the potential to affected by the alleged deficied - Data from the January an February 2022 is not available Previous maintenance direct longer works at this location.	ency. d e. or no

testing documentation for the facility's diesel fired

issues noted on thoroughness of

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155149)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/03/2022
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE
	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.		document since arrival of r Maintenance Director. What measures will be purplace and what systemic changes will be made to ensure that the deficient practice does not reoccur - Executive Director to preducation to Maintenance via in servicing. Education include proper use of forms being filled out completely each test. - Executive Director will weekly generator test documentation to ensure completeness in filling out.	r; provide Director to s and after review
K 0000	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.		How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and by what deficiency will be compled. The ED will be responsible the completion of the E04 Tool weekly for 3 months, monthly for 3 months, with reported to the Quality Assurand Performance Improved Committee. Date of compliance 11/25/2	re the re put ate reach ted le for 1 CQI then results surance ment
Bldg. 01				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMP	LETED
		155149	B. WING 11/03/2022				3/2022
					_		
NAME OF F	PROVIDER OR SUPPLIEF	3			T ADDRESS, CITY, STATE, ZIP COD		
					HARCOURT RD		
HARCOU	JRT TERRACE NU	RSING AND REHABILITATION		INDIA	ANAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	NI.	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP	BE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	MATE	DATE
	A Life Safety Code	Recertification and State	K 0	000	The creation and submission	n of	
	Licensure Survey w	vas conducted by the Indiana			this plan of correction does	not	
	Department of Heal	lth in accordance with 42 CFR			constitute an admission by	this	
	483.90(a).				provider of any conclusion	et forth	
					in the statement of deficien	cies, or	
	Survey Date: 11/03	3/22			of any violation of regulation	١.	
					This provider respectfully re	quests	
	Facility Number: 0				that the 2567 plan of correct	tion be	
	Provider Number:	155149			considered the letter of cred	lible	
	AIM Number: 100	266190			allegation and requests des	k	
					review (paper compliance)	on or	
		Code survey, Harcourt Terrace			after 11/25/22.		
	_	ilitation was found not in					
		equirements for Participation in					
		l, 42 CFR Subpart 483.90(a),					
	· ·	re and the 2012 Edition of the					
		ction Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	I	ity with a partial basement was					
		Type III (211) construction					
		ed. The facility has a fire alarm					
	1 -	detection on all levels in the					
		areas open to the corridor.					
	1	tery operated smoke detectors					
		ing rooms. The facility has a					
	of this visit.	I had a census of 73 at the time					
	of this visit.						
	All areas where the	residents have customary					
		ered and all areas providing					
	facility services we						
	lacinty services we	re sprinklered.					
	Quality Review cor	mpleted on 11/10/22					
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
	List in the REMAF	RKS section any LSC					Ī

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/03/2022 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD INDIANAPOLIS, IN 46260 HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0300 K 300 Protection Other 11/25/2022 interview; the facility failed to ensure What corrective action(s) will documentation for the preventative maintenance be accomplished for those of all battery operated smoke alarms in resident residents found to have been rooms was complete. NFPA 101 in 4.6.12.3 states affected by the deficient existing life safety features obvious to the public, practice; if not required by the Code, shall be maintained. All battery operated smoke NFPA 72, National Fire Alarm and Signaling Code, detectors have been recorded on 2010 Edition, 29.10 Maintenance and Tests states the TELS logbook form. fire-warning equipment shall be maintained and tested in accordance with the manufacturer's How other residents having the published instructions and per the requirements potential to be affected by the of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, same deficient practice will be testing, and maintenance programs shall satisfy identified and what corrective the requirements of this Code and conform to the action(s) will be taken: equipment manufacturer's published instructions. No residents were affected by This deficient practice could affect all residents, the alleged deficiency. All staff, and visitors. residents with battery operated smoke detectors had the potential Findings include: to be affected by the alleged deficiency. Based on review of Direct Supply TELS Logbook All battery operated smoke Documentation: "Detectors Test Battery Operated detectors have been recorded on Smoke Detectors" for the most recent twelve the TELS logbook form 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 What measures will be put into resident sleeping room battery operated smoke place and what systemic detector testing was not itemized by location. The changes will be made to aforementioned documentation stated "all

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detectors" were tested but the testing

documentation did not list the location of each

battery operated smoke detector cleaning

device tested. In addition, resident sleeping room

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ensure that the deficient

practice does not reoccur;

via in servicing. Education to

Executive Director to provide

education to Maintenance Director

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/03/2022
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	period was also not on interview at the texecutive Director tests battery operate an itemized list of e available for review the Executive Director during a to p.m. to 2:30 p.m. or	he most recent twelve month available for review. Based time of record review, the stated the facility regularly and smoke detectors but agreed ach device tested was not a. Based on observations with tor and the Maintenance ur of the facility from 12:20 to 11/03/22, manufacturer's		include ensuring all battery operated smoke detectors are properly recorded on the TELS logbook form. - Executive Director will institute monthly testing that is to be performed on all battery operations.	pect e ated
	0827 battery operate ceiling in resident si the unit monthly. Maffixed to the Unive Model 130505 batte installed on the ceil: 3 stated to clean the interview at the time Executive Director stated most resident same USI battery op in the room.	ted to the First Alert Model ed smoke alarm installed on the deeping Room 4 stated to clean Manufacturer's documentation ersal Security Instruments (USI) ery operated smoke alarm ing in resident sleeping Room runit annually. Based on e of the observations, the and the Maintenance Director esleeping rooms have the operated smoke alarm installed wiewed with the Executive sintenance Director during the		How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; and by what date the systemic changes for ear deficiency will be completed. The Executive Director will be responsible for the completion the K300 CQI Tool monthly for months, with results reported the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/202	ut ch e of or 6 I to
K 0321 SS=E Bldg. 01	barrier having 1-he (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat	- Enclosure are protected by a fire our fire resistance rating			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/03/2022		
	PROVIDER OR SUPPLIE JRT TERRACE NU	R JRSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD IAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	B NATE	(X5) COMPLETION DATE	
	partitions and do Doors shall be se automatic-closing nonrated or field- do not exceed 48 the door. Describe the floo	g and permitted to have applied protective plates that inches from the bottom of r and zone locations of that are deficient in						
	b. Laundries (larg c. Repair, Mainte d. Soiled Linen R gallons) e. Trash Collectic (exceeding 64 ga f. Combustible St (over 50 square f	el-Fired Heater Rooms ger than 100 square feet) nance, and Paint Shops cooms (exceeding 64 on Rooms allons) corage Rooms/Spaces feet) f classified as Severe						
	Based on observate failed to ensure 1 cas soiled linen and exceeding 64 gallo spaces by smoke re	ion and interview, the facility of over 7 hazardous areas such trash collection rooms ons were separated from other esistant partitions and doors. Colosing or automatic closing in	K 0	321	K 321 Hazardous Areas Enclosure What corrective action(s) w be accomplished for those residents found to have be affected by the deficient		11/25/2022	

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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

Based on observations with the Executive

Director and the Maintenance Director during a

Cedar Bay nurse's station.

Findings include:

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practice;

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- 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

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	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BUILDING B. WING	01	COMPLETED 11/03/2022
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	11/03/22, the Laund Cedar Bay nurse's st the room which was capacity trash and so door to the room wa closing but the door adjoining fax room automatic closing. I of the observations, the Maintenance Di- aforementioned haz was not self closing	rom 12:20 p.m. to 2:30 p.m. on lary Services room near the tation has two entry doors to see used to store 32 gallon oiled linen carts. The corridor as self closing or automatic to the room from the was not self closing or Based on interview at the time the Executive Director and rector agreed the door to the ardous area from the fax room or automatic closing. Viewed with the Executive intenance Director during the		identified and what corrective action(s) will be taken: No residents were affected the alleged deficiency. All residents on the Cedar Bay U had the potential to be affected the alleged deficiency. No other laundry rooms had door leading into an adjacent room. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur; Executive Director to proveducation to Maintenance Direction to Maintenance Direction include ensuring all laundry rodoors that have adjacent room have a self closing device installed. Executive Director will instany new door installation from laundry services room to an adjacent rooms to ensure a sectioning 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 pinto place; and by what date	d by nit d by ave a ide ector oms ns pect a elf
				the systemic changes for ea deficiency will be completed - The Maintenance Director w	

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 11/03/2022	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				responsible for the completion the K321 CQI Tool monthly formonths, with results reported the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/202	or 6 I to	
K 0353 SS=D Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of syster inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system	supply source				
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure 3 of the facility were not in accordance with for the Inspection, Water-Based Fire F. Edition, Section 5.2	•	K 0353	K 353 Sprinkler System What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice; - The 3 sprinkler heads in the area behind the dryers were	1	11/25/2022

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foreign materials, paint, and physical damage; and

shall be installed in the correct orientation (e.g.,

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cleaned and all lint was removed.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	construction 01	(X3) DATE SURVEY COMPLETED
ANDILAN	or conduction	155149	B. WING		11/03/2022
	PROVIDER OR SUPPLIER	I RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	up-right, pendent, of 5.2.1.1.2 any sprink the following shall (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not	r sidewall). Furthermore, at ler that shows signs of any of be replaced: gethe glass bulb heat responsive painted by the sprinkler sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the touch the sprinkler.		How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: - No residents were affected the alleged deficiency. All residents had the potential to leaffected by the alleged deficiency. The 3 sprinkler heads in the area behind the dryers were cleaned and all lint was removed.	the le pe d by be ncy.
	-	ice could affect over 2 staff asement laundry room.		What measures will be put in place and what systemic	ito
	Findings include:			changes will be made to ensure that the deficient	
	Director and the Matour of the facility f 11/03/22, three of the located behind the croom were loaded with time of the observation and the Matorementioned autoloaded with lint.	ons with the Executive aintenance Director during a from 12:20 p.m. to 2:30 p.m. on here ceiling mounted sprinklers dryers in the basement laundry with lint. Based on interview at revations, the Executive aintenance Director agreed the formatic sprinkler locations were wiewed with the Executive aintenance Director during the		practice does not reoccur; - Executive Director to provied education to Maintenance Director via in servicing. Education to include ensuring all sprinkler heads in the laundry room are thoroughly cleaned and free or lint. - Executive Director will insprinkler 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	ector f pect m
				assurance program will be p	

the systemic changes for each

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/03/2022
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0361 SS=E	NFPA 101 Corridors - Areas	Open to Corridor		deficiency will be completed - The Executive Director will b responsible for the completion the K353 CQI Tool weekly for months, and then monthly for months, with results reported the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/202	e of 3 6 I to
Bldg. 01	treatment rooms a waiting areas, nur and cooking facilit	Open to Corridor In patient sleeping rooms, Ind hazardous areas), Ise's stations, gift shops, Iies, open to the corridor are In the criteria under 18.3.6.1			
	failed to ensure 1 of separated from the of of resisting the pass sprinklered building 19.3.6.1(7). LSC 19 other than patient sl rooms, and hazardo corridor and unlimit space and corridors	on and interview, the facility I therapy rooms was corridor by a partition capable age of smoke as required in a g, or met an Exception per 9.3.6.1(7) states that spaces eeping rooms, treatment us areas shall be open to the ted in area, provided: (a) The which the space opens onto compartment are protected by	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 door leading into the therapy winstalled.	the
	an electrically super detection system in (b) Each space is pr sprinklers, and (c) T access to required e	rvised automatic smoke accordance with 19.3.4, and otected by an automatic The space does not to obstruct xits. This deficient practice residents, staff and visitors in		How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: - No residents were affected the alleged deficiency. All	e oe e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BU B. W		01	COMPLETED 11/03/2022	
		100148	B. W	_		11/03/2022	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			ARCOURT RD IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Findings in the 4				residents on the therapy room		
	Findings include:				had the potential to be affecte the alleged deficiency.	a by	
	Based on observation	ons with the Executive			- The latching hardware for	the	
		aintenance Director during a			door leading into the therapy v		
		From 12:20 p.m. to 2:30 p.m. on			installed .		
	1	ng hardware for the corridor					
		Room was removed from the					
	1	y had a thumb twist lock on			What measures will be put in	nto	
		nired a key to unlock from the			place and what systemic		
		door. Based on interview at			changes will be made to		
		ervations, the Executive anitenance Director agreed the			ensure that the deficient		
		vice to latch the Therapy			practice does not reoccur;Executive Director to prov	ide	
	l -	r into the door frame was		education to Maintenance Director			
	removed.	1110 1110 1100 1101110 1100			via in servicing. Education to	50101	
					include ensuring the therapy r	oom	
	This finding was re	viewed with the Executive			door has required functioning		
	Director and the Ma	aintenance Director during the			latching hardware.		
	exit conference.				- Maintenance Director to		
					ensure the therapy room door	has	
	3.1-19(b)				required functioning latching		
					hardware.		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place; and by what date		
					the systemic changes for ea		
					deficiency will be completed		
					- The Maintenance Director wi		
					responsible for the completion		
					the K361 CQI Tool monthly f months, with results reported		
					the Quality Assurance and	110	
					Performance Improvement		
					Committee		

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PARTMENT OF HEALTH AND HUMAN SERVICES					
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 093		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING 01	COMPLETED		

	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BUILDING B. WING	01	COMPLETED 11/03/2022
	PROVIDER OR SUPPLIED	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETIC DATE
				Date of compliance 11/25/2	2022
K 0363 SS=E Bldg. 01	than required end exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller CMS regulation. The apply to auxiliary flammable or come Clearance between covering is not extended to complying if provided with a the door closed wapplied. There is closing of the door release when the permitted. Nonrat unlimited height a meeting 19.3.6.3. frames shall be lad other materials in unless the smoke sprinklered. Fixed allowed per 8.3. If there are no restricts.	rials have positive latching latches are prohibited by These requirements do not spaces that do not contain abustible material. It is not to bottom of door and floor deeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is no impediment to the later. Hold open devices that door is pushed or pulled are led protective plates of lare permitted. Dutch doors 6 are permitted. Door labeled and made of steel or compliance with 8.3,			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/03/2022 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD INDIANAPOLIS, IN 46260 HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0363 K363 Corridor Doors 11/25/2022 failed to ensure 2 of over 50 corridor doors to What corrective action(s) will resident sleeping rooms had no impediment to be accomplished for those closing and latching into the door frame and residents found to have been would resist the passage of smoke. This deficient affected by the deficient practice could affect over 20 residents, staff and practice; visitors. The doors to room 38 was adjusted so that it latches into the Findings include: frame The door to room room 56 had Based on observations with the Executive a latching plate installed, to Director and the Maintenance Director during a ensure it closes correctly. tour of the facility from 12:20 p.m. to 2:30 p.m. on 11/03/22, the following was noted: How other residents having the a. the corridor door to resident sleeping Room 38 potential to be affected by the failed to latch into the door frame when tested to same deficient practice will be close multiple times. identified and what corrective b. the latching plate on the door frame for the action(s) will be taken: corridor door to resident sleeping Room 56 was No residents were affected by missing which caused a one inch gap in between the alleged deficiency. All the face of the door and the door stop on the door residents had the potential to be frame when the door was in the fully closed and affected by the alleged deficiency. latched position. The doors to room 38 was Based on interview at the time of the adjusted so that it latches into the observations, the Executive Director and the frame. Maintenance Director agreed the aforementioned The door to room room 56 had corridor doors had an impediment to closing and a latching plate installed, to latching into the door frame or would not resist ensure it closes correctly. the passage of smoke.

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exit conference.

This finding was reviewed with the Executive

Director and the Maintenance Director during the

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What measures will be put into

place and what systemic

changes will be made to ensure that the deficient

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED 11/03/2022	
		155149	B. W	ING		11/03/	ZUZZ
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
HARCOU	IRT TERRACE NUI	RSING AND REHABILITATION			ARCOURT RD IAPOLIS, IN 46260		
					I	1	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	3.1-19(b)				practice does not reoccur;		
					- Executive Director to prov	ide	
					education to Maintenance Dire	ector	
					via in servicing. Education to		
					include ensuring all doors late		
					correctly into the frame and ha	ave	
					latching plates Maintenance Director to	,	
					ensure ensuring all doors late		
					correctly into the frame and ha		
					latching plates .		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality assurance program will be p		
					into place; and by what date	uı	
					the systemic changes for ea	ch	
					deficiency will be completed		
					- The Maintenance Director w		
					responsible for the completion	of	
					the K363 CQI Tool monthly f		
					months, with results reported	l to	
					the Quality Assurance and		
					Performance Improvement Committee.		
					Committee.		
					Date of compliance 11/25/202	2	
K 0541	NFPA 101						
SS=E		ncinerators, and Laundry					
Bldg. 01	Chu	•					
	Rubbish Chutes, I	ncinerators, and Laundry					
	Chutes						
	2012 EXISTING						
	, , .	nen and trash chute,					
		tic rubbish and linen					
	•	ns directly onto any ealed by fire resistive					

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EPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDIC.	AID SERVICES				OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST	TRUCTION		(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01		COMPLETED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		A. BUILDING 01 B. WING		COMPLETED 11/03/2022	
	PROVIDER OR SUPPLIER URT TERRACE NUI	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR construction to pre	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Event further use or shall be	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	fire protection rating shall comply with shall comply make the extinguishing protes. (3) Any trash chutter trash collection roopurpose and protes. (4) Existing launt discharge into sand automatic sprinkles. 19.3.5.9 or 19.3.5. (4) Existing fuel-fesealed by fire resist further use. 19.5.4, 9.5, 8.4, N. Based on observation failed to ensure 1 of maintained in accors. (2) Standard on Inc. Handling Systems as Section 5.2.3.2.2 standard on Inc. Handling Systems as Section 5.2.3.1. Sect	utte or linen chute, icic rubbish and linen provided with automatic ection in accordance with e shall discharge into a om used for no other ected in accordance with dry chutes permitted to ne room are protected by rs in accordance with 7.) d incinerators shall be stive construction to prevent	K 0541	K541 Rubbish Chutes, incinerators, and laundry Chute 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 wa mounted magnetic holding dev. The door to the chute in the linen chute room on the first flowas 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.	ill ice. e oor he

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î î			î ´	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155149	B. W	ING		11/03/	2022
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .		8181 H	ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	D 1 1 2	tal at the co			action(s) will be taken:		
		ons with the Executive			- No residents were affected	d by	
		aintenance Director during a			the alleged deficiency. All		
		from 12:20 p.m. to 2:30 p.m. on			residents had the potential to		
		losing chute door at bottom of			affected by the alleged deficie	-	
		e Laundry room in the			- The hook on the chain wa	S	
		oped with a chain and a			removed, to allow the door to		
	-	e held in the fully open			close when released by the wa		
	-	mounted magnetic holding			mounted magnetic holding de		
		e the door with fire alarm			- The door to the chute in th		
	-	ut a hook was inserted into the			linen chute room on the first flo	oor	
	_	the door frame for the self			was closed when not in use.		
	-	I the chute door in the fully			-		
		use of the hook on the chain					
		hute door in the fully open le the use of the wall mounted			NA/hat magazinas vill ha mut im	.4	
	-	evice. When the hook was			What measures will be put in	ιτο	
	-	loor frame, the chute door			place and what systemic		
		e door was reopened, the			changes will be made to ensure that the deficient		
		inted magnetic holding device					
	-	fully open position. In			practice does not reoccur;Executive Director to provi	ido	
		door in the first floor linen			education to Maintenance Dire		
		the fully open position. A sign			via in servicing. Education to	CIOI	
		door stating "Linen chute			include ensuring the self closi	ina	
		when not in use". Based on			chute door at the bottom of the	-	
		e of the observations, the			linen chute can close		
		and the Maintenance Director			automatically as needed.		
		or at the bottom of the linen			- Maintenance Director to		
		open with the use of the hook			ensure self closing chute door	at	
		e chute door in the first floor			the bottom of the linen chute of		
		as in the fully open position.			close automatically as needed		
		J 1 1			and the door to the chute in th		
	This finding was re	viewed with the Executive			linen chute room on the first fle	-	
	_	aintenance Director during the			was closed when not in use.		
	exit conference.	Č			-		
	2.1.10(1)						
	3.1-19(b)				How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/03/2022
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0761 SS=F Bldg. 01		riew, observation and	K 0761	assurance program will be p into place; and by what date the systemic changes for ear deficiency will be completed - The Maintenance Director wiresponsible for the completion the K541 CQI Tool monthly f months, with results reported the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/202	ch ill be n of for 6 n to
	inspection and testin were completed in a Communicating oper required by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire Deprotectives, except a Code. NFPA 80 5.2 shall be inspected a annually, and a writt shall be signed and	ty failed to ensure annual ng of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers it.1 shall be permitted only in the protected by approved or assemblies. (See also Section penings required to have a fire Table 8.3.4.2 shall be ted, listed, labeled fire door window assemblies and their ware, including all frames, thorage, and sills in the requirements of NFPA 80, thorage, and Other Opening as otherwise specified in this in the states fire door assemblies and tested not less than the record of the inspection kept for inspection by the inspection of the states functional testing of		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 laundry chute room, and the stairwell door by the kitchen we added to the TELS logbook for section fire smoke doors annufire 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 the alleged deficiency. All	the vere r tal

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fire door and window assemblies shall be

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residents had the potential to be

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>			COMPLETED	
		155149	B. W	'ING		11/03/	/2022	
NAME OF P	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD			
HARCOL	IRT TERRACE NU	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260			
			1		T			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		iduals with knowledge and			affected by the alleged deficie	ncy.		
	-	e operating components of			- The doors to the oxygen			
		ing subject to testing. NFPA			storage room, corridor door to	the		
	· ·	re door assemblies shall be			laundry chute room, and the			
		From both sides to assess the			stairwell door by the kitchen w			
	overall condition of	door assembly.			added to the TELS logbook fo			
	NIEDA OO G	5040			section fire smoke doors annu	ıal		
		5.2.4.2 states as a minimum, the			fire smoke door inspection.			
	following items sha							
	_	or breaks exist in surfaces of			l	_		
	either the door or fr				What measures will be put in	ito		
		light frames, and glazing beads			place and what systemic			
		ely fastened in place, if so			changes will be made to			
	equipped.				ensure that the deficient			
	* *	e, hinges, hardware, and		practice does not reoccur;				
		eshold are secured, aligned,			- Executive Director to prov			
		er with no visible signs of			education to Maintenance Dire	ector		
	damage.				via in servicing. Education to			
	(4) No parts are mis	_			include ensuring all fire doors			
	` '	s do not exceed clearances			logged on the TELS logbook t			
	listed in 4.8.4 and 6				section fire smoke doors annu	ıal		
		g device is operational; that is,			fire smoke door inspection.			
		pletely closes when operated			- Maintenance Director to	_		
	from the full open p				ensure all fire doors are logge			
	` '	is installed, the inactive leaf			the TELS logbook under secti	on		
	closes before the ac				fire smoke doors annual fire			
	` '	are operates and secures the			smoke door inspection .			
	door when it is in the	•						
		vare items that interfere or			How the corrective action(s)			
		are not installed on the door or			will be monitored to ensure	the		
	frame.				deficient practice will not			
		fications to the door assembly			recur, i.e., what quality			
	-	ed that void the label.			assurance program will be p			
		edge seals, where required, are			into place; and by what date			
	-	their presence and integrity.			the systemic changes for ea			
	-	ice could affect all residents,			deficiency will be completed			
	staff and visitors.				- The Maintenance Director w			
					responsible for the completion			
	Findings include:				the K761 CQI Tool annually,			
					with results reported to the			

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	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BUILDING B. WING	01	COMPLETED 11/03/2022
	PROVIDER OR SUPPLIER JRT TERRACE NUF	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG TAG	Based on review of Documentation: "Fi Protectives) Annual documentation date Director and the Ma record review from 11/03/22, annual instead door assemblies in the recent twelve month doors in the facility, rooms were not including of fire doors 06/28/22. Based on Executive Director aduring a tour of the p.m. on 11/03/22, the transfilling rooms at The oxygen storage main dining room he containers and seven stored in the room. It had three liquid of E' type oxygen cylicentry door to each of fire resistance rating of the door. In addilating side of the dotop of the stairs by the resistance rating lab the door. Based on review and of the old Director and the Macould not be assured facility were include fire door inspection.	Direct Supply TELS Logbook re-Smoke Doors (Opening Fire/Smoke Door Inspection" d 06/28/22 with the Executive sintenance Director during 9:25 a.m. to 12:20 p.m. on spection documentation of fire the facility within the most in period did not include all fire in Doors to oxygen storage uded in the annual fire door inspected by the facility on a observations with the mand the Maintenance Director facility from 12:20 p.m. to 2:30 two oxygen storage and re located inside the facility, and transfilling room near the ad five liquid oxygen in 'E' type oxygen cylinders. The oxygen storage and are the nurse's station by Room oxygen containers and seven inders stored in the room. The fithe two rooms had a 1-hour glabel affixed to the hinge side tion, the corridor door to the on the first floor had a 90 the rating label affixed to the hinge side of interview at the time of record oxervations, the Executive sintenance Director agreed it it all fire door locations in the ed in the most recent annual	TAG	Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/20.	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155149	B. WING		11/03/2022	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181	TADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDENC N. IN OF CORREC	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE THE ADDRESS OF THE	ILD BE COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	DATE	
	Director and the Ma exit conference.	aintenance Director during the				
	3.1-19(b)					
K 0918	NFPA 101					
SS=F	Electrical Systems	s - Essential Electric Syste				
Bldg. 01	1	s - Essential Electric				
	System Maintenar	nce and Testing				
	1	other alternate power				
		iated equipment is capable				
		ce within 10 seconds. If the				
		n is not met during the				
		ocess shall be provided to				
	1	his capability for the life				
	1	branches. Maintenance				
	_	generator and transfer				
	NFPA 110.	ormed in accordance with				
		e inspected weekly,				
		oad 30 minutes 12 times a				
	1 '	intervals, and exercised				
	1	nths for 4 continuous hours.				
		der load conditions include				
	a complete simula					
		ual transfer of all EES				
		nducted by competent				
		nance and testing of stored				
		rces (Type 3 EES) are in				
		NFPA 111. Main and feeder				
		e inspected annually, and a dically exercising the				
		,				
	-	tablished according to uirements. Written records				
		nd testing are maintained				
		ble. EES electrical panels				
		arked, readily identifiable,				
		n normal power circuits.				
	1	ssibility of damage of the				
	I	source is a design				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/03/2022 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD INDIANAPOLIS, IN 46260 HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 K 0918 11/25/2022 K918 Electrical systems facility failed to document emergency generator monthly load testing for 2 months of the most What corrective action(s) will recent 12 month period to meet the requirements be accomplished for those of NFPA 110, 2010 Edition, the Standard for residents found to have been Emergency and Standby Powers Systems, Chapter affected by the deficient 8.4.2. Section 8.4.2 states diesel generator sets in practice; service shall be exercised at least once monthly, The load test data for January for a minimum of 30 minutes, using one of the and February 2022 was not following methods: recorded at the time of the test. (1) Loading that maintains the minimum exhaust The transfer time data for gas temperatures as recommended by the January and February 2022 was manufacturer not recorded at the time of the (2) Under operating temperature conditions and at test. not less than 30 percent of the EPS (Emergency The cool down time data for Power Supply) nameplate kW rating. January and February 2022 was Section 8.4.2.3 states diesel-powered EPS not recorded at the time of the installations that do not meet the requirements of test. 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and How other residents having the shall be exercised annually with supplemental potential to be affected by the loads at not less than 50 percent of the EPS same deficient practice will be nameplate kW rating for 30 continuous minutes identified and what corrective and at not less than 75 percent of the EPS action(s) will be taken: nameplate kW rating for 1 continuous hour for a No residents were affected by total test duration of not less than 1.5 continuous the alleged deficiency. All hours. This deficient practice could affect all residents had the potential to be residents, staff and visitors. affected by the alleged deficiency. Data from the January and Findings include: February 2022 is not available. Previous maintenance director no Based on review of "Emergency longer works at this location. No Generator-Weekly Exercise/Monthly Load Test issues noted on thoroughness of Log" documentation for the most recent twelve document since arrival of new month period with the Executive Director and the Maintenance Director. Maintenance Director during record review from 9:25 a.m. to 12:20 p.m. on 11/03/22, monthly load What measures will be put into

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/03/2022 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD INDIANAPOLIS, IN 46260 HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE testing documentation for the facility's diesel fired place and what systemic emergency generator for January and February changes will be made to 2022 was incomplete. The "Load kW" achieved ensure that the deficient for January and February 2022 monthly load practice does not reoccur; testing was left blank and was not available for Executive Director to provide review. Based on interview at the time of record education to Maintenance Director review, the Executive Director agreed the load via in servicing. Education to percent achieved for the January and February include proper use of forms and 2022 monthly load test was not available for being filled out completely after review. each test. - Executive Director will review This finding was reviewed with the Executive weekly generator test Director and the Maintenance Director during the documentation to ensure exit conference. completeness in filling out. 3.1-19(b) How the corrective action(s) 2. Based on record review and interview, the will be monitored to ensure the facility failed to ensure documentation of the deficient practice will not transfer time to the alternate power source was recur, i.e., what quality within 10 seconds for monthly load tests assurance program will be put conducted for 2 of the most recent 12 month into place; and by what date period. This deficient practice could affect all the systemic changes for each residents, staff and visitors. deficiency will be completed - The ED will be responsible for Findings include: the completion of the K918 CQI Tool weekly for 3 months, then Based on review of "Emergency monthly for 3 months, with results Generator-Weekly Exercise/Monthly Load Test reported to the Quality Assurance Log" documentation for the most recent twelve and Performance Improvement month period with the Executive Director and the Committee. Maintenance Director during record review from Date of compliance 11/25/2022 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.

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Based on interview at the time of record review, the Executive Director agreed the transfer time for

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AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER 155149	ì í	JILDING	01	COMPL 11/03/	ETED
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 HA	DDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
	January and Februa not available for rev	ry 2022 monthly load test was view.					
		viewed with the Executive aintenance Director during the					
	facility failed to ensige generators was allow period after a load to 110 8.4.5(4) require minutes shall be prothe Emergency Powdown. This delay p	review and interview, the sure 1 of 1 emergency wed a 5 minute cool down est for 2 of 12 months. NFPA as a minimum time delay of 5 ovided for unloaded running of ver Supply (EPS) prior to shut provides additional engine cool int practice could affect all visitors.					
	Log" documentation month period with the Maintenance Direct 9:25 a.m. to 12:20 period testing documentation emergency generate 2022 was incompled January and Februa was left blank and we based on interview the Executive Direct for January and February	Exercise/Monthly Load Test in for the most recent twelve the Executive Director and the tor during record review from i.m. on 11/03/22, monthly load on for the facility's diesel fired or for January and February te. The "cool down" time for rry 2022 monthly load testing was not available for review. at the time of record review, tor agreed the cool down time or or was a supplied to the cool down time or or was a supplied to the cool down time or was 2022 monthly load test					
		viewed with the Executive aintenance Director during the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/03/2022	
		100148	B. W.			11/03	12022
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	7.112	DATE
	exit conference.						
	3.1-19(b)						
K 0923	NFPA 101						
SS=E		Cylinder and Container					
Bldg. 01	Storag	•					
-		Cylinder and Container					
	Storage						
	Greater than or ed	qual to 3,000 cubic feet					
	Storage locations	are designed, constructed,					
		accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000 c						
	_	are outdoors in an					
		n an enclosed interior					
		mited- combustible					
		door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		s by 20 feet (5 feet if					
		closed in a cabinet of					
		onstruction having a					
		re protection rating.					
		Il to 300 cubic feet					
		compartment, individual					
		e for immediate use in					
		with an aggregate volume ual to 300 cubic feet are not					
	· ·	red in an enclosure.					
	1	handled with precautions					
	as specified in 11.						
		ign readable from 5 feet is					
		ate of a cylinder storage					
		ign includes the wording as					
		FION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/03/2022 155149 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD INDIANAPOLIS, IN 46260 HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Based on observation and interview, the facility K 0923 K 923 Gas equipment 11/25/2022 failed to ensure 1 of 1 cylinders of nonflammable What corrective action(s) will gases such as oxygen was properly secured from be accomplished for those falling. NFPA 99, Health Care Facilities Code, residents found to have been 2012 Edition, Section 11.3.3 states storage for affected by the deficient nonflammable gases with a total volume equal to practice; or less than greater than 8.5 cubic meters (300 The one oxygen cylinder was cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. properly affixed and supported to NFPA 99, Section 11.3.3.2 states precautions in the Cedar Bay crash cart. handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states How other residents having the freestanding cylinders shall be properly chained potential to be affected by the or supported in a proper cylinder stand or cart. same deficient practice will be This deficient practice could affect over 10 identified and what corrective residents, staff and visitors in the vicinity of the action(s) will be taken: Cedar Bay nurse's station. No residents were affected by the alleged deficiency. All Findings include: residents on Cedar Bay had the potential to be affected by the Based on observations with the Executive alleged deficiency. The one oxygen cylinder was Director and the Maintenance Director during a tour of the facility from 12:20 p.m. to 2:30 p.m. on properly affixed and supported to 11/03/22, one of one oxygen cylinders was the Cedar Bay crash cart. standing upright on floor at the Cedar Bay nurse's station and was not properly chained or What measures will be put into supported in a proper cylinder stand or cart. place and what systemic Based on interview at the time of the changes will be made to observations, the Executive Director and the ensure that the deficient Maintenance Director agreed one of one oxygen practice does not reoccur; cylinders at the Cedar Bay nurse's station was not Executive Director to provide properly chained or supported in a proper cylinder education to Maintenance Director

stand or cart and secured it to a crash cart nearby.

via in servicing. Education to

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/03/2022
	PROVIDER OR SUPPLIE	JRSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		reviewed with the Executive Maintenance Director during the		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 puinto place; and by what date the systemic changes for each deficiency will be completed - The Maintenance Direcotr will responsible for the completion the K923 CQI Tool weekly for months, then monthly for 3 months, with results reported the Quality Assurance and Performance Improvement Committee. Date of compliance 11/25/2022	he ut ch II be of 3 to

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