| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING -- B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 07/17/23<br><br>Facility Number: 000241<br>Provider Number: 155636<br>AIM Number: 100291310<br><br>At this Emergency Preparedness survey, Harrison Terrace was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 110 certified beds. At the time of the survey, the census was 69.<br><br>Quality Review completed on 07/20/23 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 07/17/23<br><br>Facility Number: 000241<br>Provider Number: 155636<br>AIM Number: 100291310<br><br>At this Life Safety Code survey, Harrison Terrace was found not in compliance with Requirements | K 0000 | | |

| 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 69 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.<br><br>Quality Review completed on 07/20/23 | | | |
| K 0100<br>SS=E<br>Bldg. 01 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.<br>Based on observation and interview, the facility failed to ensure 1 of 7 cross-corridor door sets would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 | K 0100 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· Fire door by room 63 door has been fixed to self-close and latch. All seven fire doors in the | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | residents, staff and visitors in the vicinity of the corridor door set by Room 63.<br><br>Findings include:<br><br>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 north door in the cross-corridor door set by Room 63 which 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 failed to self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the north door in the cross-corridor door set by Room 63 would not fully self close and latch into the door frame.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | facility have been audited and are self-closing effectively.<br><br>· 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;<br><br>· All residents that reside in the facility are at risk of being affected. All fire doors have been audited and will continue to be audited weekly times 4 weeks and monthly times 5 months. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· 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 designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br><br>· All fire doors have been audited and will continue to 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 meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. ED in-serviced and educated Maintenance Director per attached in-service form.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br><br>· All issues have been resolved by August 1, 2023. | |
| K 0293 SS=E | NFPA 101<br>Exit Signage | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| Bldg. 01 | Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>Based on observation and interview, the facility failed to ensure 1 of 12 doors to the outside of the facility were not mistaken as a facility exit. LSC Section 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include:<br><br>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 Meridian Hill's dining room door to the courtyard was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the Maintenance Director stated the door to the courtyard is not an exit to the public way, the door had been posted with a NO Exit sign but a resident most likely removed the signage and agreed the Meridian Hill's door to the courtyard did not have a NO EXIT sign posted. | K 0293 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· New stickers for the Exit Door was ordered and have been adhered to all 12 doors that meet the requirement of being labeled as “not an exit”.<br><br>· 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;<br><br>· All residents have the ability to be affected by this deficiency.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· All doors will be audited weekly times 4 weeks and monthly times 5 months by Maintenance Director and/or Designee. The results will be | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>· 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 meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br><br>· August 1, 2023 | |
| K 0300 SS=E | NFPA 101<br>Protection - Other | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| Bldg. 01 | Protection - Other<br>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.<br>Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 6 of 55 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 50 residents, staff and visitors.<br><br>Findings include:<br><br>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, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room 45, 48, 55, 68, 69 and 72 each indicated it was manufactured 03/12/12. The manufacturer's documentation also stated "replace unit within 10 years of installation date". Sleeping Room 37 also had a Kidde Model i9010 battery operated smoke alarm installed on the ceiling but the manufacturer's documentation | K 0300 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· Six rooms were noted in survey to not have battery operated smoke detector. All smoke detectors have been exchanged with lithium ion battery operated smoke detectors.<br><br>· 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;<br><br>· All residents have the potential to be affected by this deficient practice. All smoke detectors purchased have been hospital grade and updated to be in compliance.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· All smoke detectors have been checked to be in compliance | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | affixed to the smoke alarm indicated it was manufactured 07/16/22. Based on interview at the time of the observations, the Maintenance Director stated the facility has a total of 55 resident sleeping rooms, some smoke alarms in resident sleeping rooms have been changed out within the most recent ten year period but agreed the smoke alarms installed in the aforementioned 6 resident sleeping rooms were each greater than 10 years old.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | with the 10-year lithium ion battery operated smoke detectors. This 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 meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br><br>· All smoke detectors 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 meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | submit an amended plan of correction with the updated plan of correction date.<br><br>August 1, 2023 | |
| K 0321<br>SS=D<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Hazard - see K322)<br>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. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 2 staff and visitors in the vicinity of the kitchen.<br><br>Findings include:<br><br>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 and agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0321 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· Kitchen door frame and latch have been repaired to effectively close to be in compliance with regulation.<br><br>· 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;<br><br>· All residents have the ability to be affected by this deficiency. The door frame and latch have been repaired to work effectively to be effective and in compliance with the regulation.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· All 15 hazardous areas will be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by smoke resistant partitions and doors by Maintenance Director and/or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>· All 15 hazardous areas will be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by smoke resistant partitions and doors. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br>· August 1, 2023 | |
| K 0341<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Installation<br>Fire Alarm System - Installation | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 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.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br>Based on record review, observation and interview; the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the fire alarm system inspection contractor's "Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems" documentation dated 06/24/22 | K 0341 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· The fire panel circuit has been labeled.<br><br>· 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;<br><br>· All residents have the potential to be affected by this deficient practice.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· The fire panel circuit has been labeled. Please see attached | 08/15/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:10 a.m. from 12:50 p.m. on 07/17/23, the exact location of the dedicated branch circuit disconnecting means was not identified. Section 4 "System Information" of the 06/24/22 inspection and testing documentation stated the fire alarm system disconnection means was located at the "Emergency Panel" in the "Electrical Room" but it did not identify which electrical panel and which electrical room. 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, circuit breaker #27 in the wall mounted electrical panel identified as "Panel EM" in the electrical room by the restrooms near the main entrance lobby for the facility was identified with red marking as "fire alarm" but the circuit breaker was in the off position and was not locked. No other fire alarm disconnecting means could be located in the facility. The facility's main fire alarm control panel unit located in the Mapleton Wing storage room near Room 46 was not in the trouble mode. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the exact location of the dedicated branch circuit disconnecting means for the facility's fire alarm system could not be located during the survey.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | photo for proof of completion. Maintenance Director has been educated per attached.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br><br>· The fire panel circuit has been labeled. Please see attached photo of proof of completion.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br><br>· This deficiency was fixed with a completion date of August 1, 2023. | |
| K 0351 SS=E | NFPA 101<br>Sprinkler System - Installation | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| Bldg. 01 | Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>1. Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 1 ceiling's in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include:<br><br>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 following ceiling mounted sprinkler locations were each missing its | K 0351 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· All 5 escutcheon rings are placed around the sprinkler. And protective cap in storage room near room 26 has been removed.<br><br>· 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;<br><br>· All residents have the potential to be affected by this deficiency. | 08/15/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | escutcheon:<br>a. Brickyard storage room.<br>b. Brickyard restroom.<br>c. storage room by Room 26.<br>d. storage room by Room 66.<br>e. restroom in the Therapy Room.<br>Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler locations were each missing its respective escutcheon.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling mounted sprinklers in the storage room by Room 26 was installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.3.1.5.2 states protective caps and straps shall be removed from all sprinklers prior to the time when the sprinkler system is placed in service. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of Room 26.<br><br>Findings include:<br><br>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 protective cap for the ceiling mounted sprinkler in the storage room by Room 26 was affixed to the sprinkler. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor | | · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· All escutcheons will be audited monthly times 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors by Maintenance Director and/ or Designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>· All escutcheons will be audited monthly times 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | stated that portion of the facility had experienced recent roof leaks, new sprinkler piping may have been installed recently as part of the roof leak repair and agreed the aforementioned sprinkler location still had its protective cap affixed. The Field Maintenance Supervisor removed the cap at the time of the observations.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br>This deficient practice was corrected by August 15, 2023. | |
| K 0353<br>SS=F<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on record review and interview, the facility failed to maintain automatic sprinkler systems in | K 0353 | · what corrective action(s) will be accomplished for those | 08/15/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 04/17/23 with the Maintenance Director and the Field Maintenance Supervisor during record review from 9:10 a.m. from 12:50 p.m. on 07/17/23, deficiencies were noted for the facility's dry pipe fire sprinkler systems. The "Deficiency Summary" section of the 04/17/23 report indicated numerous sprinkler locations in the facility were either missing its escutcheon, had damaged deflectors, were corroded or loaded or measured too short or too long. Based on interview at the time of record review, the Maintenance Director provided "Kitchen Sprinkler Heads" documentation dated 06/19/23 from the sprinkler system contractor stating some corrections were made to kitchen sprinkler locations but additional kitchen sprinkler | | residents found to have been affected by the deficient practice;<br>· All damaged escutcheons from the 4/17/2023 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 by IEI.<br><br>· 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;<br><br>· This deficient practice has the potential to affect all residents. All escutcheons will be audited monthly for 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br><br>· All escutcheons will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | location corrections were still needed to be made. The Maintenance Director also provided "Purchase Agreement" documentation dated 06/19/23 from the sprinkler system contractor to address the 04/17/23 sprinkler system deficiencies. Based on interview at the time of record review, the Maintenance Director stated the 06/19/23 "Purchase Agreement" has been approved by the facility but not all deficiencies noted in the 04/17/23 sprinkler system inspection documentation and the 06/19/23 "Purchase Agreement" had been made by the time of the survey.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | audited monthly times 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and;<br>· All escutcheons will be audited 6 months to ensure proper separation from other spaces by smoke resistant partitions and doors by Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | correction date.<br>· This deficiency was corrected by August 15, 2023. | |
| K 0372<br>SS=E<br>Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier walls was protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of Room 37.<br><br>Findings include:<br><br>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 annular space surrounding a four inch in diameter horizontal sprinkler pipe which penetrated the attic smoke barrier wall above the corridor door set by Room 37 was not | K 0372 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· Smoke barrier wall has been fixed.<br><br>· 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;<br><br>· All smoke barrier walls have been audited with no further findings and will be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | firestopped. Based on interview at the time of the observations, the Maintenance Director stated the sprinkler piping was recently installed as replacement piping and agreed the aforementioned opening in the attic smoke barrier wall above the corridor door set by Room 37 was not firestopped to maintain the fire resistance rating of the smoke barrier wall.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | smoke resistant partitions and doors by maintenance director and/ or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>· All escutcheons will be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by smoke resistant partitions and doors. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If 0372Director in-serviced with education on regulation. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>· All escutcheons will be audited weekly times 4 weeks and monthly times 5 months to ensure | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | proper separation from other spaces by smoke resistant partitions and doors. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br>· This deficient practice was corrected by August 1, 2023. | |
| K 0914 SS=E Bldg. 01 | NFPA 101<br>Electrical Systems - Maintenance and Testing<br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 2 of 55 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 4 residents and staff.<br><br>Findings include:<br><br>Based on review of the facility's receptacle testing documentation dated 04/25/23 and 04/26/23 with the Maintenance Director and the Field Maintenance Supervisor during record review | K 0914 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>· All electrical receptacles were replaced with hospital grade receptacles.<br><br>· 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;<br><br>· All residents have the potential to be affected by this deficiency. All outlets have been replaced with proper hospital grade electrical receptacles.<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>· All electrical receptacles will | 08/05/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | from 9:10 a.m. from 12:50 p.m. on 07/17/23, select electrical receptacles in resident sleeping Rooms 3, 13, 15, 30, 31, 32, 34 and 39 were each listed as "Fail" as the results of receptacle testing. Based on interview at the time of record review, the Maintenance Director stated receptacle locations which failed April 2023 testing were replaced but could not verify each receptacle location which failed testing was replaced with hospital-grade receptacles. 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, all receptacle locations in Room 13 and Room 15 were not hospital-grade.<br><br>These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by smoke resistant partitions and doors by Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance. Education to Maintenance Director per attached in-service form.<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>· All electrical receptacles will be audited weekly times 4 weeks and monthly times 5 months to ensure proper separation from other spaces by smoke resistant partitions and doors by Maintenance Director and/ or designee. The results will be reviewed monthly in QAPI meeting and ensure 95% compliance threshold. If not met, then there will be an action plan developed to ensure compliance.<br><br>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155636 | A. BUILDING 01<br>B. WING | 07/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.<br>· This deficiency was fixed by August 1, 2023. | |