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	09/12/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/12/24 Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310 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. The facility has 110 certified beds. At the time of the survey, the census was 73. Quality Review completed on 09/16/24	E 0000	Please consider this plan of correction as our credible allegation of compliance to the Life Safety Survey completed on 9/12/24.	
K 0000 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). Survey Date: 09/12/24 Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310 At this Life Safety Code survey, Harrison Terrace was found not in compliance with Requirements	K 0000	Please consider this plan of correction as our credible allegation of compliance to the Life Safety Survey completed on 9/12/24.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Taylor Shuey	Executive Director	10/11/2024

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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility 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 73 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 09/16/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure fire resistance rating labels on 1 of 7 cross corridor door sets were legible. In addition, 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 residents, staff and visitors in the vicinity of the cross corridor set by Room 63 in Roslyn's Way. Findings include:	K 0100	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The door with the missing fire rating tag is being replaced. It has been ordered through a third party vendor. • 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 residents residing on the	10/18/2024

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	Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, the fire resistance rating label on the north door in the cross corridor door set by resident sleeping Room 63 in Roslyn's Way was painted and was not legible. The south door in the cross corridor door set was equipped with a 90-minute fire resistance rating label. Each door in the cross corridor door set was equipped with latching hardware to latch each door into the door frame but the north door in the door set failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the north door in the aforementioned cross corridor door set would not latch into the door frame when tested to close and was not equipped with a legible fire resistance rating label. These findings were reviewed with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)		Roslyn's Way cottage could have the potential to be negatively impacted by this deficient practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED will in-service the Maintenance Director on ensuring all fire resistant doors have the proper label visible on the door by 9/27/2024. Audit tools have been created and will be completed weekly times four then monthly after that times 5 to ensure tags are intact. Maintenance Director and/ or Care Companions will complete daily walk throughs to ensure that fire rating tags are still intact and brought information to morning meeting. • 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 The corrective action will be monitored by the Doors CQI tool. This will be completed weekly times four and then monthly times five to be monitored for six months. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is	

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			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. The door has been ordered as of September 27, 2024. Installation of new door will be completed by October 18, 2024. Audit tools have been created and will be completed weekly times four then monthly after that times 5 to ensure tags are intact.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 18 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. Findings include: Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, 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	K 0321	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire barrier door to the kitchen were fixed and now latch effectively. Also, the accurate number of trash receptacles have been rectified to the correct amount in the kitchen. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were impacted by the deficient practice due to residents not having the ability to access the kitchen.	09/27/2024

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	failed to self close and latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. The kitchen contained over two 32 gallon capacity trash receptacles. Based on interview at the time of the observations, the Maintenance Director and the Regional Director of Maintenance Operations 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 Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)		what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director and kitchen staff in-serviced by Executive Director on deficient practice with doors and trash receptacles. All doors have been checked and all doors are latching appropriately. There is also a correct number of kitchen receptacles in the kitchen. The audit tool for the doors and kitchen receptacles will be completed weekly times four and monthly times five to ensure compliance. Maintenance Director and/ or managers will complete daily walk throughs to ensure that doors latch and the proper number of trash receptacles are in the kitchen and brought information to morning meeting. 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 The corrective actions will be monitored for 6 months and as needed if 95% compliance is not met. The Doors Audit tools will be completed weekly times 4 then monthly times 5. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it	

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			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. The system changes will be completed and systemic changes in place by September 28, 2024.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 26. Findings include: Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, the corridor door to resident sleeping Room 26 failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Regional Director of Maintenance Operations agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive	K 0363	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Room 26 door was fixed. All corridor doors have been checked and in compliance. 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; Any resident has the potential to be negatively affected by this deficient practice. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED will in-service Maintenance Director on corridor doors and smoke barriers by 9/27/2024. Audit tools for corridor doors have been created and implemented for	09/27/2024

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	Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)		completion. The audit tool will be completed weekly times four and monthly times five for six months. If 95% compliance is not captured then an action plan will be put in place to be in compliance. Maintenance Director and/ or Care Companions will complete daily walk throughs to ensure that doors working properly and intact and information brought to morning meeting of any findings. 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 The corrective action will be monitored by the Doors CQI tool. This will be completed weekly times four and then monthly times five to be monitored for six months. 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. By September 28, 2024 these systemic changes will be	

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			completed and monitored for compliance for at least 6 months.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for select resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect over 50 residents, staff and visitors. Findings include:	K 0914	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Annual Electrical Receptacle test was recompleted 10/6/2024. 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; Any resident has the potential to be negatively affected by this deficient practice. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED will in-service Maintenance Director on electrical receptacle annual testing by 10/11/2024. Audit tools for electrical receptacles completed through TELS on 10/6/24. The audit tool will be completed again in 6 months. If 95% compliance is not captured then an action plan will be put in place to be in compliance. Maintenance Director and/ or designee will notify if not in compliance. how the corrective action(s)	10/11/2024

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	Based on review of Direct Supply TELS Logbook Documentation "Test and Document the Electrical Receptacle Inspection" dated 04/13/24 with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during record review from 9:10 a.m. to 12:50 p.m. on 09/12/24, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was not available for review. The 04/13/24 inspection documentation only included resident sleeping Rooms 1 through 16. Based on interview at the time of record review, the Maintenance Director and the Regional Director of Maintenance Operations stated additional resident sleeping room electrical receptacle testing documentation was not available for review and agreed electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, all resident sleeping rooms in the facility had a mix of hospital-grade and non-hospital-grade receptacles installed in the rooms. These findings were reviewed with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The corrective action was completed 10/6/24 of the audit for the electrical receptacle 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. By October 11, 2024 these systemic changes will be completed and monitored for compliance every six months.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on observation and interview, the facility	K 0918	what corrective action(s) will	09/27/2024

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	failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, one of one emergency generator transfer switches located outside the facility in the south courtyard was in an unlocked detached weatherproof storage cabinet. Based on interview at the time of the observations, the Maintenance Director and the Regional Director of Maintenance Operations agreed the emergency generator transfer switch was in an unlocked detached weatherproof storage cabinet outside the facility. These findings were reviewed with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure 36-month period emergency generator testing for 1 of 1 emergency generators was in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical		be accomplished for those residents found to have been affected by the deficient practice; Evapar is scheduled to complete another load bank test following proper guidelines for September 30, 2024. 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 residents could be negatively affected by this deficient practice. Evapar is coming back out to redo the test so that no residents can be affected by this deficient practice. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director has been in-serviced on the proper load bank test is completed properly by regulation. Evapar is scheduled for September 30, 2024 to complete another load bank test accurately to meet proper guidelines. This will be checked annually with TELS and reviewed in QAPI to meet 100%, than an action plan may be implemented. All audit tools are reviewed in QAPI. 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	

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	system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors in the main building (Building 01). Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator Under Load" documentation with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during record review from 9:10 a.m. to 12:50 p.m. on 09/12/24, monthly load testing documentation for 02/26/24, 05/13/24, 06/18/24, 07/05/24 and 08/22/24 did not achieve 30% load. Review of the emergency generator inspection contractor's "Load Bank Test Report" documentation dated 12/20/23 indicated thirty-six-month period emergency generator testing for four continuous hours for the diesel fired emergency generator for the facility was not performed in accordance with NFPA 110, Section 8.4.9.7. NFPA 110, Section 8.4.9.7 states where the test required by 8.4.9 is combined with the annual load bank test, the first three hours shall be at not less than the minimum		Annual load bank test will be brought to QAPI and reviewed to ensure it has been completed according to regulation and submitted through TELS. If 100% accuracy is not completed, this information will be brought to QAPI and an action plan may be implemented. 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. The deficient practice will be rectified by September 30, 2024.	

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	loading required by 8.4.9.5 and the remaining hour shall be at not less than 75% of the nameplate rating of the EPS. The last three hours of the 12/20/23 load testing documentation indicated the load was 69.5%. Based on interview at the time of record review, the Maintenance Director and the Regional Director of Maintenance Operations stated additional documentation of supplemental load testing for four hours within the most recent three-year period was not available for review. Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, the facility has one diesel fired emergency generator located outside the building near the south courtyard. The manufacturer's nameplate rating for the generator indicated the generator was rated at 300 kW and was manufactured in May 2017. These findings were reviewed with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a	K 0920	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All offices have been audited and are now in compliance as of 9/27/24. how other residents having the potential to be affected by the	09/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. BUILDING 01 B. WING	09/12/2024

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
	substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the main entrance lobby. Findings include: Based on observations with the Maintenance Director and the Regional Director of Maintenance Operations during a tour of the facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, a coffee pot, a microwave oven and a refrigerator were plugged into a multiplug adaptor plugged into a wall mounted electrical outlet box in the Director of Nursing's (DON) office near the main entrance lobby. Based on interview at the time of the observations, the Maintenance Director and the Regional Director of Maintenance Operations agreed a multiplug adaptor was being used as a substitute for fixed wiring in the DON office. These findings were reviewed with the Executive Director, the Maintenance Director and the Regional Director of Maintenance Operations during the exit conference. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the deficient practice. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director and managers have been in-serviced by Executive Director about proper electrical receptacles. Maintenance Director will complete audit tool for electrical receptacles to be completed weekly times four and monthly times five for 95% or higher compliance. If 95% compliance is not achieved, action plan may be created and reviewed during QAPI. Maintenance Director and/ or managers will complete daily walk throughs to ensure that offices are still in compliance and bring the information to morning meeting. 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 The corrective action will be monitored by the Electrical Receptacle CQI tool. This will be completed weekly times four and then monthly times five to be monitored for six months. by what date the systemic	

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			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. This systemic change will be implemented September 30, 2024. All offices have been audited with 100% compliance as of September 27, 2024.	