keith davis

PRINTED: 03/06/2025 FORM APPROVED OMB NO. 0938-039

03/05/2025

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/20/2025	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the In accordance with 42 Survey Date: 02/20/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I Terrace Nursing and compliance with En Requirements for M Participating Provided 483.73.	225 20070 55149 66190 Preparedness survey, Harcourt describing the Rehabilitation was found in the regency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of	E 0000		
	Quality Review con	npleted on 02/21/25			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/20/ Facility Number: 00 Provider Number: 1 AIM Number: 1002	00070 55149 66190	K 0000		
	At this Life Safety (Code survey, Harcourt Terrace			
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

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 disclodays 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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Senior executive director

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>0</u> 1	(X3) DATE SURVEY COMPLETED 02/20/2025	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET 8181 H INDIAN		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	Nursing and Rehabic compliance with Remodicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one-story facil determined to be of and fully sprinklere system with smoke corridors and in all facility has battery or resident sleeping rocapacity of 110 and of this visit. All areas where the access were sprinkled facility services were small wooden shed was not sprinklered. Quality Review control of the safety of the safety services were small wooden shed was not sprinklered.	elitation was found not in equirements for Participation in 1, 42 CFR Subpart 483.90(a), are and the 2012 Edition of the etion Association (NFPA) 101, and a second	TAG	DEFICIENCY	DATE
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress -	- General			
Š	facility failed to ma from obstructions ir facility. LSC 19.2.3 required width shall equipment, provide conditions are met: (a) The wheeled equ	on and staff interview, the intain the means of egress free a 1 of 6 corridors within the .4(4) states, projections into the be permitted for wheeled d that all of the following aipment does not reduce the corridor width to less than 60	K 0211	We respectfully request desi review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;	pe ints
	in. (1525 mm.) (b) The health care	occupancy fire safety plan and		No residents were affecte	ed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155149	B. WI	NG		02/20/	2025
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD ARCOURT RD	-	
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	_		IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Idress the relocation of the	+	TAG			DATE
	0.0	during a fire or similar			by this alleged deficient practice bed frames,	ce.	
	emergency.	during a me or similar			potty chair, tables, chairs and		
		uipment is limited to the			bedside table have been remo	oved	
	following:	•			from the area at the end of Wi		
	i. Equipment in use and carts in use				Bend hall.		
		ncy equipment not in use					
	iii. Patient lift and t				How other residents having th		
	This deficient practice could affect approximately				potential to be affected by the		
	16 residents, 4 staff and 2 visitors.				same deficient practice will be	!	
	Diadia and adada.				identified and what corrective		
	Findings include:				action(s) will be taken;		
	Based on observation	ons made with the			All residents/staff have th	ne	
	Maintenance Supervisor during a tour of the				same potential to be affected	by	
	facility on 02/20/25	at 12:05 p.m., there were: two			this alleged deficient practice		
		chair, two tables, two chairs,					
		being stored in the area at the					
		nd hall. Based on an interview			-bedframes, potty chair, tables		
		ce Supervisor at the time of			chairs and a bedside table have		
		acknowledged the items in the			been removed from the end of	f	
		that because this area was nded to place items here to			Willow Bend hall.		
		y could be taken to the			- Maintenance supervisor w	,,,,	
		a or placed in the trash.			 Maintenance supervisor w educated on 3/3/25 by the Ser 		
	and an anomage the				Executive Director on maintain		
	This item was discu	ussed with the Maintenance			means of egress. (see attachr	-	
		Executive Director during the			A)		
	exit conference held				,		
	3.1-19(b)						
					What measures will be put int	to	
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec	ur;	
					- Maintenance Supervisor w	as	
					educated on 3/3/25 by the Ser	nior	
					Executive Director on maintain	ning	
			1		means of egress (see attachr	_{nent}	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/20/2025
	PROVIDER OR SUPPLIE	R RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD IAPOLIS, IN 46260	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION PRIATE DATE
				A) - appropriate corrections we by immediately removing it question from the end of W Bend hall.	tems in
				Maintenance to conduct at ensure compliance. (see attachment B)	- udit to
				How the corrective as will be monitored to ensure deficient practice will not rewhat quality assurance prowill be put into place; Ongoing compliance this corrective action will be monitored via facility QAPI program, with meetings be every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be compweekly x 4 weeks, monthly 6 months, and quarterly the until compliance is achieved If Threshold of 100% met, an action plan will be	e the ecur, ogram with e eing held oleted of times ereafter ed.
				developed to ensure comp By what date the systemic changes will be completed Completion date: 3/7/	ļ;
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities	5			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2025		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	_	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on observation failed to provide an returning cooking a when the kitchen he was designed and in extinguishing system. Ventilation Control Commercial Cookin Edition Section 12. requiring protection or rearranged without fire-extinguishing so or servicing agent, where the design of the fire-extinguishing so revicing agent, where the design of the fire-extinguishing so revicing agent, where the design of the fire-extinguishing so revicing agent, where the design of the fire-extinguishing so revicing agent, where the design of the fire-extinguishing agent, which is the design of the fire-extinguishing agent, which is the design of the fire-extinguishing agent, which is the design of the fire-extinguishing agent at the fire-extinguishing agent agent agent at the fire-extinguishing agent agent agent agent agent at the fire-extinguishing agent age	approved method for ppliances to where they were pod extinguishing equipment astalled for 1 of 1 kitchen hood m. NFPA 96, Standard for and Fire Protection of ang Operations Section 2011 1.2.2, states cooking appliances a shall not be moved, modified, but prior re-evaluation of the yestem by the system installer unless otherwise allowed by the extinguishing system. It is the fire-extinguishing the provided the are moved for the purposes of the earlier moved design obking operations, and any continguishing system nozzles in an approved design 1.2.3.1 states an approved vided that will ensure that the dot on approved design ient practice could affect as its, 6 staff, and 2 visitors in the	K 03		We respectfully request desireview in this matter. Thank you for your consideration. What corrective action(s) will accomplished for those reside found to have been affected be deficient practice; No residents were affect by this alleged deficient practice - an approved method has been installed to ensure that the 6-burner stove and the flat gri returned to an approved design location. Installation of a safe set position system was instal 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 this alleged deficient practice	be ents by the ed ce. Il are gn ety eled	03/07/2025
	facility on 02/20/25 stove and the flat gr cooking line under not provided with a ensure that the appl	ons made with the visor during a tour of the at 1:26 p.m., the six (6) burner will which was located on the the hood in the kitchen was approved method that would inance was returned to an eation after it had been moved			- an approved method had been installed to ensure that the burner stove and the flat grill a returned to an approved design location. Installation of a safet set position system was instal on 3/5/25.	he 6 are gn :y	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETE					
AND PLAN	OF CORRECTION	155149	A. BUILDING <u>01</u> COMPLE B. WING 02/20/2				
					ADDRESS, CITY, STATE, ZIP COD	==,=0,	
NAME OF F	PROVIDER OR SUPPLIEF	2			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION	INDIANAPOLIS, IN 46260				<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	interview at the tim	d/or cleaning. Based on e of the observation, the visor stated that he was not			Maintenance supervisor was educated on 3/3/25 by the Sel Executive Director on providin		
		ed method should be provided			approved method for returning cooking appliances to an approved		
		opliance was returned to an					
		cation after maintenance or e would have something done			design location. (see attachment A)		
	to the kitchen stove or floor to meet code			addominonerty			
	compliance as soon	as possible.					
	This item was discu	ussed with the Maintenance					
	Supervisor and the Executive Director during the						
	exit conference held on 02/20/25.						
	3.1-19(b)				What measures will be put into	0	
					place or what systemic change		
					will be made to ensure that the		
					deficient practice does not rec	:ur;	
					- Maintenance		
					supervisor to conduct audit to		
					ensure compliance with the six burner stove and the flat grill b		
					located in their approved design	-	
					location. (see attachment B)	_	
					_		
					Maintenance supervisor was		
					educated on 3/3/25 by the Sei		
					Executive Director on providing	-	
					approved method for returning cooking appliances to an appr	-	
					design location. (see		
					attachment A)		
					appropriate corrections were r	made	
					to ensure that the six burner s		
					and flat grill are returned to an	1	
					approved design location.	ition	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	A. BUILDING <u>01</u> COM		(X3) DATE S' COMPLE 02/20/2	PLETED	
	PROVIDER OR SUPPLIER JRT TERRACE NUI	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 0363	NFPA 101			How the corrective action(s) we monitored to ensure the defic practice will not recur, what quassurance program will be puplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be complete weekly x 4 weeks, monthly tin 6 months, and quarterly there until compliance is achieved. If Threshold of 100% is met, an action plan will be developed to ensure complian. By what date the systemic changes will be completed; Completion date: 3/7/25	will be ient uality ut into h held nes eafter not		
SS=E Bldg. 01	Corridor - Doors Based on observation failed to ensure 1 of would completely re-	on and interview, the facility I door to Central Supply esist the passage of smoke. ice could affect approximately and 2 visitors.	K 0363	We respectfully request des review in this matter. Thank you for your consideration.	I	03/07/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155149	B. Wl	ING		02/20/	2025
	PROVIDER OR SUPPLIER JRT TERRACE NUI	RSING AND REHABILITATION	•	8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
	SUMMARY: (EACH DEFICIEN REGULATORY OR Findings include: Based on observation Maintenance Superfacility on 02/20/25 Central Supply official hole through the donor this was acknowled Supervisor at the tirthat he would fix the	RSING AND REHABILITATION STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Ons made with the visor during a tour of the at 12:40 p.m., the door to the ce had a three-eighths inch or that opened to the corridor. diged by the Maintenance me of observation who stated he hole immediately. Isseed with the Maintenance Executive Director during the		8181 H	ARCOURT RD	pe nts y the ed ce. to eeen e of e	(X5) COMPLETION DATE
					Maintenance supervisor was educated on 3/3/25 by the Ser Executive Director on door fire protection ratings to ensure no passage of smoke. (see attachment A)	;	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	ILDING	onstruction 01	(X3) DATE : COMPL 02/20/	ETED
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		APOLIS, IN 46260		
(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)	ATE	(X5) COMPLETION DATE
				What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not reconstruction.	es e	
				- The three eighths hole in th 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/by the Senior Executive Director door fire protection ratings ensure no passage of smoke.	25 tor	
				The Maintenance Director to conduct audit to ensure compliance. (see attachment	В)	
				How the corrective action(s) version monitored to ensure the deficient practice will not recur, what quassurance program will be publiced.	ent uality	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 02/20/2025
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 F	ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0374	NEDA 101			Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being hevery other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be complete weekly x 4 weeks, monthly time 6 months, and quarterly therea 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	d es fter ot
K 0374 SS=E Bldg. 01	Barrie Based on observation failed to ensure 2 or would restrict the mr 20 minutes. LSC, S doors in smoke barriers to only the minimum of operation which is of the movement of sm affects 32 residents. Findings include:	on and interview, the facility of 8 sets of smoke barrier doors have been at least ection 19.3.7.8 requires that riers shall comply with LSC, Section 8.5.4.1 requires doors to close the opening leaving clearance necessary for proper defined as 1/8 inch to restrict moke. This deficient practice to 6 staff and 2 visitors.	K 0374	We respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; No residents were affecte by this alleged deficient practice - The gap the smoke barrier doors between	e nts the d e. in
	Based on observation	ons made with the		resident rooms 11 and 12, and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155149 B. WING 02/20/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD HARCOURT TERRACE NURSING AND REHABILITATION INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Maintenance Supervisor during a tour of the rooms 31 and 33 have been facility on 02/20/25 from 11:30 a.m. to 1:30 p.m., the eliminated and both sets of doors following was noted: close correctly with no gaps. 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 How other residents having the separate occasions. potential to be affected by the 2) The smoke barrier doors between resident room same deficient practice will be #31 and resident room #33 failed to fully close identified and what corrective leaving a three-inch gap when tested on three action(s) will be taken; separate occasions. All residents/staff have the same Based on an interview at the time of each potential to be affected by this observation, the Maintenance Supervisor stated alleged deficient practice 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 - The gaps in both soon as possible. set of smoke barrier doors have ben eliminated and close correctly This item was discussed with the Maintenance with no gaps. Supervisor and the Executive Director during the exit conference held on 02/20/25. - Maintenance Director was educated on 3/3/25 3.1-19(b) 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

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educated on 3/3/25 by the Senior

Executive Director on

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/20/2025
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COD IARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) maintenance of smoke barrier doors. (see attachment A) smoke barrier doors in question have been corrected Maintenance Director to audit ensure compliance. (see attachment B)	DATE
				How the corrective action(s) we monitored to ensure the deficipractice will not recur, what quassurance program will be purplace; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive Director. CQI tool identified as attachment B will be complete weekly x 4 weeks, monthly tin 6 months, and quarterly there until compliance is achieved. If Threshold of 100% is met, an action plan will be developed to ensure compliants by what date the systemic shanger will be completed.	ient uality t into held ed nes after not
				changes will be completed; Completion date: 3/7/25	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/20/2025	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LIGO DEPOTE TO THE OWN ATTOMATION.		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Insp Based on observation failed to ensure the maintained for 1 of accordance with NF device, equipment, arrangement, level of feature is required for provision of this Consystem, condition, as protection, or other maintained unless the maintenance. NFPA for Fire Doors and Office Section 11.4.1.1 required evice shall be instanced door. Section 11.4.1 shall close automatic release of a fusible statistical transportation until the autobeen reset. This definancy as 32 resident in the main Dining frindings include: Based on observation Maintenance Superfacility on 02/20/25 fire door between the	of protection, or any other for compliance with the de, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such a 80, 2010 Edition, the Standard Other Opening Protectives, quires an automatic-closing alled on every rolling steel a.2 states rolling steel doors cally upon activation or link or detector. Section for the automatic closing is shall remain in the closed tomatic-closing device has icient practice could affect as section and kitchen.	K 0	761	We respectfully request desireview in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; No residents were affected by this alleged deficient practice. The rouplastic container that would prevent the metal rolling fire defrom 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 in this alleged deficient practice. -The round plastic contains.	ce ents y the ed ce. nd cor e e by	03/07/2025
	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.				that would prevent the metal refire door from closing was remimmediately	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		A. BUILDING <u>01</u> COMP		(X3) DATE SURVEY COMPLETED 02/20/2025			
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	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			The Maintenance Director was educated on 3/3/25 by the Se Executive Director on the standards of fire doors. (see attachment A)			
	exit conference held 3.1-19(b)	_		What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not reconstruction.	es e		
				- Maintenance Director educated on 3/3/25 by the Se Executive Director on the standards of fire doors. (see attachment A) - the item block the door was removed immediately - Maintenance Direct audit o ensure compliance. (see	ring or to		
				How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance prograwill be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being every other month, and is overseen by the Executive	e r, r, am		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		(X3) DATE SURVEY COMPLETED 02/20/2025		
	ROVIDER OR SUPPLIEI JRT TERRACE NU	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 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 complete weekly x 4 weeks, monthly tim 6 months, and quarterly therea until compliance is achieved. If Threshold of 100% is r met, an action plan will be developed to ensure complian. By what date the systemic changes will be completed; Completion date: 3/7/25	nes after not		

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