STATEMENT OF DEFICIENCIES Y1) PROVI		V1) DDOVIDED/GLIDDLIED/GLIA	DDOVIDED/CLIDDLIED/CLIA (V2) MULTIDLE CONC		NSTRUCTION (Y3) DATE		ATE SUDVEV	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155636	B. WIN	IG		09/12/	/2024	
NAME OF T	DROLUDED OF GURDY TO		' 1	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF I	PROVIDER OR SUPPLIEI	K	I		ELLESLEY BLVD			
HARRIS	ON TERRACE		l	INDIAN	APOLIS, IN 46219			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Dida								
Bldg	An Emergency Dro	paredness Survey was	E 000	00	Diago consider this plan of			
		ndiana Department of Health in	E 000	UU	Please consider this plan of correction as our credible			
	accordance with 42	-			allegation of compliance to the	e l ife		
					Safety Survey completed on	C EIIO		
	Survey Date: 09/12	2/24			9/12/24.			
	Facility Number: (
	Provider Number:	155636						
	AIM Number: 100	0291310						
		Preparedness survey, Harrison						
		in compliance with Emergency						
	_	irements for Medicare and						
	_	ting Providers and Suppliers, 42						
	CFR 483.73.							
	The facility has 110	0 certified beds. At the time of						
	the survey, the cens	sus was 73.						
	Quality Review con	mpleted on 09/16/24						
K 0000								
Dida 04								
Bldg. 01	A Life Sofety Code	e Recertification and State	17.00	00	Diago consider this plan of			
		vas conducted by the Indiana	K 00	UU	Please consider this plan of correction as our credible			
	1	-			allegation of compliance to the	e Life		
	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/12/24				Safety Survey completed on	5		
					9/12/24.			
	Sarvey Date: 09/12	- . - .						
	Facility Number: (
	Provider Number:							
	AIM Number: 100	7291310						
	At this Life Safety	Code survey, Harrison Terrace						
	· ·	ompliance with Requirements						

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

(X6) DATE

TITLE

Taylor Shuey Executive Director 10/11/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	CONSTRUCTION 01	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
		155636	B. WING		09/12/2024		
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE			STREET ADDRESS, CITY, STATE, ZIP COD 1924 WELLESLEY BLVD INDIANAPOLIS, 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 OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and					
	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 Requirem	nents - Other					
S	failed to ensure fire 7 cross corridor door addition, the facility corridor door sets we the door frame per 4 existing life safety fif not required by the maintained or remo could affect over 20	on and interview, the facility resistance rating labels on 1 of or sets were legible. In a failed to ensure 1 of 7 cross rould self close and latch into 4.6.12.3. LSC 4.6.12.3 requires features obvious to the public the Code, shall be either either ved. This deficient practice the residents, staff and visitors in ross corridor set by Room 63	K 0100	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The door with the missing fire rating tag is being replaced. It been ordered through a third pendor. • how other residents having the potential to be affee by the same deficient practice be identified and what correct action(s) will be taken; All residents residing on the	has party cted		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JVK221

Facility ID: 000241

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION D O O O O O O O O O O O O	(X3) DATE SURVEY COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		1924	ET ADDRESS, CITY, STATE, ZIP COD WELLESLEY BLVD ANAPOLIS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	Based on observation Director and the Re Maintenance Operator facility from 12:50 fire resistance rating cross corridor door 63 in Roslyn's Way legible. The south of set was equipped worating label. Each of set was equipped worating label. Each of set was equipped worating label of the when tested to close interview at the time Maintenance Direct Maintenance Direct aforementioned croplatch into the door for was not equipped worating label. These findings were Director, the Maintenance Director Director, the Maintenance Director Dir	ons with the Maintenance gional Director of tions during a tour of the p.m. to 2:10 p.m. on 09/12/24, the g label on the north door in the set by resident sleeping Room was painted and was not door in the cross corridor door ith a 90-minute fire resistance door in the cross corridor door ith latching hardware to latch door frame but the north door dt to latch into the door frame e multiple times. Based on the observations, the for and the Corporate for agreed the north door in the ses corridor door set would not frame when tested to close and with a legible fire resistance.		Roslyn's Way cottage could the potential to be negative impacted by this deficient practice. • what measures will put into place and what systemages will be made to end that the deficient practice deficient. ED will in-service the Maint Director on ensuring all fire resistant doors have the product label visible on the door by 9/27/2024. Audit tools have created and will be completed weekly times four then more after that times 5 to ensure are intact. Maintenance Director and/ or Care Companions were completed daily walk through ensure that fire rating tags a intact and brought information morning meeting. • how the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be place; and The corrective action will be monitored by the Doors CQ. This will be completed weel times four and then monthly five to be monitored for six months. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptar Plan of Correction, if it is	I have y I be temic sure pes not enance pper been ed thly tags ector vill as to are still on to o e will but into s I tool. kly v times

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JVK221

Facility ID: 000241

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		A. BUILDING B. WING	01	COMPLETED 09/12/2024	
	PROVIDER OR SUPPLIER		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)	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	failed to ensure 1 of as trash collection rowas separated from resistant partitions a closing or automatic 7.2.1.8. This deficies staff and visitors in Findings include: Based on observation Director and the Reg Maintenance Operate facility from 12:50 proposition with a magnetic release with fire alangements.	on and interview, the facility over 18 hazardous areas such coms (exceeding 64 gallons) other spaces by smoke and doors. Doors shall be self eclosing in accordance with cent practice could affect over 2 the vicinity of the kitchen.	K 0321	determined that the correction not be completed by the date previously submitted, the Divis needs to be contacted as soor possible. The facility will need submit an amended plan of correction with the updated plate correction date. The door has been ordered as September 27, 2024. Installati of new door will be completed October 18, 2024. Audit tools been created and will be completed weekly times four the monthly after that times 5 to ensure tags are intact. what corrective action(s) what corrective action from the kitchen were fixed and now latch effectively. Also, the accurate number of trash receptacles haven the potential to be affected by 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 access the kitchen.	sion n as to an of s of on by have hen will 09/27/2024 ce; ave g the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JVK221

Facility ID: 000241

If continuation sheet

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NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE SUMMARY STATEMENT OF DEFICIENCIE (X4) ID PREFIX TAG 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 Operations during the exit conference. 3.1-19(b) STREET ADDRESS, CITY, STATE, ZIP COD 19/24 WELLESLEY BLVD INDIANAPOLIS, IN 46219 INDIANAPOLIS, IN 46219 (X5) PREFIX (EACH DEFICIENCY) TAG PREFIX (EACH DEFICIENCY) TAG What measures will be put into place and what systemic changes 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 of Maintenance Director and the Regional Director of the kitchen would not kitchen receptacles. All doors have been checked and all doors are latching appropriately. There is also a correct number of 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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
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HARRISON TERRACE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219			155636	B. WING 09/12/2024			2024	
HARRISON TERRACE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219					STREET A	ADDRESS, CITY, STATE, ZIP COD		
INDIANAPOLIS, IN 46219	NAME OF P	PROVIDER OR SUPPLIER	2					
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Regional Director of Maintenance Operations during the exit conference. 3.1-19(b) 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						T		
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daily walk throughs to ensure that doors latch and the proper number of trash receptacles are in the kitchen and brought information to		during the exit conf	erence.			1 · · · · · · · · · · · · · · · · · · ·		
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I I morning meeting						morning meeting.	טוו נט	
Inoming meeting.						Thorning meeting.		
how the corrective action(s)						how the corrective actions	(e)	
will be monitored to ensure the							` ,	
deficient practice will not recur,								
i.e., what quality assurance						1	• •	
program will be put into place; and							and	
The corrective actions will be						1	, and	
monitored for 6 months and as							S	
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						1		
changes for each deficiency will						1		
be completed. After submitting an						1		
acceptable Plan of Correction, if it						1	-	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155636		ì í	JILDING	DNSTRUCTION 01	(X3) DATE : COMPL 09/12/	ETED	
	ROVIDER 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)	TE	(X5) COMPLETION DATE
K 0363 SS=E	NFPA 101 Corridor - Doors				is determined that the correction will not be completed by the day previously 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. The system changes will be completed and systemic change in place by September 28, 202	ate sion n as I to an of ges	
Bldg. 01	Based on observation failed to ensure 1 of resident sleeping roclosing and latching would resist the past practice could affect visitors in the vicinit 26. Findings include: Based on observation Director and the Remaintenance Operate facility from 12:50 corridor door to resist to latch into the door multiple times. Base the observations, the Regional Direct agreed the aforement impediment to latch would not resist the	itions during a tour of the p.m. to 2:10 p.m. on 09/12/24, the dent sleeping Room 26 failed or frame when tested to close and on interview at the time of the Maintenance Director and for of Maintenance Operations attioned corridor door had an ing into the door frame and	K 0	363	what corrective action(s) where accomplished for those residents found to have been affected by the deficient practice. Room 26 door was fixed. All corridor doors have been check and in compliance. how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; Any resident has the potential 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 recur; ED will in-service Maintenance Director on corridor doors and smoke barriers by 9/27/2024. Audit tools for corridor doors he been created and implemented.	ce; sked g the to	09/27/2024

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/12/2024
	PROVIDER OR SUPPLIER ON TERRACE	2	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION DATE
	·	enance Director and the of Maintenance Operations Ference.		completion. The audit tool completed weekly times for monthly times five for six if 95% compliance is not of then an action plan will be place to be in compliance. Maintenance Director and Companions will complete walk throughs to ensure the working properly and interinformation brought to momeeting of any findings. how the corrective action will be monitored to ensure deficient practice will not rive., what quality assurance program will be put into place. This will be completed we times four and then month five to be monitored for simonths. by what date the systematical characteristic plan of Correction date that the correction will not be completed by the previously submitted, the needs to be contacted as possible. The facility will submit an amended plan accorrection with the update correction date. By September 28, 2024 the systemic changes will be	our and months. captured e put in . // or Care e daily hat doors et and eming etion(s) re the recur, se lace; and be required explicition. It is the recur, se lace; and lace explicition. It is the recur, se lace explicition in the second explicition in the date date date division soon as need to of ed plan of

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PRINTED: 10/17/2024 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155636 B. WING 09/12/2024 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 DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE completed and monitored for compliance for at least 6 months. K 0914 **NFPA 101** SS=E Electrical Systems - Maintenance and Bldg. 01 Based on record review, observation and K 0914 what corrective action(s) will 10/11/2024 interview; the facility failed to ensure be accomplished for those documentation of electrical outlet receptacle residents found to have been testing for select resident sleeping rooms was affected by the deficient practice; available for review in accordance with NFPA 99. Annual Electrical Receptacle test NFPA 99, Health Care Facilities Code, 2012 was recompleted 10/6/2024. Edition, Section 6.3.4.1.3 states receptacles not how other residents having listed as hospital-grade at patient bed locations the potential to be affected by the and in locations where deep sedation or general same deficient practice will be anesthesia shall be tested at intervals not identified and what corrective exceeding 12 months. NFPA 99, Health Care action(s) will be taken; Any resident has the potential to

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

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 negatively affected by this

how the corrective action(s)

compliance. Maintenance Director

and/ or designee will notify if not in

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visitors.

Findings include:

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be put in place to be in

compliance.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155636	B. WING	09/12/2024		
	PROVIDER OR SUPPLIE	R	1924	T ADDRESS, CITY, STATE, ZIP COD WELLESLEY BLVD ANAPOLIS, IN 46219		
HARRIST	JIVILITIAGE		IINDIA			
(X4) ID PREFIX TAG	REGULATORY O Based on review of Documentation "To Receptacle Inspect Executive Director the Regional Direct during record reviet on 09/12/24, electr testing documentat rooms within the m was not available f inspection docume sleeping Rooms 1 at the time of record Director and the Ro Maintenance Operaresident sleeping re-	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION of Direct Supply TELS Logbook est and Document the Electrical ion" dated 04/13/24 with the the Maintenance Director and tor of Maintenance Operations ow from 9:10 a.m. to 12:50 p.m. ical receptacle inspection and ion for all resident sleeping nost recent twelve month period for review. The 04/13/24 Intation only included resident through 16. Based on interview dreview, the Maintenance egional Director of ations stated additional form electrical receptacle testing and available for review and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIME DEFICIENCY) will be monitored to ensure the deficient practice will not recursive., what quality assurance program will be put into place. The corrective action was completed 10/6/24 of the audithe electrical receptacle by what date the systemic changes for each deficiency was completed. After submitting acceptable Plan of Correction is determined that the correct will not be completed by the copreviously submitted, the Divineeds to be contacted as soon	DATE DATE DATE DATE DATE	
	agreed electrical redocumentation for within the most reconot available for rewith the Maintenar Director of Maintenar of the facility from 09/12/24, all reside had a mix of hospit	ceptacle inspection and testing all resident sleeping rooms tent twelve month period was view. Based on observations are Director and the Regional nance Operations during a tour 12:50 p.m. to 2:10 p.m. on tent sleeping rooms in the facility		possible. The facility will nee submit an amended plan of correction with the updated plan correction date. By October 11, 2024 these systemic changes will be completed and monitored for compliance every six months.	d to lan of	
	Director, the Maint	re reviewed with the Executive tenance Director and the of Maintenance Operations ference.				
K 0918 SS=C Bldg. 01		s - Essential Electric Syste	W 0010		00/27/2021	
	 Based on observ 	ation and interview, the facility	K 0918	what corrective action(s)	will 09/27/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	` ′	A. BUILDING 01			COMPLETED	
		155636	B. W		~ ·	09/12/2024		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
	NI TEDDACE				/ELLESLEY BLVD			
ПАККІЗС	ON TERRACE			INDIAN	IAPOLIS, IN 46219			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ercurrent protective devices in			be accomplished for those			
		Supply Systems (EPSS) circuits			residents found to have been			
		y to authorized persons.			affected by the deficient practi			
		rd for Emergency and Standby			Evapar is scheduled to comple			
	-	10 Edition, Section 6.5.4 states			another load bank test following	•		
		s in EPSS circuits shall be			proper guidelines for Septemb	per		
		rized persons only. This			30, 2024.			
	-	ould affect all residents, staff			how other residents havir	-		
	and visitors.				the potential to be affected by			
					same deficient practice will be)		
	Findings include:				identified and what corrective			
					action(s) will be taken;			
		ons with the Maintenance			All residents could be negative	-		
	Director and the Re	-			affected by this deficient pract			
	_	ations during a tour of the		Evapar is coming back out to redo				
	-	p.m. to 2:10 p.m. on 09/12/24,			the test so that no residents ca	an		
	_	ncy generator transfer switches			be affected by this deficient			
		facility in the south courtyard			practice.			
		detached weatherproof			what measures will be pu	t		
	_	ased on interview at the time of			into place and what systemic			
	· ·	e Maintenance Director and			changes will be made to ensu			
	-	tor of Maintenance Operations			that the deficient practice does	s not		
		cy generator transfer switch			recur;			
		detached weatherproof			Maintenance Director has bee			
	storage cabinet outs	side the facility.			in-serviced on the proper load			
	Those findings wan	a marriage and writh the Evenantive			bank test is completed proper			
	_	e reviewed with the Executive			regulation. Evapar is schedule			
		enance Director and the of Maintenance Operations			September 30, 2024 to compl			
	during the exit conf	•			another load bank test accura	•		
	during the exit conf	erence.			to meet proper guidelines. Thi			
	2 1 10(b)				be checked annually with TEL			
	3.1-19(b)				and reviewed in QAPI to meet			
	2 Rased on record	review, observation, and			100%, than an action plan ma implemented. All audit tools a	-		
		ity failed to ensure 36-month			reviewed in QAPI.	ı C		
		generator testing for 1 of 1			how the corrective action	(c)		
		ors was in accordance with			will be monitored to ensure the			
		A 110. NFPA 99, Health Care						
		12 Edition, Section 6.4.1.1.6.1			deficient practice will not recu	ι,		
		Type 2 essential electrical			i.e., what quality assurance	and		
	states Type I and I	ype 2 essential electrical	ı		program will be put into place;	, anu	I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155636	(X2) MULTIPLE (A. BUILDING B. WING	O1	COMP	E SURVEY LETED 2/2024
	PROVIDER OR SUPPLIER		1924	r address, city, state, zip c WELLESLEY BLVD NAPOLIS, IN 46219	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	system power source as Type 10, Class 2 NFPA 110. NFPA Emergency and State Edition, Section 8.4 tested at least once Section 8.4.9.1 state continuously for the (See Section 4.2). assigned class is graph permitted to termin hours. Section 8.4. this test shall be spe 8.4.9.5.3. Section 8.4. this test shall be spe 8.4.9.5.3. Section 8 EPS's, loading shall This deficient pract staff, and visitors in 01). Findings include: Based on review of Documentation "Er Generator Under Le Executive Director, the Regional Direct during record revie on 09/12/24, month for 02/26/24, 05/13 08/22/24 did not accemergency generate "Load Bank Test R 12/20/23 indicated emergency generate hours for the diesel the facility was not NFPA 110, Section 8.4.9.7 states where combined with the	res (EPSS) shall be classified (2, Level 1 generator sets per 110, the Standard for 110,		Annual load bank test brought to QAPI and reensure it has been con according to regulation submitted through TEL accuracy is not complete information will be brought and an action plan may implemented. by what date the substance of confident and the few will not be completed by previously submitted, the needs to be contacted possible. The facility was usubmit an amended place correction with the updicorrection date. The deficient practice was rectified by September	eviewed to impleted in and LS. If 100% eted, this ught to QAPI y be systemic ciency will ubmitting an irrection, if it correction by the date the Division as soon as will need to an of dated plan of	

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		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		155636	B. WING 09/12/2024			
NAME OF PROVIDER OR SUPPLIER HARRISON TERRACE			1924 V	ADDRESS, CITY, STATE, ZIP COD VELLESLEY BLVD NAPOLIS, IN 46219		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S BLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	loading required by shall be at not less trating of the EPS. The shall be at not less trating of the EPS. The shall be at not less trating of the EPS. The shall be at not less than the s	8.4.9.5 and the remaining hour han 75% of the nameplate. The last three hours of the glocumentation indicated the ased on interview at the time of Maintenance Director and the of Maintenance Operations cumentation of supplemental thours within the most recent as not available for review. Ons with the Maintenance gional Director of tions during a tour of the p.m. to 2:10 p.m. on 09/12/24, the sel fired emergency generator building near the south nufacturer's nameplate rating dicated the generator was divas manufactured in May				
	Director, the Mainte	e reviewed with the Executive enance Director and the of Maintenance Operations Ference.				
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure non were not used as a stage LSC 19.5.1 requires 9.1. LSC 9.1.2 requequipment to complement to co	ent - Power Cords and on and interview, the facility -fused multiplug adapters substitute for fixed wiring. s utilities to comply with Section aires electrical wiring and ly with NFPA 70, National 11 Edition. NFPA 70, Article unless specifically permitted, ables shall not be used as a	K 0920	what corrective action(s) to be accomplished for those residents found to have been affected by the deficient practical All offices have been audited are now in compliance as of 9/27/24. how other residents having the potential to be affected by	ice; and	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/12/2024 155636 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219 HARRISON TERRACE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE substitute for fixed wiring of a structure. LSC same deficient practice will be Section 4.5.7 states any building service identified and what corrective equipment or safeguard provided for life safety action(s) will be taken; shall be designed, installed and approved in All residents have the potential to accordance with all applicable NFPA standards. be affected by the deficient This deficient practice could affect over 10 practice. residents, staff and visitors in the vicinity of the what measures will be put main entrance lobby. into place and what systemic changes will be made to ensure Findings include: that the deficient practice does not recur: Based on observations with the Maintenance Maintenance Director and Director and the Regional Director of managers have been in-serviced Maintenance Operations during a tour of the by Executive Director about proper facility from 12:50 p.m. to 2:10 p.m. on 09/12/24, a electrical receptacles. coffee pot, a microwave oven and a refrigerator Maintenance Director will were plugged into a multiplug adaptor plugged complete audit tool for electrical into a wall mounted electrical outlet box in the receptacles to be completed Director of Nursing's (DON) office near the main weekly times four and monthly entrance lobby. Based on interview at the time of times five for 95% or higher the observations, the Maintenance Director and compliance. If 95% compliance is the Regional Director of Maintenance Operations not achieved, action plan may be agreed a multiplug adaptor was being used as a created and reviewed during QAPI. substitute for fixed wiring in the DON office. Maintenance Director and/ or managers will complete daily walk These findings were reviewed with the Executive throughs to ensure that offices are Director, the Maintenance Director and the still in compliance and bring the Regional Director of Maintenance Operations information to morning meeting. during the exit conference. how the corrective action(s) will be monitored to ensure the 3.1-19(b) 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

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monitored for six months.

by what date the systemic

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155636 B. WING 09/12/2024 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 CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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.

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