STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155149	A. BUILDING -- B. WING	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/20/25 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 At this Emergency Preparedness survey, Harcourt Terrace Nursing and Rehabilitation 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 75. Quality Review completed on 02/21/25	E 0000		
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: 02/20/25 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 At this Life Safety Code survey, Harcourt Terrace	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
keith davis	Senior executive director	03/05/2025

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	Nursing and Rehabilitation was found not in compliance with Requirements 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 with a partial basement was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 110 and had a census of 75 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one small wooden shed at the rear of the facility that was not sprinklered. Quality Review completed on 02/21/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 6 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and	K 0211	**We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected	03/07/2025

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	training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility on 02/20/25 at 12:05 p.m., there were: two bedframes, a potty chair, two tables, two chairs, and a bedside table being stored in the area at the end the Willow Bend hall. Based on an interview with the Maintenance Supervisor at the time of the observation, he acknowledged the items in the corridor and added that because this area was rarely used, staff tended to place items here to store them until they could be taken to the outdoor storage area or placed in the trash. This item was discussed with the Maintenance Supervisor and the Executive Director during the exit conference held on 02/20/25. 3.1-19(b)		by this alleged deficient practice. -bed frames , potty chair, tables, chairs and bedside table have been removed from the area at the end of Willow Bend hall. 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/staff have the same potential to be affected by this alleged deficient practice -bedframes, potty chair, tables, chairs and a bedside table have been removed from the end of Willow Bend hall. - Maintenance supervisor was educated on 3/3/25 by the Senior Executive Director on maintaining means of egress. (see attachment A) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance Supervisor was educated on 3/3/25 by the Senior Executive Director on maintaining means of egress. (see attachment	

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			A) - appropriate corrections were made by immediately removing items in question from the end of Willow Bend hall. - Maintenance to conduct audit to ensure compliance. (see attachment B) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 3/7/25	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities			

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	Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 32 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility on 02/20/25 at 1:26 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved	K 0324	**We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. - an approved method has been installed to ensure that the 6-burner stove and the flat grill are returned to an approved design location. Installation of a safety set position system was installed on 3/5/25. - 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/staff have the same potential to be affected by this alleged deficient practice - an approved method has been installed to ensure that the 6 burner stove and the flat grill are returned to an approved design location. Installation ofa safety set position system was installed on 3/5/25. - The	03/07/2025

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	for maintenance and/or cleaning. Based on interview at the time of the observation, the Maintenance Supervisor stated that he was not aware what approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was discussed with the Maintenance Supervisor and the Executive Director during the exit conference held on 02/20/25. 3.1-19(b)		Maintenance supervisor was educated on 3/3/25 by the Senior Executive Director on providing an approved method for returning cooking appliances to an approved design location. (see attachment A) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance supervisor to conduct audit to ensure compliance with the six burner stove and the flat grill being located in their approved design location. (see attachment B) - Maintenance supervisor was educated on 3/3/25 by the Senior Executive Director on providing an approved method for returning cooking appliances to an approved design location. (see attachment A) - appropriate corrections were made to ensure that the six burner stove and flat grill are returned to an approved design location. Installation of a safety set position	

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			system was installed on 3/5/25. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 3/7/25	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 door to Central Supply would completely resist the passage of smoke. This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors.	K 0363	**We respectfully request desk review in this matter. Thank you for your consideration.**	03/07/2025

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	Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility on 02/20/25 at 12:40 p.m., the door to the Central Supply office had a three-eighths inch hole through the door that opened to the corridor. This was acknowledged by the Maintenance Supervisor at the time of observation who stated that he would fix the hole immediately. This item was discussed with the Maintenance Supervisor and the Executive Director during the exit conference held on 02/20/25. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. - The three-eighths hole in the door to the central supply office has been filled and corrected and would completely resist any passage of smoke. - 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/staff have the same potential to be affected by this alleged deficient practice - The three-eighths hole in the door to the central supply office door has been filled and corrected and would completely resist any passage of smoke. - The Maintenance supervisor was educated on 3/3/25 by the Senior Executive Director on door fire protection ratings to ensure no passage of smoke. (see attachment A)	

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - The three eighths hole in the central supply office door has been filled and corrected and would completely resist any passage of smoke. - The maintenance director was educated on 3/3/25 by the Senior Executive Director on door fire protection ratings to ensure no passage of smoke. (see attachment A) - The Maintenance Director to conduct audit to ensure compliance. (see attachment B) - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;	

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			Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 3/7/25	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 2 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 32 residents, 6 staff and 2 visitors. Findings include: Based on observations made with the	K 0374	**We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. - The gap in the smoke barrier doors between resident rooms 11 and 12, and	03/07/2025

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	Maintenance Supervisor during a tour of the facility on 02/20/25 from 11:30 a.m. to 1:30 p.m., the following was noted: 1) The smoke barrier doors between resident room #11 and resident room #12 failed to fully close leaving a three-inch gap when tested on three separate occasions. 2) The smoke barrier doors between resident room #31 and resident room #33 failed to fully close leaving a three-inch gap when tested on three separate occasions. Based on an interview at the time of each observation, the Maintenance Supervisor stated that the door coordinator mounted at the top of each door was not functioning properly and that he would either have them adjusted or replaced as soon as possible. This item was discussed with the Maintenance Supervisor and the Executive Director during the exit conference held on 02/20/25. 3.1-19(b)		rooms 31 and 33 have been eliminated and both sets of doors close correctly with no gaps. - 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/staff have the same potential to be affected by this alleged deficient practice - The gaps in both set of smoke barrier doors have ben eliminated and close correctly with no gaps. - Maintenance Director was educated on 3/3/25 by the Senior Executive Director on maintenance of smoke barrier doors. (see attachment A) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director was educated on 3/3/25 by the Senior Executive Director on	

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			maintenance of smoke barrier doors. (see attachment A). - smoke barrier doors in question have been corrected - Maintenance Director to audit to ensure compliance. (see attachment B) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 3/7/25	

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K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation and interview, the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel fire door was in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect as many as 32 residents, 6 staff and 2 visitors while in the main Dining Room and kitchen. Findings include: Based on observations made with the Maintenance Supervisor during a tour of the facility on 02/20/25 at 11:36 a.m., the metal rolling fire door between the kitchen and main Dining Room was blocked from fully closing by a round plastic container that would stop the door from fully closing in the event of a fire emergency.	K 0761	**We respectfully request desk review in this matter. Thank you for your consideration.** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. - The round plastic container that would prevent the metal rolling fire door from closing in the event of an emergency was removed immediately - 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/staff have the same potential to be affected by this alleged deficient practice -The round plastic container that would prevent the metal rolling fire door from closing was removed immediately	03/07/2025

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	Based on interview at the time of observation, the Maintenance Supervisor said that staff know better than to put items up on the shelf that would hinder the closing of the door but sometimes they forget and do it anyways. This item was discussed with the Maintenance Supervisor and the Executive Director during the exit conference held on 02/20/25. 3.1-19(b)		- The Maintenance Director was educated on 3/3/25 by the Senior Executive Director on the standards of fire doors. (see attachment A) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance Director educated on 3/3/25 by the Senior Executive Director on the standards of fire doors. (see attachment A) - the item blocking the door was removed immediately - Maintenance Director to audit o ensure compliance. (see attachment B) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Director. CQI tool identified as attachment B will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 3/7/25	