02/13/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3								
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/16/2024		
	PROVIDER OR SUPPLIE	R IRSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/16/24 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 At this Emergency Preparedness survey, Harcourt Terrace Nursing and Rehabilitation was found not 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 76. Quality Review completed on 01/17/24 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:		E 00	000	The creation and submission this plan of correction does not constitute an admission by the provider of any confusion set in the statement of deficiencies of any violation of the regulation. This provider request that the 2 correction be considered the letter of credible allegation and request desk review (paper compliance) on or after 2/10/2	ot is forth es or ion. e			
E 0004 SS=F	, ,	54(a), 418.113(a), 15(a), 483.475(a), 483.73(a),							

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

484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a),

Develop EP Plan, Review and Update

§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),

491.12(a), 494.62(a)

Annually

Bldg. --

(X6) DATE

Scott Piotrowicz **Executive Director** 02/12/2024

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

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TITLE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		l í	JILDING	NSTRUCTION	(X3) DATE COMPI 01/16	ETED			
	PROVIDER OR SUPPLIEF JRT TERRACE NU	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	The [facility] must Federal, State and preparedness requised must develop estate comprehensive ending program that mees section. The emergency Place of the following elem. (a) Emergency Place of the following elem. (a) Emergency Place of the following elem. (a) Emergency Place of the following elem. (b) Emergency Place of the following elem. * [For hospitals at §485.625(a):] Emor CAH] must confederal, State, and preparedness requised comprehensive ending elementary elementary. * [For LTC Facilities Emergency Planter of the following elementary elementary. * [For ESRD Facilies Emergency Planter of the following elementary. * [For ESRD Facilies Emergency Planter of the facilies elementary. * [For ESRD Fa	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated],							

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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 01/16/2024		
	PROVIDER OR SUPPLIER JRT TERRACE NUI	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, 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)	TE	(X5) COMPLETION DATE	
	failed to maintain an plan that was review annually in accorda This deficient practive. Findings include: Based on review of Preparedness Plan of the Maintenance Sudocumentation of an reviewed by the fact twelve-month perion. A review of the emorpresented for record update or update pathroughout the entire plan. Based on interreview, the Mianten facility Administration of the faction of the entire plan. Based on interreview, the Mianten facility Administration of the faction of t	riew and interview, the facility in emergency preparedness wed and updated at least ince with 42 CFR 483.73(a). ice could affect all occupants. The facility's Emergency on 01/16/24 at 9:51 a.m. with approvisor present, in emergency program illity within the most recent d was not available for review. ergency preparedness plan illings of any kind located re emergency preparedness riew at the time of record nance Supervisor said that the for may have a different copy in reral failed attempts to locate the emergency preparedness ator, and the Miantenance reed that an updated binder if for record review at the time	E 00	004	. An EP plan was completed a is now in place which as been reviewed and signed by the El 2. All residents could be affect and Plan is now in place 3. Two Manuals are now in the building, one with Ed and one Maintenance which are up-to-and signed by the ED. 4. The manuals will be up-date as needed and reviewed quart in Safety Committee. If any concerns are identified, an act plan will be implemented. Rev annually will be added to the Thecklist and QAPI calendar be the ED. 5. Completion 1/18/24	D. ed with date ed erly ion iew	01/18/2024	
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §483. §485.68(b), §485.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),						

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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 01/16/2024	
	PROVIDER OR SUPPLIER	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	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	(b) Policies and prodevelop and imples preparedness policies on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policies reviewed and by years. *[For LTC facilities and procedures. To develop and imples preparedness policies and procedures proparedness policies and procedures preparedness policies and procedures preparedness policies and imples preparedness policies and procedures and proced	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 at §483.73(b):] Policies the LTC facility must ement emergency cies and procedures, based			
	(a) of this section, paragraph (a)(1) c communication pla section. The policibe reviewed and u	r plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.			
	procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication plasection. The polic address managen nonmedical emerglimited to: Fire; eq	PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the en at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not uipment, power, or water ed emergencies; and natural			

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/16/2024			
	PROVIDER OR SUPPLIEF	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	safety of the partic. The policies and previewed and upd *[For ESRD Facilia and procedures. develop and imple preparedness policition on the emergency (a) of this section, paragraph (a)(1) communication placetion. The policition be reviewed and updares. These ements are limited to, fire, failures, care-relassupply interruption likely to occur in that area. Based on record refailed to develop and preparedness policities and procedupdated at least and CFR 483.73(b). The all residents in the failures in the failures are considered as and procedupdated at least and CFR 483.73(b). The all residents in the failures in the failures in the failures are considered as a facility within the reperiod was not available.	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water in, and natural disasters in facility's geographic view and interview, the facility implement emergency es and procedures. The ures must be reviewed and inally in accordance with 42 is deficient practice could affect facility. The facility's Emergency on 01/16/24 at 9:51 a.m. with	E 0013	1 An EP Plan was reviewed and signed by ED 2 All residents could be affected 3 The manual is signed by and will be Annually hence for ED will be educated to ensure emergency plan including polic and procedures are reviewed a signed annually or as needed. 4 It will be reviewed annual the first QAPI meeting of each new year, this will be added to TELs checklist 5 Completion 1/18	ED th. the cies and			

procedures presented for records review did not

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039		
AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	ì í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/16/2024		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD IAPOLIS, IN 46260			
(X4) ID PREFIX	SUMMARY (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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION	
E 0029 SS=F	have an update of a the entire plan. Bass record review, the M that the facility Adr copy in his office. A locate an updated copreparedness plan, Miantenance Super updated binder coul review at the time of 403.748(c), 416.5441.184(c), 482.1	4(c), 418.113(c), 5(c), 483.475(c), 483.73(c),		TAG			DATE	
Bldg	§403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485. §485.920(c), §486 §494.62(c).	20(c), 486.360(c),						
	an emergency preplan that complies local laws and must least every 2 years. Based on record record to develop an	eparedness communication s with Federal, State and st be reviewed and updated ears [annually for LTC view and interview, the facility d maintain an emergency	E 00	029	Included in the EP plan is the Facility Communication pla		01/18/2024	
	with Federal, State,	nunication plan that complies and local laws in accordance (3(c). This deficient practice apants.			2 All residents could be affected 3 The Communication Plan be up-dated as needed and reviewed quarterly in Safety meeting. ED will be educated the ensure the Emergency			

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Based on review of the facility's Emergency

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communication plan is reviewed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BU B. WI			COMPL 01/16/	
		133149	B. WI			01/10/	2024
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
HARCOU	IRT TERRACE NUI	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		on 01/16/24 at 9:51 a.m. with	+	TAG			DATE
	the Maintenance Su				and signed annually and as needed.		
		n emergency preparedness			4 The Communication plan	will	
	program communication plan reviewed by the facility within the most recent twelve-month				be reviewed at the quarterly S		
					meeting. This will be added to the		
	period was not avail	lable for review. A review of			TELs Check list and QAPI		
		aredness plan communication			Calendar.		
	• •	ecords review did not have an			5 1/18/24		
	•	located throughout the entire					
	•	rview at the time of record					
		nance Supervisor said that the or may have a different copy in					
	•	reral failed attempts to locate					
		the emergency preparedness					
		ator, and the Miantenance					
	Supervisor both agr	eed that an updated binder					
	could not be located	l for record review at the time					
	of this survey.						
E 0036	403.748(d), 416.5	4(d), 418.113(d),					
SS=F		5(d), 483.475(d), 483.73(d),					
Bldg	484.102(d), 485.6	, ,					
	485.727(d), 485.93						
	491.12(d), 494.62 EP Training and T	• •					
	-	6.54(d), §418.113(d),					
	- ' ' -	0.84(d), §482.15(d),					
	. , , .	475(d), §484.102(d),					
		625(d), §485.727(d),					
	§485.920(d), §486	6.360(d), §491.12(d),					
	§494.62(d).						
	*[For PNICHIA at 8	403.748, ASCs at §416.54,					
	•	13, PRTFs at §441.184,					
		Hospitals at §482.15,					
	•	2, CORFs at §485.68,	1				
	_	5, "Organizations" under					
	_	at §485.920, OPOs at					
		IC/FHQs at §491.12:] (d)					
	-	ng. The [facility] must					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		A. BUILDING B. WING		COMPLETED 01/16/2024	
	PROVIDER 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	preparedness trai that is based on the in paragraph (a) of assessment at passection, policies and (b) of this section, plan at paragraph training and testing reviewed and updd *[For LTC facilities and testing. The land maintain an estraining and testing the emergency plan of this section, risk (a)(1) of this section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/III maintain an emergency plan is this section, risk at (a)(1) of this section, risk at (a)(1) of this section at paragraph (b) of communication plans this section. The train must be reviewed 2 years. The ICF/III requirements for eat §483.470(i).	ragraph (a)(1) of this nd procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least 3483.475(d):] Training and ID must develop and gency preparedness training am that is based on the et forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every			

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Event ID:

 $TYW021 \qquad {\tt Facility\ ID:} \quad 000070$

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PRINTED: 02/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/16/2024		
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	dialysis facility multiple emergency preparation on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the community of this section. The orientation prograupdated at every 20 Based on record revision of the section of this section. The orientation prograupdated at every 20 Based on record revision of the section of the emergency preparation of the entire plan. Base record review, the Matthe facility Adricopy in his office. A locate an updated of preparedness plan, the section of the section	when and interview, the facility and maintain an emergency and testing program that applated at least annually in CFR 483.73(d). This deficient at all occupants. The facility's Emergency on 01/16/24 at 9:51 a.m. with approximate program reviewed by the approximate recent twelve-month lable for review. A review of paredness training and testing for records review did not any kind located throughout and on interview at the time of Miantenance Supervisor said ministrator may have a different after several failed attempts to opp of the emergency the Administrator, and the visor both agreed that an lid not be located for record	E 00	036	1.A Plan was reviewed and signly the ED 2. All residents could be affect by this deficiency. 3. The Emergency plan will will up-dated and as needed at the quarterly safety meeting. ED educate dto ensure to ensure emergency plan is reviewed as signed annually. 4. The Plan will be up-dated annually and as needed by the and will be reviewed by the QA committee. This will be added Tels and QAPI Calendar	ed I be e nd EED	01/18/2024

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		l í	UILDING	NSTRUCTION	(X3) DATE COMPL 01/16/	ETED		
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
E 0039 SS=F Bldg	441.184(d)(2), 484.483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49. EP Testing Requires \$416.54(d)(2), \$4.5460.84(d)(2), \$4.5460.84(d)(2), \$4.5485.625(d)(2), \$4.6485.625(d)(2), \$	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d), , §494.62(d)(2). 16.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan ility] must do all of the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149			UILDING	NSTRUCTION	(X3) DATE COMPL 01/16 /	ETED		
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	functional exercises (B) A mock disasts (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an er (iii) Analyze the [famaintain document exercises, and emthe [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a community based (A) When a community based functional exercises plan at least annut the following: (i) Participate in a community based functional exercises of the emergency exempt from engascale community-facility-based functional exercise of this section is coinclude, but is not (A) A second full-	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. acility's] response to and station of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must is to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the						

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 $TYW021 \qquad {\tt Facility\ ID:} \quad 000070$

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	
		155149	B. WI	NG		01/16	/2024
NAME OF F	PROVIDER OR SUPPLIE	R.	_		ADDRESS, CITY, STATE, ZIP COD	_	
		RSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	functional exercis	•					
	(B) A mock disas						
		ercise or workshop that is					
	1	and includes a group					
	discussion using						
	I	emergency scenario, and a					
	-	atements, directed					
		pared questions designed					
	to challenge an e	mergency plan.					
	(3) Testing for ho	spices that provide inpatient					
	_ ` '	e hospice must conduct					
	I	the emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community						
	(A) When a comn	nunity-based exercise is not					
	accessible, condu	uct an annual individual					
	facility-based fund	ctional exercise; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	gency that requires activation					
	of the emergency	plan, the hospice is					
		aging in its next required					
	full-scale commu	nity based or facility-based					
		e following the onset of the					
	emergency event						
	` '	dditional annual exercise					
		but is not limited to the					
	following:						
	1 ' '	-scale exercise that is					
	1	d or a facility based					
	functional exercis						
	(B) A mock disas						
		rercise or workshop led by a					
	facilitator that includes a group discussion						
	using a narrated, clinically-relevant						
	emergency scenario, and a set of problem						
	statements, directed messages, or prepared questions designed to challenge an						
	l ·	ed to challenge an					
	emergency plan.		1				1

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPI	LETED
		155149	B. WIN	NG		01/16	/2024
		1	- 	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			ARCOURT RD		
HARCO	LIDT TEDDACE NILI	RSING AND REHABILITATION			APOLIS, IN 46260		
ПАКСО	UKT TERRACE NU	RSING AND REHABILITATION		INDIAN	APOLIS, IN 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(iii) Analyze the h	nospice's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and en	nergency events and revise					
		ergency plan, as needed.					
	'						
	*[For PRFTs at §4	141.184(d), Hospitals at					
	§482.15(d), CAH						
	- ' '	PRTF, Hospital, CAH] must					
	. ,	s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					
	that is community						
	· · · · · · · · · · · · · · · · · · ·	nunity-based exercise is not					
	, ,	ıct an annual individual,					
		ctional exercise; or					
	•	Hospital, CAH] experiences					
	, ,	or man-made emergency					
		vation of the emergency					
		is exempt from engaging in					
	its next required f	ull-scale community based					
		ity-based functional exercise					
		et of the emergency event.					
	(ii) Conduct	an [additional] annual					
	exercise or and th	nat may include, but is not					
	limited to the follo	wing:					
	(A) A second full-	-scale exercise that is					
	community-based						
	-	ctional exercise; or					
	*	ock disaster drill; or					
	, ,	p exercise or workshop that					
	, ,	tor and includes a group					
	discussion, using						
	_	emergency scenario, and a					
	1	atements, directed					
		pared questions designed					
	to challenge an e	·					
	_	he [facility's] response to					

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and maintain documentation of all drills,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE				
Α	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING			COMPLETED 01/16/2024	
			155149	B. W	ING		01/16	/2024	
1	NAME OF P	ROVIDER OR SUPPLIER	- }			ADDRESS, CITY, STATE, ZIP COD			
						ARCOURT RD			
	HARCOU	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260			
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
]	PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
	TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		•	s, and emergency events						
		and revise the [facility's] emergency plan, as needed.							
		needed.							
		*[For PACE at §46	60.84(d):1						
		-	PACE organization must						
		, ,	to test the emergency						
		plan at least annu	ally. The PACE						
		organization must	do the following:						
		(i) Participate in a	an annual full-scale exercise						
		that is community-							
	(A) When a community-based exercise is not								
	accessible, conduct an annual individual,								
		facility-based fund							
		, ,	xperiences an actual natural						
			ergency that requires						
			mergency plan, the PACE						
		-	gaging in its next required						
			nity based or individual, ctional exercise following the						
		onset of the emerg	_						
			in additional exercise every						
		, ,	he year the full-scale or						
			e under paragraph (d)(2)(i)						
			onducted that may include,						
		but is not limited to	-						
		(A) A second full-	scale exercise that is						
		community-based	or individual, a facility						
		based functional e	exercise; or						
		(B) A mock disast	ter drill; or						
		, ,	ercise or workshop that is						
		•	and includes a group						
		discussion, using							
		_	emergency scenario, and a						
		set of problem sta							
			pared questions designed						
		to challenge an er	- · · ·						
		. ,	PACE's response to and						
			ntation of all drills, tabletop						
		exercises and em	ieroency evenis and revise					1	

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Event ID:

TYW021 Facility ID: 000070

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149		UILDING	NSTRUCTION	(X3) DATE COMPL 01/16 /	ETED	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Gency plan, as needed.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	ГЕ	(X5) COMPLETION DATE	
	*[For LTC Facilitie (2) The [LTC facilitie to test the emerge year, including unathe emergency pro ICF/IID] must do ti (i) Participate in a that is community. (A) When a commaccessible, condufacility-based function (B) If the [LTC facactual natural or macquires activation LTC facility is exercequired a full-scaindividual, facility-following the onse (ii) Conduct an actual may include, If following: (A) A second full-community-based based functional et (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or prepto challenge an er (iii) Analyze the [Linesponse to and mall drills, tabletop exelled in the community of the commu	es at §483.73(d):] ity] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, he following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual, ctional exercise. idity] facility experiences an anan-made emergency that an of the emergency plan, the mpt from engaging its next alle community-based or based functional exercise et of the emergency event. diditional annual exercise but is not limited to the escale exercise that is a or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et he [LTC facility] facility] facility's						

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155149	l í	ILDING	NSTRUCTION	COMPL 01/16/	ETED
	F PROVIDER OR SUPPLIEF DURT TERRACE NU	RSING AND REHABILITATION		8181 HA	DDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	exercises to test the twice per year. The following: (i) Participate in a strate is community (A) When a community (A) When a community (B) If the ICF/IID enatural or man-man activation of the enditor is exempt from enfull-scale community-based functions on the empression of the empression (B) A second full-community-based facility-based function (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem state messages, or presto challenge an enful (iii) Analyze the IC maintain document exercises, and enthe ICF/IID's empersions.	cc/IID must conduct the emergency plan at least the ICF/IID must do the an annual full-scale exercise based; or annuity-based exercise is not tect an annual individual, ctional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID agaging in its next required aity-based or individual, ctional exercise following the agency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. cr/IID's response to and antation of all drills, tabletop mergency events, and revise regency plan, as needed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155149	B. W	ING		01/16	/2024
C.				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		8181 H	ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION		INDIAN.	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following:						
		full-scale exercise that is					
	community-based						
	, ,	ommunity-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.						
	` '	A experiences an actual ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer	-					
		ditional exercise every 2					
	' '	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
		limited to the following:					
		full-scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	(B) A mock d	isaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
		emergency scenario, and a					
		tements, directed					
		pared questions designed					
	to challenge an er	- · ·					
	. ,	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	86.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test t	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					

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	OF CORRECTION	IDENTIFICATION NUMBER 155149	A. BUILDING B. WING	onstruction 	COMPLETED 01/16/2024		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, 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)	(X5) COMPLETION DATE		
	exercise is led by group discussion, relevant emergency problem statemen prepared question emergency plan. I actual natural or n requires activation OPO is exempt from required testing export the emergency (ii) Analyze the OF maintain document exercises, and emitte [RNHCI's and needed. *[RNCHIs at §403	PO's response to and station of all tabletop ergency events, and revise OPO's] emergency plan, as					
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually, a group discussion I narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and emithe RNHCI's emer Based on record reversalled to conduct explan at least twice punannounced staff of procedures. The LT following:	er-based, tabletop exercise A tabletop exercise is a ed by a facilitator, using a -relevant emergency et of problem statements, s, or prepared questions nge an emergency plan. NHCl's response to and station of all tabletop sergency events, and revise gency plan, as needed. riew and interview, the facility ercises to test the emergency	E 0039	1.EP Testing requirements will initiated by the facility in the form of a round table completed on 2/6/24 2. All residents could be affect 3. The facility will perform a rotable and emergency	orm ted		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/16/2024				
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE			
	accessible, conduct facility-based function. If the LTC facility or man-made emerge of the emergency please from engaging its not community-based of full-scale functional the onset of the acturation (ii) Conduct an addinclude, but is not lia. A second full-scale community-based of functional exercise. In the scale of the community-based of functional exercise. In the scale of the	an annual individual, ional exercise. y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based lexercise for 1 year following nal event. itional exercise that may imited to the following: the exercise that is or an individual, facility-based drill; or see or workshop that is led by a des a group discussion, using y relevant emergency scenario, in statements, directed red questions designed to ency plan. The facility's response to and action of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This bould affect all occupants. The facility's Emergency on 01/16/24 at 9:51 a.m. with appervisor present, an annual full-scale exercise		preparedness procedure in the form of a round table on 2/6/24. dealing with a Torna Facility will schedule a full-scaexercise will be completed in 14 days. 4. Once a quarter at the Safet Meeting EP testing will be reviewed. Emergency QAPI to will be completed quarterly to ensure exercises/events are completed per plan. If 100% is achieved, an action plan will be developed. 5 Completed by 2/23/24.	do. ale next y pol			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	A. BUILI B. WING	DING	STRUCTION	(X3) DATE : COMPL 01/16/	ETED
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0000	emergency plan, or that is community-based function drill, or a tabletop e by a facilitator that using a narrated, cli scenario, and a set of directed messages, designed to challeng on interview at the Miantenance Super Administrator may office. After several different copy of the plan, the Administrator but had supervisor both agr	as second full-scale exercise assed or an individual, onal exercise, a mock disaster exercise or workshop that is led includes a group discussion, nically relevant emergency of problem statements, or prepared questions as an emergency plan. Based time of record review, the visor said that the facility have a different copy in his failed attempts to locate a exemergency preparedness ator, and the Miantenance eed that a different binder with the aforementioned this survey.					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/16 Facility Number: 0 Provider Number: 100 At this Life Safety O Nursing and Rehabic compliance with Re Medicare/Medicaid Life Safety from Fin	00070 155149	K 000		The creation and submission of this plan of correction does no constitute an admission by this provider of any confusion set f in the statement of deficiencies of any violation of the regulation. This provider request that the 2 correction be considered the letter of credible allegation and request desk review (paper compliance) on or after 2/10/26	t s orth s or on.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/16/2024		
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP COL ARCOURT RD IAPOLIS, IN 46260)	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION
TAG	Life Safety Code (L	SC), Chapter 19, Existing ancies and 410 IAC 16.2.	TAG	BEIGER		DATE
	determined to be of and fully sprinklered system with smoke corridors and in all a The facility has batt in all resident sleepi	Type III (211) construction d. The facility has a fire alarm detection on all levels in the areas open to the corridor. ery operated smoke detectors ing rooms. The facility has a had a census of 76 at the time				
	access were sprinkle facility services were	residents have customary ered and all areas providing re sprinklered except for one at the rear of the facility that				
	Quality Review con	npleted on 01/17/24				
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 0.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPI	LETED
		155149	B. W	ING		01/16	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			IAPOLIS, IN 46260		
	Г		1		I		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DETERMET)		DATE
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
		N/A					
		-Fired Heater Rooms					
		er than 100 square feet)					
	, ,	nance, and Paint Shops					
	-	coms (exceeding 64					
	gallons)	, J					
	e. Trash Collectio	n Rooms					
	(exceeding 64 gal	llons)					
	f. Combustible Storage Rooms/Spaces						
	(over 50 square fe	eet)					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	•					
		on and interview, the facility	K 0	321	1 The doors have had new	door	01/18/2024
		corridor door to 1 of 6			closures installed		
	hazardous areas, su				2 All residents could be		
		d room, a storage room of			affected		
		es over 50 square feet in size,			3 Doors in question have h	ad	
		a self-closing device which or to automatically close and			closures installed by the Maintenance Director, Hazard	laa	
		frame. This deficient practice					
		rame. This deficient practice by as 14 residents, 4 staff and 2			door areas will be checked we to ensure proper closure.	cekiy	
	visitors.	, 45 17 1051001116, 7 Statt and 2			4 On Weekly rounds		
	. 151615.				Maintenance Director will che	ck	
	Findings include:				all doors for proper closures a		
					will report findings to the QAP		
	Based on observation	ons made during a tour of the			Committee for review.		
		at 12:37 p.m. during a tour of			5 Completed 1/18/24		
	the facility with the	Maintenance Director, the					
	following was note	d:					
	l '	to the Bio-hazard room next to					
		and transfilling room had a					
		device attached to it. For some					
	reason, the arm to the self-closing device that						
		had been removed. This room					
		160 square feet in size. (14 feet					
	by 12 feet) This roo	om was being used for storage					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	r í	JILDING	nstruction 01	(X3) DATE COMPL 01/16/	ETED
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 HA	DDRESS, CITY, STATE, ZIP COD ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
K 0353 SS=E Bldg. 01	b) the Medical Recostacks of paper recostacks	ords office had numerous ords stacked all over the office. Ed approximately 224 square by 14 feet) and the door dor did not have a self-closing to the state of t					

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 01/16/2024
	PROVIDER OR SUPPLIEI JRT TERRACE NU	RSING AND REHABILITATION	8181	T ADDRESS, CITY, STATE, ZIP COD HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure 31 located throughout cleaned in accordar Standard for the Ins Maintenance of Wa Systems, 2011 Edit sprinklers shall not be free of corrosion physical damage; a correct orientation sidewall). Furthern that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not This deficient pract residents, 8 staff. at Findings include: Based on observation facility on 01/16/22 p.m. during a tour of Maintenance Direct a) the corridor sprint had paint on the sprint of the sprint of the sprint on the sprint of the corridor sprint had paint on the sprint of the sp	on, and interview; the facility of over 200 sprinkler heads the facility were replaced or new with NFPA 25. NFPA 25, spection, Testing, and ster-Based Fire Protection ion, Section 5.2.1.1.1 states show signs of leakage; shall a, foreign materials, paint, and and shall be installed in the (e.g., up-right, pendent, or nore, at 5.2.1.1.2 any sprinkler any of the following shall be get the glass bulb heat responsive sprinklers that are loaded with to clean sprinklers with any a vacuum provided that the crouch the sprinkler. Indicate the sprinklers ice could affect as many as 36 and 4 visitors. The sprinklers that are loaded with the sprinkler ice could affect as many as 36 and 4 visitors.	K 0353	1.The sprinkler heads will be cleaned or replaced for those cited. 2. All residents could be affed 3. Vendor has bee contacted take care of sprinkler heads paint, Maintenance will condition rounds to ensure the integrity the sprinkler heads are not compromised. 4. Maintenance when doing rounds will monitor heads for debris on sprinkler heads and remove if possible. He will refindings to QAPI Committee. 5> Completion Date 2/15/24	cted. I to with uct y of d

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/16/2024		
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	c) the bathroom spr had paint on it. d) the closet sprinkl had paint on it. e) the bathroom spr had paint on it. f) the corridor sprin had paint on the spr g) the sprinkler head #7 had paint on it. h) the sprinkler head #8 had paint on it. i) the sprinkler head #9 had paint on it. j) the sprinkler head #11 had paint on it. k) the sprinkler head #13 had paint on it. l) the sprinkler head #14 had paint on it. m) the sprinkler head #15 had paint on it. o) the sprinkler head #26 had paint on it. o) the sprinkler head #28 had paint on it. p) the sprinkler head #32 had paint on it. q) the center sprinkler head #31 had paint on it. r) the sprinkler head #32 had paint on it. q) the center sprinkler head the center had paint s) the sprinkler head the center had paint s) the sprinkler head t	er head in resident room #4 er head in resident room #5 inkler head in resident room #5 kler outside resident room #6 inkler head. d in the closet of resident room		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
	room have paint on u) the corridor sprin had paint on the spr	akler outside resident room #48 inkler head. d in the closet of resident room					

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Event ID:

TYW021

Facility ID: 000070

If continuation sheet

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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TO MHS 9 had paint on it. x) the two sprinkler heads in resident room #50 have paint on them. y) the sprinkler heads in the closet of resident room #59 had paint on it. z) the two sprinkler heads in resident room #60 have paint on them. ag) the six sprinkler heads in resident room #60 have paint on them. bb) the Clinical Educators office has paint on the sprinkler head in the closet. Based on an interview at the time of each observation, the Maintenance Supervisor stated that his vendor had made him aware of the painted sprinkler heads and they are working to have them replaced as soon as possible. This finding was reviewed with the Maintenance Supervisor and the Administrator at the exit conference. 3.1-19(b)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMP		E SURVEY PLETED		
HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (X5) W) the sprinkler head in the closet of resident room #49 had paint on it. x) the two sprinkler heads in resident room #50 have paint on them. y) the sprinkler heads in the closet of resident room #59 had paint on it. z) the two sprinkler heads in resident room #60 have paint on them. bb) the Clinical Educators office has paint on the sprinkler head in the closet. Based on an interview at the time of each observation, the Maintenance Supervisor stated that his vendor had made him aware of the painted sprinkler heads and they are working to have them replaced as soon as possible. This finding was reviewed with the Maintenance Supervisor and the Administrator at the exit conference. 3.1-19(b)	155149		B. W	B. WING			01/16/2024	
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Supervisor and the Administrator at the exit conference. 3.1-19(b)		This finding was reviewed with the Maintenance Supervisor and the Administrator at the exit						
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3.1-19(b)								
		conterence.						
		3.1-19(b)						
K 0374 NFPA 101	K 0374	NFPA 101						
SS=E Subdivision of Building Spaces - Smoke		_	lding Spaces - Smoke					
Bldg. 01 Barrie	Bldg. 01							
Subdivision of Building Spaces - Smoke		Subdivision of Bui	lding Spaces - Smoke					
Barrier Doors		Barrier Doors						
2012 EXISTING		2012 EXISTING						
Doors in smoke barriers are 1-3/4-inch thick		Doors in smoke ba	arriers are 1-3/4-inch thick					
solid bonded wood-core doors or of								
construction that resists fire for 20 minutes.								
Nonrated protective plates of unlimited height								
are permitted. Doors are permitted to have		-						
fixed fire window assemblies per 8.5. Doors								
are self-closing or automatic-closing, do not		•	<u> </u>					
		require latching, and are not required to swing						
in the direction of egress travel. Door opening								

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Event ID:

TYW021 Facility ID: 000070

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CENTERSTON	CALEBICANCE & ALEBIC	IIID SERVICES				01.12	D 110. 0700 007
STATEMEN	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. WIN	B. WING		01/16/2024	
			Щ,	_		,	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
				ARCOURT RD			
HARCOURT TERRACE NURSING AND REHABILITATION			INDIAN	APOLIS, IN 46260		1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1			TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION					DATE
	for swinging or ho	for swinging or horizontal doors.					
	19.3.7.6, 19.3.7.8	, 19.3.7.9					
	Based on observation	on and interview, the facility	K 0374		1 Maintenance immediately(on 01/16/24) adjusted doors in question so they would close		01/16/2024
	failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least						
	20 minutes. LSC 19.3.7.8 requires doors in smoke			properly.			
	barriers shall compl	ly with LSC Section 8.5.4. LSC		2 26 residents could be			
	8.5.4.1 requires doors in smoke barrier shall close				affected. All doors were inspe	cted	
	the opening leaving only the minimum clearance			to ensure proper closure by the			
	necessary for proper operation. This deficient			Maintenance Director.			
	practice could affect some residents going to the			3 Maintenance Director			
	Physical Therapy gym plus staff and visitors			immediately after survey was			
	while in the basement corridor and adjoining			completed adjusted doors so they			
	areas, including the kitchen and laundry area.			would close correctly.			
	and radially area.				4 During monthly drills the		
	Findings include:			Maintenance Director will mo		nitor	
					proper door closings to ensure		
	Based on observation	ons made during a tour of the			they are closing properly. He		
		at 12:50 p.m. during a tour with			report findings to Safety	•••	
	•	pervisor, the set of smoke			Committee and QAPI committee	-ee	
		Cedar Bay unit did not fully			for review and compliance		
		n three separate occasions.			5 Completed 1/16/24.		
		ch gap between the doors			0 00mpicted 1/10/24.		
		r fullest because the					
		function as intended. Based					
		the time of observations, the					
		tor acknowledged these smoke					
		ot close completely adding that					
		n services as soon as possible.					
	ne would have then	i sei vices as soon as possible.					
	This finding was re	viewed with the Administrator					
	at the exit conference						
	at the exit conferen						
	3.1-19(b)						

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