PRINTED: 08/10/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155636	B. WING		07/17/2023	
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE		1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD APOLIS, IN 46219			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 07/17 Facility Number: 0 Provider Number: 1002 At this Emergency I Terrace was found i Preparedness Requi Medicaid Participat CFR 483.73.	00241 155636 291310 Preparedness survey, Harrison in compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 O certified beds. At the time of	E 0000			
	, , , , , , , , , , , , , , , , , , ,					
	Quality Review con	npleted on 07/20/23				
K 0000 Bldg. 01						
g. 0 .	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/17 Facility Number: 0 Provider Number: 1002	00241 155636	K 0000			
		mpliance with Requirements				

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

TITLE (X6) DATE

Taylor Shuey Executive Director 08/04/2023

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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/17/2023
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE		1924 W	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD IAPOLIS, IN 46219		
(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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	for Participation in Subpart 483.90(a), 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facily Type V (000) const The facility has a find detection in the contract the corridor. The facility a census of 69 at the All areas where resilvere sprinklered.	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to acility has battery operated stalled in all resident sleeping has a capacity of 110 and had te time of this visit. idents have customary access The facility has one detached facility storage services which			
	Quality Review cor	npleted on 07/20/23			
K 0100 SS=E Bldg. 01	Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard ci on Form CMS-256 Based on observation failed to ensure 1 of would self close and 4.6.12.3. LSC 4.6.5 features obvious to the Code, shall be estanding the section of the code.	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included	K 0100	what corrective action(s) be accomplished for those residents found to have been affected by the deficient praction. Fire door by room 63 do has been fixed to self-close a latch. All seven fire doors in the doors in the doors.	tice; or nd

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CC			COMPL	ETED
		155636	B. WING 07/17/2023			2023	
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
LIADDICA					ELLESLEY BLVD		
HARRIS	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI AN OF CODDECTION		(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'	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	residents, staff and	visitors in the vicinity of the			facility have been audited and	are	
	corridor door set by				self-closing effectively.		
	,						
	Findings include:				· how other residents havir	na	
	8				the potential to be affected by	-	
	Based on observation	ons with the Maintenance			same deficient practice will be		
		eld Maintenance Supervisor			identified and what corrective		
		facility from 12:50 p.m. to 3:10			action(s) will be taken;		
		ne north door in the cross-			astonio, wiii bo takon,		
	•	Room 63 which was held in			· All residents that reside in	1	
		ion with a magnetic hold open			the facility are at risk of being	'	
		e with fire alarm system			affected. All fire doors have be	en	
		hardware and a self closing			audited and will continue to be		
	_	Colose and latch into the door			audited weekly times 4 weeks		
		o close multiple times. Based			Ţ.	anu	
		time of the observations, the			monthly times 5 months. The	lu dina	
					results will be reviewed month	-	
		for agreed the north door in the			QAPI meeting and ensure 95%		
		set by Room 63 would not			compliance threshold. If not m		
	fully self close and	latch into the door frame.			then there will be an action pla		
	7E1 (* 1'	t didd n			developed to ensure complian	ce.	
		e reviewed with the Executive					
	·	enance Director and the Field			· what measures will be pu	ıt	
	-	visor during the exit			into place and what systemic		
	conference.				changes will be made to ensur		
					that the deficient practice does	not	
	3.1-19(b)				recur;		
					· All fire doors have been		
					audited and will continue to be		
					audited weekly times 4 weeks	and	
					monthly times 5 months by		
					Maintenance Director or desig	nee.	
					The results will be reviewed		
					monthly in QAPI meeting and		
					ensure 95% compliance threst	nold.	
					If not met, then there will be ar	า	
					action plan developed to ensu	re	
					compliance. Education to		
					Maintenance Director per attac	ched	
					in-service form.		
	1		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 07/17/2023			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1924 WELLESLEY BLVD INDIANAPOLIS IN 46219				
	ON TERRACE SUMMARY: (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	II PRE	NDIAN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) how the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place All fire doors have been audited and will continue to be audited weekly times 4 weeks monthly times 5 months by Maintenance Director and/ or Designee. The results will be reviewed monthly in QAPI meand ensure 95% compliance threshold. If not met, then the will be an action plan develop ensure compliance. ED in-ser and educated Maintenance Director per attached in-service form. by what date the system changes for each deficiency we be completed. After submitting the control of the control o	eting reed to viced ce	(X5) COMPLETION DATE
K 0293	NFPA 101				acceptable Plan of Correction is determined that the correction will not be completed by the dipreviously submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated placorrection date. All issues have been resolved by August 1, 2023.	on ate sion n as d to	

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Exit Signage

SS=E

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		l í	JILDING	onstruction 01	(X3) DATE COMPI 07/17	LETED	
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE			1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD APOLIS, IN 46219			
(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)	TE	(X5) COMPLETION DATE
Bldg. 01	accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6 Based on observation failed to ensure 1 of facility were not mi Section 7.10.8.3.1 stairway that is neit access and that is lool likely to be mistake by a sign that reads EXIT sign shall have inches high, with a and the word EXIT such sign is an appredeficient practice of staff and visitors. Findings include: Based on observation Director and the Fied during a tour of the p.m. on 07/17/23, the door to the courtyar EXIT sign or a NO at the time of the observation Director stated the dexit to the public way with a NO Exit sign removed the signage.	al signs are displayed in 1.10 with continuous erved by the emergency existing less than 30 occupants exit travel is obvious.) on and interview, the facility 1.12 doors to the outside of the staken as a facility exit. LSC tates any door, passage, or ther an exit nor a way of exit cated or arranged so that it is in for an exit shall be identified as follows: NO EXIT. The NO re the word NO in letters 2 estroke width of 3/8ths inch, below the word NO, unless oved existing sign. This bould affect over 20 residents, ons with the Maintenance supervisor facility from 12:50 p.m. to 3:10 the Meridian Hill's dining room in divident of the courty and in the exit of the courty and is not an analy, the door had been posted to but a resident most likely the and agreed the Meridian urtyard did not have a NO	K 0	293	 what corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. New stickers for the Exit Door was ordered and have be adhered to all 12 doors that me the requirement of being label as "not an exit". how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the abto be affected by this deficient what what the deficient practice does the deficient practice and deficient practice and deficient practice does the defici	een eet ed ng the ility cy.	08/05/2023

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	OF CORRECTION	IDENTIFICATION NUMBER 155636	A. BUILDING B. WING	01	COMPLETED 07/17/2023
	PROVIDER OR SUPPLIER ON TERRACE		1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219	
(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)	(X5) COMPLETION DATE
	Director, the Mainte	e reviewed with the Executive enance Director and the Field visor during the exit		reviewed monthly in QAPI me and ensure 95% compliance threshold. If not met, then the will be an action plan develop ensure compliance.	re
K 0300	3.1-19(b)			how the corrective action will be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place. All doors will be audited weekly times 4 weeks and monthly times 5 months by Maintenance Director and/or Designee. The results will be reviewed monthly in QAPI me and ensure 95% compliance threshold. If not met, then the will be an action plan develop ensure compliance. by what date the system changes for each deficiency who be completed. After submittin acceptable Plan of Correction is determined that the correct will not be completed by the correction of the previously submitted, the Divineeds to be contacted as soo possible. The facility will nee submit an amended plan of correction with the updated placorrection date. August 1, 2023	eeting eeting ere eed to iic will ng an n, if it ion date ision on as d to
K 0300 SS=F	NFPA 101 Protection - Other				

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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 07/17/2023 155636 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1924 WELLESLEY BLVD HARRISON TERRACE INDIANAPOLIS, IN 46219 (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 Bldg. 01 Protection - Other List in the REMARKS section any LSC 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 observation and interview, the facility K 0300 08/05/2023 what corrective action(s) will failed to replace battery operated smoke alarms be accomplished for those installed in 6 of 55 resident sleeping rooms in residents found to have been accordance with NFPA 72. NFPA 72, 2010 affected by the deficient practice; Edition, Section 14.2.1.1.1 states inspection, Six rooms were noted in testing, and maintenance programs shall satisfy survey to not have battery the requirements of this Code and conform to the operated smoke detector. All equipment manufacturer's published instructions. smoke detectors have been Section 14.4.8.1 states unless otherwise exchanged with lithium ion battery recommended by the manufacturer's published operated smoke detectors. instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond how other residents having to operability tests but shall not remain in service the potential to be affected by the longer than 10 years from the date of manufacture. same deficient practice will be This deficient practice could affect over 50 identified and what corrective residents, staff and visitors. action(s) will be taken; Findings include: All residents have the potential to be affected by this Based on observations with the Maintenance deficient practice. All smoke Director and the Field Maintenance Supervisor detectors purchased have been during a tour of the facility from 12:50 p.m. to 3:10 hospital grade and updated to be p.m. on 07/17/23, manufacturer's documentation in compliance. affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident what measures will be put sleeping Room 45, 48, 55, 68, 69 and 72 each into place and what systemic indicated it was manufactured 03/12/12. The changes will be made to ensure manufacturer's documentation also stated that the deficient practice does not "replace unit within 10 years of installation date". recur; Sleeping Room 37 also had a Kidde Model i9010 battery operated smoke alarm installed on the All smoke detectors have ceiling but the manufacturer's documentation been checked to be in compliance

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	OF CORRECTION	IDENTIFICATION NUMBER 155636	A. BUILDING B. WING	01	COMPLETED 07/17/2023
	PROVIDER OR SUPPLIER ON TERRACE		1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219	
(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
	affixed to the smoke manufactured 07/16 time of the observat Director stated the f resident sleeping roo within the most rece the smoke alarms in resident sleeping roo years old.	e alarm indicated it was /22. Based on interview at the ions, the Maintenance facility has a total of 55 coms, some smoke alarms in coms have been changed out ent ten year period but agreed stalled in the aforementioned 6 coms were each greater than 10 ereviewed with the Executive enance Director and the Field		with the 10-year lithium ion be operated smoke detectors. The will be audited weekly times 4 weeks and monthly times 5 months by Maintenance Direct and/ or Designee. The results be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not meeting and ensure compliance threshold in service form. • how the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place. • All smoke detectors will audited weekly times 4 weeks monthly times 5 months by Maintenance Director and/ or Designee. The results will be reviewed monthly in QAPI meand ensure 95% compliance threshold. If not met, then the will be an action plan develop ensure compliance. • by what date the system changes for each deficiency who be completed. After submitting acceptable Plan of Correction is determined that the c	ttor will net, an nce. ector n(s) e r, ; and pe and eting re ed to ic vill g an , if it on ate sion n as

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r '	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155636	A. BUILDING B. WING	01		LETED 7/ 2023
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE		1924 \	STREET ADDRESS, CITY, STATE, ZIP COD 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
				submit an amended plan correction with the updated correction date.		
				August 1, 2023		
K 0321 SS=D Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automation is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated by smoke resisting ors in accordance with 8.4. of-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in				
	a. Boiler and Fuel	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet)				
	c. Repair, Mainter	nance, and Paint Shops noms (exceeding 64 n Rooms				

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(over 50 square feet)

f. Combustible Storage Rooms/Spaces

g. Laboratories (if classified as Severe

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Y	COD
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE STREET ADDRESS, CITY, STATE, ZIP 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	SHOULD BE COMPLETION
Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 15 hazardous areas such as trash collection rooms (exceeding 64 gallons) was separated from other spaces by smoke resistant partitions and doors. Findings include: Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 07/17/23, the corridor door to the kitchen which was nearest the kitchen range hood was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The kitchen contained over two 32 gallon capacity trash receptacles. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the kitchen would not fully self close and latch into the door frame when tested to close multiple times. The kitchen contained over two 32 gallon capacity trash receptacles. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the kitchen would not fully self close and latch into the door frame and agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)	chose we been ent practice; me and latch be effectively ance with ents having ected by the be will be corrective n; we the ability deficiency. atch have c effectively to impliance with will be put ystemic e to ensure etice does not as areas will nes 4 weeks months to ition from ite resistant by and/or is will be QAPI meeting pliance

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/17/2023
	PROVIDER OR SUPPLIEI	?	1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219	
(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)	(X5) COMPLETION DATE
IAU	REGULATORY OF	CLSC IDENTIFYTING INFORMATION	IAG	will be an action plan developed ensure compliance. Education Maintenance Director per attainservice form. how the corrective action will be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place; All 15 hazardous areas who be audited weekly times 4 were and monthly times 5 months to ensure proper separation from other spaces by smoke resistal partitions and doors. The resuluil be reviewed monthly in QAI meeting and ensure 95% compliance threshold. If not meeting and ensure compliance there will be an action pladeveloped to ensure compliance completed. After submittin acceptable Plan of Corrections is determined that the corrective will not be completed by the dipreviously submitted, the Division needs to be contacted as soon possible. The facility will needs submit an amended plan of correction with the updated place correction date.	ed to a to ched (s) e f, and vill eks o ant lts API et, an ice. c vill g an , if it on ate sion n as d to
K 0341 SS=F	NFPA 101 Fire Alarm Syster	n - Installation		· August 1, 2023	

Fire Alarm System - Installation

Bldg. 01

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SUI	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMPLETE	ED	
155636 B. WING 07/17/20	23	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 1924 WELLESLEY BLVD		
HARRISON TERRACE INDIANAPOLIS, IN 46219		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION DEFITY (EACH DEFICIENCY MIST BE DESCRIBED BY FILL DEFITY (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	OMPLETION	
TAG REGULATOR FOR ESC IDENTIFFING INFORMATION TAG	DATE	
A fire alarm system is installed with systems		
and components approved for the purpose in accordance with NFPA 70, National Electric		
Code, and NFPA 72, National Fire Alarm		
Code to provide effective warning of fire in any		
part of the building. In areas not continuously		
occupied, detection is installed at each fire		
alarm control unit. In new occupancy,		
detection is also installed at notification		
appliance circuit power extenders, and		
supervising station transmitting equipment.		
Fire alarm system wiring or other		
transmission paths are monitored for		
integrity.		
18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8		
	8/15/2023	
interview; the facility failed to maintain 1 of 1 fire be accomplished for those		
alarm systems in accordance with NFPA 72, residents found to have been		
National Fire Alarm Code, 2010 Edition. Section affected by the deficient practice;		
10.5.5.2.1 states, the location of the dedicated . The fire panel circuit has		
branch circuit disconnecting means shall be been labeled.		
permanently identified at the control unit. Section		
10.5.5.2.2 states, for fire alarm systems the circuit how other residents having		
disconnecting means shall be identified as "FIRE" the potential to be affected by the		
ALARM CIRCUIT." Section 10.5.5.2.3 states for same deficient practice will be		
fire alarm systems the circuit disconnecting means identified and what corrective		
shall have a red marking. Section 10.5.5.2.4 states action(s) will be taken;		
the circuit disconnecting means shall be		
accessible only to authorized personnel. Section All residents have the		
10.5.5.3 states the dedicated branch circuit(s) and potential to be affected by this		
connections shall be protected against physical deficient practice.		
damage. This deficient practice could affect all		
residents, staff and visitors. • what measures will be put		
into place and what systemic Findings include: changes will be made to ensure		
Based on review of the fire alarm system that the deficient practice does not recur;		
Based on review of the fire alarm system recur; inspection contractor's "Form for Inspection,		
Testing and Maintenance of Fire Alarms and The fire panel circuit has		
i i come una maniconance el me matino ana i i i i i i i i i i i i i i i i i i		

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	ľ í	UILDING	onstruction 01	(X3) DATE : COMPL 07/17/	ETED
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE		STREET ADDRESS, CITY, STATE, ZIP COD 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219					
(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 APPROPRIA DEFICIENCY)	λΤЕ	(X5) COMPLETION DATE
TAG	with the Maintenan Maintenance Super from 9:10 a.m. from exact location of the disconnecting means and testing docume system disconnectic "Emergency Panel" did not identify white electrical room. Bas Maintenance Direct Supervisor during a p.m. to 3:10 p.m. of the wall mounted el "Panel EM" in the crestrooms near the facility was identifical alarm" but the circulary position and was not disconnecting means facility. The facility unit located in the Maintenance Direct Supervisor agreed to dedicated branch citthe facility's fire ala located during the supervisor was the supervisor agreed to the facility's fire ala located during the supervisor was the supervisor agreed to the facility's fire ala located during the supervisor was the supervisor agreed to the facility's fire ala located during the supervisor was the supervisor agreed to the facility's fire ala located during the supervisor was the supervisor agreed to the facility's fire ala located during the supervisor was the supervisor agreed to the facility of the supervisor agreed to the supervisor agreed to the facility of the supervisor agreed to the supervisor agreed to the supervisor agreed to the facility of the supervisor agreed to the	ce Director and the Field visor during record review in 12:50 p.m. on 07/17/23, the edidicated branch circuit is was not identified. Section iton" of the 06/24/22 inspection intation stated the fire alarm on means was located at the in the "Electrical Room" but it it is electrical panel and which is ed on observations with the itor and the Field Maintenance in tour of the facility from 12:50 in 07/17/23, circuit breaker #27 in itertical panel identified as electrical panel identified as electrical room by the main entrance lobby for the ed with red marking as "fire in the beat of the locked. No other fire alarm is could be located in the y's main fire alarm control panel Mapleton Wing storage room into the trouble mode. Based time of the observations, the for and the Field Maintenance the exact location of the rout disconnecting means for arm system could not be		TAG	photo for proof of completion. Maintenance Director has bee educated per attached. how the corrective action will be monitored to ensure the deficient practice will not recurie., what quality assurance program will be put into place The fire panel circuit has been labeled. Please see attack photo of proof of completion. by what date the system changes for each deficiency will be completed. After submitting acceptable Plan of Correction is determined that the correctivill not be completed by the dipreviously submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated plan correction date. This deficiency was fixed with a completion date of Aug 1, 2023.	en (s) e r, ; and ched ic dig an , if it on ate sion n as d to an of	DATE
	Maintenance Super conference. 3.1-19(b)	visor during the exit					
K 0351 SS=E	NFPA 101 Sprinkler System	- Installation					

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Event ID:

6Y8R21

Facility ID: 000241

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155636	B. WING 07/17/2023				2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ELLESLEY BLVD		
HARRISC	ON TERRACE				APOLIS, IN 46219		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING						
	-	nd hospitals where required					
	by construction type						
		approved automatic					
		accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.						
		nstruction, alternative					
	_ ·	es are permitted to be					
	-	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.	dana ana mat na arrina di in					
		klers are not required in					
		patient sleeping rooms the closet does not exceed					
		sprinkler coverage covers					
	-	t as required by NFPA 13,					
	Standard for Insta						
	Systems.	nation of optimizer					
	_	19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		ation and interview, the facility	K 0	351	· what corrective action(s)	will	08/15/2023
		e ceiling construction for 1 of	110.	351	be accomplished for those		00/10/2023
		ance with NFPA 13, Standard			residents found to have been		
	for the Installation of	of Sprinkler Systems. NFPA			affected by the deficient practi	ce;	
	13, 2010 edition, Se	ection 6.2.7.1 states plates,			· All 5 escutcheon rings are	е	
	escutcheons, or other	er devices used to cover the			placed around the sprinkler. A	nd	
	annular space aroun	d a sprinkler shall be metallic,			protective cap in storage room	l	
	or shall be listed for	use around a sprinkler. This			near room 26 has been remov	ed.	
	deficient practice co	ould affect over 20 residents,					
	staff and visitors.				 how other residents havir 	ng	
					the potential to be affected by	the	
	Findings include:				same deficient practice will be	ļ	
					identified and what corrective		
		ons with the Maintenance			action(s) will be taken;		
		ld Maintenance Supervisor					
		facility from 12:50 p.m. to 3:10			· All residents have the	ļ	
	_	ne following ceiling mounted			potential to be affected by this		
sprinkler locations were each missing its				deficiency.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
		155636	B. WING		07/17/2023	
		<u> </u>	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		VELLESLEY BLVD		
HARRIS	ON TERRACE			IAPOLIS, IN 46219		
(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 APPROPRIA	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	escutcheon:					
	a. Brickyard storage			· what measures will be p	ut	
	b. Brickyard restroo			into place and what systemic		
	c. storage room by			changes will be made to ensu	ire	
	d. storage room by			that the deficient practice doe	s not	
	e. restroom in the T			recur;		
	Based on interview					
		aintenance Director agreed		· All escutcheons will be		
	the aforementioned	sprinkler locations were each		audited monthly times 6 mont	hs	
	missing its respective	ve escutcheon.		to ensure proper separation fr	rom	
				other spaces by smoke resist	ant	
	These findings were	e reviewed with the Executive		partitions and doors by		
	Director, the Mainte	enance Director and the Field		Maintenance Director and/ or		
	Maintenance Super	visor during the exit		Designee. The results will be		
	conference.			reviewed monthly in QAPI me	eting	
				and ensure 95% compliance		
	3.1-19(b)			threshold. If not met, then the	re	
				will be an action plan develop	ed to	
	2. Based on observa	ation and interview, the facility		ensure compliance. Education	n to	
	failed to ensure 1 of	f 1 ceiling mounted sprinklers		Maintenance Director per atta	ched	
	in the storage room	by Room 26 was installed in		in-service form. Education to		
	accordance with NI	FPA 13. NFPA 13, Standard for		Maintenance Director per atta	ched	
	the Installation of S	prinkler Systems, 2010 Edition,		in-service form.		
	Section 8.3.1.5.2 sta	ates protective caps and straps				
	shall be removed fr	om all sprinklers prior to the				
	time when the sprin	kler system is placed in		· how the corrective action	n(s)	
	service. This defici	ent practice could affect over		will be monitored to ensure th	e	
	20 residents, staff a	nd visitors in the vicinity of		deficient practice will not recu	r,	
	Room 26.			i.e., what quality assurance		
				program will be put into place	; and	
	Findings include:			· All escutcheons will be		
				audited monthly times 6 mont	hs	
	Based on observation	ons with the Maintenance		to ensure proper separation fr		
	Director and the Fig	eld Maintenance Supervisor		other spaces by smoke resist	ant	
	during a tour of the	facility from 12:50 p.m. to 3:10		partitions and doors. The resu		
		ne protective cap for the ceiling		will be reviewed monthly in Q		
	mounted sprinkler i	n the storage room by Room 26		meeting and ensure 95%		
	was affixed to the s	prinkler. Based on interview at		compliance threshold. If not m	net,	
the time of the observations, the Maintenance			then there will be an action pl			

Director and the Field Maintenance Supervisor

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developed to ensure compliance.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE : COMPL 07/17/	ETED	
	PROVIDER OR SUPPLIER			1924 WI	DDRESS, CITY, STATE, ZIP COD ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	recent roof leaks, no been installed recent repair and agreed the location still had its Field Maintenance the time of the obset These findings were Director, the Maintenance	of the facility had experienced aw sprinkler piping may have a spart of the roof leak are aforementioned sprinkler protective cap affixed. The Supervisor removed the cap at rvations. The ereviewed with the Executive enance Director and the Field wisor during the exit			by what date the systemic changes for each deficiency who completed. After submitting acceptable Plan of Correction, is determined that the correctic will not be completed by the dapreviously submitted, the Divisioneeds to be contacted as soor possible. The facility will need submit an amended plan of correction with the updated placorrection date. This deficient practice was corrected by August 15, 2023.	ill g an if it on ate ion as to	
K 0353 SS=F Bldg. 01	Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any is automatic sprinkle 9.7.5, 9.7.7, 9.7.8	supply source RKS information on non-required or partial er system.					
		view and interview, the facility utomatic sprinkler systems in	K 035	3	· what corrective action(s) be accomplished for those	will	08/15/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		r í	JILDING	onstruction 01	(X3) DATE COMPL 07/17 /	ETED	
	F PROVIDER OR SUPPLIE	3		1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD APOLIS, IN 46219		
(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
IAU	accordance with NI sprinkler systems is maintained in accordance for the Inspection, Water-Based Fire F Section 4.1.4.1 stat designated represer deficiencies or imp the inspection, test this standard. Corr performed by quality a qualified contract records shall be made availty jurisdiction upon recould affect all resifacility. Findings include: Based on review of inspection contract. Testing and Mainte Sprinkler Systems with the Maintenan Maintenance Super from 9:10 a.m. from deficiencies were in fire sprinkler systems section of the 04/17 sprinkler locations missing its escutched were corroded or lot too long. Based on review, the Mainten "Kitchen Sprinkler O6/19/23 from the stating some correct section or recorded or lot too long. Based on review, the Mainten "Kitchen Sprinkler Sprinkler O6/19/23 from the stating some correct."	FPA 25. LSC 9.7.5 requires all hall be inspected, tested, and redance with NFPA 25, Standard Testing, and Maintenance of Protection Systems. NFPA 25, es the property owner or natative shall correct or repair airments that are found during and maintenance required by ections and repairs shall be fied maintenance personnel or or. NFPA 25, 4.3.1 requires de for all inspections, tests, and the system components and able to the authority having equest. This deficient practice dents, staff, and visitors in the staff, and visitors in the decumentation dated 04/17/23 are Director and the Field evisor during record review in 12:50 p.m. on 07/17/23, otted for the facility's dry pipe ms. The "Deficiency Summary" 17/23 report indicated numerous in the facility were either een, had damaged deflectors, anded or measured too short or interview at the time of record mance Director provided Heads" documentation dated sprinkler system contractor thions were made to kitchen but additional kitchen sprinkler		IAU	residents found to have been affected by the deficient praction. All damaged escutcheons from the 4/17/202 bid has been completed. All damaged escutcheons from the bid through "IEI" from the 6/20/2023 "IEI" bid will be completed by August 15, 2023 IEI. • how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; • This deficient practice has the potential to affect all reside All escutcheons will be audited monthly for 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors Maintenan Director and/ or designee. The results will be reviewed month QAPI meeting and ensure 95% compliance threshold. If not methen there will be an action pladeveloped to ensure compliant Education to Maintenance Director and what systemic changes will be made to ensure that the deficient practice does recur. • All escutcheons will be	23 Be by september of the september of	DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		A. BUILDING B. WING	01	COMPLETED 07/17/2023	
	PROVIDER OR SUPPLIER ON TERRACE		1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD JAPOLIS, IN 46219	
(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
	The Maintenance D "Purchase Agreeme 06/19/23 from the s address the 04/17/22 Based on interview the Maintenance Di "Purchase Agreeme facility but not all d 04/17/23 sprinkler s documentation and Agreement" had bec survey. These findings were	the 06/19/23 "Purchase on made by the time of the reviewed with the Executive onance Director and the Field		audited monthly times 6 mont to ensure proper separation fro ther spaces by smoke resists partitions and doors. The result will be reviewed monthly in Queeting and ensure 95% compliance threshold. If not methen there will be an action pladeveloped to ensure compliant Education to Maintenance Dirper attached in-service form. • how the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place and; • All escutcheons will be audited 6 months to ensure proseparation from other spaces smoke resistant partitions and doors by Maintenance Director and/or designee. The results be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not meeting and ensure compliant by what date the system changes for each deficiency who is determined that the correction will not be completed by the depreviously submitted, the Divineds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated plan of	om ant ant alts API aet, an ace. ector a(s) e r, roper by I or will aet, an ace. ic vill g an , if it on ate sion n as d to

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CENTERS FO	R MEDICARE & MEDIC				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/17/2023	
		100000			07/17/2023	
	PROVIDER OR SUPPLIEF ON TERRACE	8	1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219		
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0372	NFPA 101			correction date. This deficiency was corrected by August 15, 2023.		
SS=E Bldg. 01	Subdivision of Builbarrie Subdivision of Builbarrie Subdivision of Builbarrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smoke in duct penetration systems where are its installed for smote to the smoke barrier 19.3.7.3, 8.6.7.1(1) Describe any med system in REMAR Based on observation failed to ensure 1 or protected to maintate the smoke barrier was requires smoke barrier was requires smoke barrier was required to maintate the sm	nall be constructed to a tance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.	K 0372	 what corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. Smoke barrier wall has be fixed. 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; All smoke barrier walls have been audited with no further findings and will be audited we times 4 weeks and monthly times 5 months to ensure proper 	ce; een g the ve ekly	

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above the corridor door set by Room 37 was not

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separation from other spaces by

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	r í	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 07/17 /	ETED
	PROVIDER OR SUPPLIEF			1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD IAPOLIS, IN 46219		
(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
	observations, the M sprinkler piping wa replacement piping aforementioned ope wall above the corr not firestopped to n rating of the smoke These findings were Director, the Maint	ening in the attic smoke barrier idor door set by Room 37 was naintain the fire resistance			smoke resistant partitions and doors by maintenance directo and/ or designee. The results be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not meeting and ensure compliance threshold and developed to ensure compliance Education to Maintenance Dirper attached in-service form. what measures will be printo place and what systemic changes will be made to ensure that the deficient practice doe recur; All escutcheons will be audited weekly times 4 weeks monthly times 5 months to enproper separation from other spaces by smoke resistant partitions and doors. The resure will be reviewed monthly in Qameeting and ensure 95% compliance threshold. If 0372Director in-serviced with education on regulation. Education Maintenance Director per attached in-service form.	r will net, an nce. ector ut re s not and sure ults API ration	
					will be monitored to ensure the deficient practice will not recursive., what quality assurance program will be put into place. All escutcheons will be audited weekly times 4 weeks monthly times 5 months to en	r, and	

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	OF CORRECTION	IDENTIFICATION NUMBER 155636	A. BUILDING B. WING	01	COMPLETED 07/17/2023
	PROVIDER OR SUPPLIER		1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD IAPOLIS, IN 46219	
(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
				proper separation from other spaces by smoke resistant partitions and doors. The result will be reviewed monthly in Questing and ensure 95% compliance threshold. If not meeting and ensure 95% compliance threshold. If not meeting and ensure compliance threshold. If not meeting and ensure compliance threshold. If not meeting and ensure compliance threshold. If not meeting the an action pladeveloped to ensure compliance and eveloped to ensure compliance. By what date the system changes for each deficiency where the completed. After submitting acceptable Plan of Correction is determined that the correction will not be completed by the difference of previously submitted, the Divisioneeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated plan correction date. This deficient practice was corrected by August 1, 2023.	API net, an nice. ic vill g an , if it on ate sion n as d to an of
K 0914 SS=E Bldg. 01	Testing Electrical Systems Testing Hospital-grade reclocations and when anesthesia is adminitial installation, r Additional testing indefined by docume Receptacles not list these locations are exceeding 12 mon	- Maintenance and - Maintenance and eptacles at patient bed re deep sedation or general inistered, are tested after eplacement or servicing. s performed at intervals ented performance data. sted as hospital-grade at e tested at intervals not ths. Line isolation monitors are tested at intervals of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/17/2023	
	PROVIDER OR SUPPLIER		1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219	
(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
	the LIM test switch activates both visu LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, roresults. 6.3.4 (NFPA 99) Based on record revinterview; the facilinonhospital-grade eannual testing in 2 or replaced with hospi 70, The National Electric S17.18(B) signification of the four or more, shall be provided were ceptacles. They slightly so identified. It is rotal, immediate repnon-hospital grade however, that non-freplaced with hospi modification of use receptacles need repractice could affect. Based on review of documentation date the Maintenance Direction of the Maintenance D	riew, observation and ty failed to ensure lectrical receptacles that failed of 55 resident rooms were tal-grade receptacles. NFPA ectrical Code, 2011 Edition, at rates each patient bed location ith a minimum of four hall be permitted to be of the hadruplex type, or any three. All receptacles, whether had location it is a minimum of cour hall be permitted to be of the hadruplex type, or any three. All receptacles, whether had lacement of existing receptacles. It is intended, hospital grade receptacles be tal grade receptacles upon the renovation, or as existing blacement. This deficient it over 4 residents and staff.	K 0914	 what corrective action(s) be accomplished for those residents found to have been affected by the deficient pract All electrical receptacles were replaced with hospital greceptacles. how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this deficiency. All outlets have be replaced with proper hospital grade electrical receptacles. what measures will be printo place and what systemic changes will be made to ensuthat the deficient practice doe recur; All electrical receptacles 	ice; rade ing the e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/17/2023	
	F PROVIDER OR SUPPLIEI SON TERRACE	₹	1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD VAPOLIS, IN 46219	
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF from 9:10 a.m. fror electrical receptacle 3, 13, 15, 30, 31, 32 "Fail" as the results on interview at the Maintenance Direct which failed April could not verify each failed testing was receptacles. Based Maintenance Direct Supervisor during a p.m. to 3:10 p.m. o locations in Room hospital-grade. These findings wer Director, the Maint	STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION In 12:50 p.m. on 07/17/23, select es in resident sleeping Rooms 2, 34 and 39 were each listed as 3 of receptacle testing. Based time of record review, the tor stated receptacle locations 2023 testing were replaced but the receptacle location which eplaced with hospital-grade on observations with the tor and the Field Maintenance a tour of the facility from 12:50 In 07/17/23, all receptacle 13 and Room 15 were not The reviewed with the Executive	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) be audited weekly times 4 we and monthly times 5 months to ensure proper separation from other spaces by smoke resists partitions and doors by Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI me and ensure 95% compliance threshold. If not met, then the will be an action plan develop ensure compliance. Education Maintenance Director per attain-service form. • how the corrective action will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place. • All electrical receptacles be audited weekly times 4 we and monthly times 5 months to ensure proper separation from other spaces by smoke resists partitions and doors by Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI me and ensure 95% compliance threshold. If not met, then their will be an action plan develop ensure compliance. • by what date the system changes for each deficiency we can be added to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the system changes for each deficiency we can be a considered to the cons	eks o n ant eting re ed to n to ched n(s) e r, and will eks o n ant eting re ed to
				be completed. After submittin acceptable Plan of Correction	-

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LINIERS FUR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0936-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		A. BU	ILDING	01	COMPLETED		
155636 B. WING				07/17/	2023		
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE				1924 W	ADDRESS, CITY, STATE, ZIP COD /ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID	SUMMARY S	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 APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					is determined that the correction will not be completed by the depreviously submitted, the Divis needs to be contacted as soor possible. The facility will need submit an amended plan of correction with the updated plat correction date. This deficiency was fixed	ate sion n as I to	

August 1, 2023.

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