WEDICAKE & WEDIC				OMB NO. 0938-039		
IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED		
	155846	B. WING		03/08/2024		
		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL IN 46032				
ACT OF CARWEL		CARIVIE				
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
•		PREFIX	CROSS-REFERENCED TO THE APPROPRI			
REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
conducted by the In accordance with 42	diana Department of Health in CFR 483.73.	E 0000				
Provider Number: AIM Number: 201: At this Emergency Restoracy of Carme with Emergency Pro Medicare and Medi	155846 362150  Preparedness survey, el was found not in compliance eparedness Requirements for caid Participating Providers					
The facility has 72 of the survey, the cense Quality Review corns 403.748(b)(8), 416 (iv), 441.184(b)(8), 483.73(b)(8), 47), 494.62(b)(7) Roles Under a Wa §403.748(b)(8), §4 (C)(iv), §441.184(l) §482.15(b)(8), §4 §485.625(b)(8), §4 [(b) Policies and preparedness polion the emergency	certified beds. At the time of sus was 71.  mpleted on 03/12/24  6.54(b)(6), 418.113(b)(6)(C)  6.54(b)(6), 483.475(b)  6.5625(b)(8), 485.920(b)  aiver Declared by Secretary  6.54(b)(6), §418.113(b)(6)  6.54(b)(6), §460.84(b)(9),  6.373(b)(8), §483.475(b)(8),  6.485.920(b)(7), §494.62(b)(7).  corocedures. The [facilities]  implement emergency  ficies and procedures, based  or plan set forth in paragraph					
֡	An Emergency Preconducted by the Irraccordance with 42 Survey Dates: 03/0 Facility Number: 0 Provider Number: AIM Number: 201 At this Emergency Predictor Neglicity Provider Number: AIM Number: 42 Compared to the survey of Carmon with Emergency Provider Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 42 Compared to the survey, the censure of Carmon Number: 43 Compared to the survey, the censure of Carmon Number: 44 Compared to the Survey of Carmon Number: 44 Compared to the Survey of Carmon Number: 45 Compared to the Survey of Carmon Numb	DEF CORRECTION IDENTIFICATION NUMBER 155846  ROVIDER OR SUPPLIER  ACY OF CARMEL  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Dates: 03/07/24 and 03/08/24  Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150  At this Emergency Preparedness survey, Restoracy of Carmel was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 72 certified beds. At the time of the survey, the census was 71.  Quality Review completed on 03/12/24  403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C) (iv), 441.184(b)(8), 482.15(b)(8), 483.475(b) (8), 483.73(b)(8), 485.625(b)(8), 485.920(b)	TOF DEFICIENCIES DF CORRECTION  IDENTIFICATION NUMBER  155846  ROYOF CARMEL  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Dates: 03/07/24 and 03/08/24  Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150  At this Emergency Preparedness survey, Restoracy of Carmel was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 72 certified beds. At the time of the survey, the census was 71.  Quality Review completed on 03/12/24  403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C) (iv), 441.184(b)(8), 485.625(b)(8), 485.920(b) (7), 494.62(b)(7)  Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6) (C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.73(b)(8), §483.75(b)(8), §485.625(b)(8), §485.920(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph	TO F DEFICIENCIES DE CORRECTION DENTIFICATION NUMBER 155846  ROVIDER OR SUPPLIER ACY OF CARMEL  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Dates: 03/07/24 and 03/08/24  Facility Number: 155846 AIM Number: 201362150  At this Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 72 certified beds. At the time of the survey, the census was 71.  Quality Review completed on 03/12/24  403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C) (iv), 441.184(b)(8), 485.625(b)(8), 485.920(b) (7), 494.62(b)(7) ROSS REFINENCE TO THE APPROPRIATE CONTROL OF THE APPROPRIAT		

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

TITLE (X6) DATE

Ryan Levengood Executive Director 03/25/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2024			
		ROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
	(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		section. The policible reviewed and departs [annually forminimum, the policible address the follows:  (8) [(6), (6)(C)(iv), [facility] under a weak Secretary, in accordance with a procedures. (8) The waiver declared by accordance with a provision of care a sidentified by emergation of care as identified by emergation of the care and treatment at identified by emergation and treatment at its process and treatment at identified by emergation and treatment at its process.	(7), or (9)] The role of the raiver declared by the ordance with section 1135 provision of care and ternate care site identified nagement officials.  (403.748(b):] Policies and the role of the RNHCI under a	E 00	026	Disclaimer: This Plan of Correction constitt this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure the Emergency Preparedness Plan (EPP) included the role of the LTC faunder a waiver declared by the Secretary, in accordance with	of s this ists ts	04/02/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This finding was re Director and Maint	Id not locate this paperwork.  Eviewed with the Executive enance Director at the time of a during the exit conference on		corrective Action for resider found to have deficiency: Till 1135 waiver was placed in the EPP Binders on 3/18/2024.	he
				Identify other residents havi the same potential deficienc An audit was conducted of 6 Cottages EEP Binders. The a identified that all 6 EEP Binde were missing the 1135 waiver EEP Binders now have the 11 waiver.	y: of 6 audit rs
				Measures put into place or systemic changes: As of 3/18/2024 all EPP Binders inc the 1135 waiver	clude
				Plan to monitor performance to maintain compliance: No monitoring required as the deficiency is corrected. Exect Director will review EPP 1x per year to ensure 1135 waiver is included in EPP Binder.	utive er
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital must standby power sy emergency plan s this section and ir	ILTC Emergency Power tion for Participation: and standby power systems. It implement emergency and stems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1)			

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155846		A. BUILDING  B. WING			COMPLETED 03/08/2024		
	PROVIDER OR SUPPLIER			616 GR	.DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY L, IN 46032		
(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	The [LTC facility a implement emergy systems based or forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requirement and Tile 12-4, Tile 12-5, and Code (NFPA 101 Amendments Tile 12-4), and structure is built of structure or building 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, Norde.  482.15(e)(3), §483 Emergency gener and LTC facilities source to power end LTC facilities] source to power end the power systems open emergency, unless *[For hospitals at §483.73(g), and Compare the systems of the power systems open emergency, unless *[For hospitals at §483.73(g), and Compare the systems of the power systems open emergency, unless *[For hospitals at §483.73(g), and Compare the systems of the power systems of the	d standby power systems. and the CAH] must ency and standby power a the emergency plan set (a) of this section.  33.73(e)(1), §485.625(e)(1) ator location. The e located in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system in, and [maintenance] and in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs ithat maintain an onsite fuel imergency generators must it will keep emergency iderational during the					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846		UILDING	NSTRUCTION	(X3) DATE COMPI 03/08		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
	reference by the I Federal Register is 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information Reson this material at NA go to:  http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characteristic (1) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000.  (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NF 2012.  (iv) TIA 12-4 to NF 2013.  (v) TIA 12-5 to NF 2013.  (vi) TIA 12-6 to NF 2014.  (viii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to NF 11, 2011.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	LETED
		155846	B. W.	NG		03/08	/2024
NAME OF I	DROWIDER OF CUIRDLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF			616 GR	REEN HOUSE WAY		
RESTOR	ACY OF CARMEL			CARME	EL, IN 46032		
(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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	l ` '	PA 101, issued October					
	22, 2013.	EDA 101 issued October					
	(xi) 11A 12-4 to Ni 22, 2013.	FPA 101, issued October					
	1	standard for Emergency and					
	1 ' '	ystems, 2010 edition,					
		chapter 7, issued August 6,					
	2009						
	Based on record review and interview, the facility E 004		)41	Disclaimer:		04/02/2024	
	failed to implement the emergency power system				This Plan of Correction constit	utes	
	inspection, testing,	and maintenance requirements			this facility's written allegation	of	
	found in the Health	Care Facilities Code, NFPA			compliance for the deficiencie	s	
	110, and Life Safety Code in accordance with 42				cited. However, submission of	this	
	CFR 483.73(e)(2). This deficient practice could				Plan of Correction is not an		
	affect all occupants				admission that a deficiency ex		
					or that one was cited correctly		
	Findings include:				This Plan of Correction is		
	D 1	ta a set.			submitted to meet requiremen	ts	
		eview with the Maintenance			established by the state and		
		Executive Director (ED) on /24 documentation of a			federal law.		
		or the emergency generator			Alleged deficiency: Egiled to		
		ne last 36 months was not			Alleged deficiency: Failed to ensure a four-hour run test for		
		7. Based on interview at the			emergency generator was	uic	
	1 ~	iew, the Maintenance Director			conducted within the last 36		
		ties contractor on each day of			months.		
		not get a response and finally					
		on of a four-hour continuous			Corrective Action for resider	nt(s)	
	run conducted in th	e past 36 months was not			found to have deficiency: On		
	available for review	at the time of the survey.			3/18/2024 The Maintenance		
					Director performed a four-hou	r run	
		viewed with the Executive			test for the six emergency		
		enance Director at the time of			generators. An issue was		
		during the exit conference on			identified in Cottage #6's		
	03/08/24.				generator. Buckey Power		
					Systems was notified of the is		
					with Cottage #6's generator a		
					they are scheduled to come th		
					week to correct the issue. No		
					other issues were identified.		İ

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155846	B. W	ING		03/08/	2024
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	_	
			616 GREEN HOUSE WAY				
RESTOR	ACY OF CARMEL		CARMEL, IN 46032				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					Identify other residents havi	na	
					the same potential deficienc	_	
					On 3/18/2024 the Maintenand	-	
					Director conducted an audit to		
					ensure 6 of 6 generators had		
					four-hour run test conducted v		
					the past 36 months and found	l that	
					none of the generators were i		
					compliance with this regulatio		
					On 3/18/2024 The Maintenan		
					Director performed a four-hou	r run	
					test for the six emergency		
					generators. An issue was identified in Cottage #6's		
					generator. Buckey Power		
					Systems was notified of the is	sue	
					with Cottage #6's generator a		
					they are scheduled to come the		
					week to correct the issue. No		
					other issues were identified.		
					Measures put into place or		
					systemic changes: The		
					maintenance director placed a	a	
					preventative maintenance ren		
					into our TELS System on	-	
					3/18/2024 to have a four-hour	run	
					test performed on all 6 of the		
					generators every 36 months.		
					Plan to monitor performance	o to	
					maintain compliance: The	<del>,</del> 10	
					Executive Director or designe	e will	
					do a monthly audit of all requi		
					TELS preventative maintenan		
					tasks x6 months to ensure 10		
					compliance of completion of		
					preventative maintenance tas	ks.	
					The results of the audit will be	<b>;</b>	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155846		A. BUILDING B. WING			COMPLETED 03/08/2024		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RESTOR	ACY OF CARMEL				EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX CROSS-REFERENCED TO THE APPROPI  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		ΓE	(X5) COMPLETION DATE
					submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.		
K 0000							
Bldg. 01	Licensure Survey w Department of Health 483.90(a).  Survey Dates: 03/0  Facility Number: 0 Provider Number: 1 AIM Number: 2013  At this Life Safety C Carmel was found in Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa  The facility consists 06). Each building is determined to be of was fully sprinklere system with smoke a reas open to the co- detectors in the resid has a capacity of 72 time of this survey.	13753 155846 162150 Code survey, Restoracy of ot in compliance with articipation in 142 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  of six buildings (01 through as a one-story cottage Type V (111) construction and d. Each cottage has a fire alarm detection in the corridors, rridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the	K 0	000			
		dents have customary access d all areas providing facility					

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	T OF HEALTH AND HU R MEDICARE & MEDIC					ORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULT A. BUILI B. WING	TIPLE CONSTRUCTION DING 01	COM	(X3) DATE SURVEY COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIE		6	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032			
	1					T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE LE APPROPRIATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	Т	AG DEFICIENCY)		DATE	
	_	klered, with exception of a administration building.					
	_	atified as Cottage #2. The city of 12 and had a census of is survey.					
	Quality Review completed on 03/12/24						
K 0211 SS=F Bldg. 01	11 NFPA 101 FF Means of Egress - General		K 021	Disclaimer: This Plan of Correction this facility's written a compliance for the decited. However, submitted in the plan of Correction is admission that a definition or that one was cited. This Plan of Correction submitted to meet recestablished by the stafederal law.	allegation of eficiencies mission of this not an ciency exists correctly. on is quirements	04/02/2024	
	facilities led to the of the garage, which	facility exits, in each of the 6 driveway parking area in front th in some cases had cars way and obstructed access to		Alleged deficiency: ensure 1 of 3 exit dis	charge paths		

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the public way. The MD stated that in the past he

believed NO PARKING signs had been installed

to prevent people from parking where the sidewalk terminated into the driveway at each of the 6

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accessible.

public way was always readily

Corrective Action for resident(s)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  03/08/2024				
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(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)	(X5) COMPLETION DATE		
	buildings and stated This finding was re Director and Maint	I that this would be corrected.  viewed with the Executive enance Director at the time of a during the exit conference on		found to have deficiency: The vehicle identified obstructing to discharge path that leads from garage to the public way was relocated.  Measures put into place or systemic changes: On 3/19/2024 the maintenance director permanently affixed "I Parking Signs" on the 6 Cottar garage doors. During daily roanyone observed parking in the exit discharge paths that lead the garage to the public way wimmediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked facility grounds to audit/inspectany of the exit discharge path that lead from the garage to the public way was readily access and he found no other concered. Plan to monitor performance maintain compliance: The maintenance director or design will audit the exit discharge path that lead from the garage to the public way to ensure all are always readily accessible 5 x week for 1 month, 3 x a week months, and 2 x a week for 3 months.  The results of the audit will be submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will reviewed in QAPI meetings.	No ge unds ne from will cate e our ct if s ne sible ns.  • to nee aths ne per for 2		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155846	B. WI	NG		03/08/	/2024
NAME OF PROVIDER OR SUPPLIER  RESTORACY OF CARMEL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		STATEMENT OF DEFICIENCIE	<u> </u>	616 GF CARMI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA	.TE	
PREFIX TAG K 0761 SS=F Bldg. 01	Based on observation interview, the facility inspection and testing assemblies were considered in the same of the	on, records review, and ty failed to ensure annual ng of at least 1 fire door impleted in accordance of LSC inicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies.  3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, semblies and fire window in accompanying hardware, so, closing devices, anchorage, ince with the requirements of a for Fire Doors and Other so, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not	K 0	TAG 761	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure annual inspection for the fire door assembly at the Oxyg Transfilling rooms for each of buildings.	tutes of s f this tists tis he gen the 6	O4/02/2024
	less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:  (1) No open holes or breaks exist in surfaces of either the door or frame.  (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.  (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.				Corrective Action for resider found to have deficiency: The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. An inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of buildings were conducted on 3/18/2024.  Identify other residents having same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each the 6 building's fire door	nual the 6	

(4) No parts are missing or broken.

(5) Door clearances do not exceed clearances

assemblies at the Oxygen

Transfilling rooms. No concerns

NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/08/2024
PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	•
SUMMARY (EACH DEFICIENT REGULATORY OF LIsted in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open process of the active door comfrom the full open process before the active door when it is in the self-closing hardward door when it is in the self-closes before the active door	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 5.3.1.7. g device is operational; that is, upletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the	616 GF	REEN HOUSE WAY	pr placed e task ct fire ygen of the 6  ce to linee will quired hance 100% of tasks. be hmittee ce
Oxygen Transfilling Based on observation 6 buildings had a tragarage and each Oxone 90-minute fire interview at the time observation, the MI inspection was not for the Oxygen Rocon This finding was reached birector and Mainterview and observation.	g room was available for review. on during the tour each of the ansfilling room located in the tygen Transfilling room has door assembly. Based on e of records review and O stated an annual fire door completed within the last year		reviewed in QAPI meeting.	
3.1-19(b)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIE		616	ET ADDRESS, CITY, STATE, ZIP ( GREEN HOUSE WAY RMEL, IN 46032	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DUE OF THE VINCE DIFFERENCE OF THE VINCE	ID PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION
K 0918 SS=F Bldg. 01	NFPA 101 Electrical System Electrical System System Maintena The generator or source and assoc of supplying servi 10-second criteric monthly test, a pr annually confirm safety and critical and testing of the switches are perf NFPA 110. Generator sets are exercised under I year in 20-40 day once every 36 mc Scheduled test un a complete simula automatic or man loads, and are co personnel. Mainte energy power sou accordance with circuit breakers a program for perio components is es manufacturer req of maintenance a and readily availa and circuits are m and separate from Minimizing the po- emergency powe consideration for 6.4.4, 6.5.4, 6.6.4	cother alternate power stated equipment is capable ce within 10 seconds. If the on is not met during the ocess shall be provided to this capability for the life branches. Maintenance generator and transfer ormed in accordance with re inspected weekly, oad 30 minutes 12 times a intervals, and exercised onths for 4 continuous hours. Inder load conditions include ated cold start and ual transfer of all EES inducted by competent enance and testing of stored arces (Type 3 EES) are in NFPA 111. Main and feeder re inspected annually, and a dically exercising the stablished according to uirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, in normal power circuits. In the provided in the resource is a design new installations.  (NFPA 99), NFPA 110,	TAG			DATE
		O (NFPA 70) view and interview, the facility of 1 Emergency Power	K 0918	<b>Disclaimer:</b> This Plan of Correctio	n constitutes	04/02/2024

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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 B. WING 03/08/2024 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Standby System in accordance with NFPA 110, this facility's written allegation of Standard for Emergency and Standby Power compliance for the deficiencies Systems, Section 8.4.9, as required by NFPA 99 cited. However, submission of this Health Care Facilities Code, Section 6.4.1.1.6.1. Plan of Correction is not an NFPA 110 Section 8.4.9 states that all Level 1 admission that a deficiency exists Emergency Power Systems shall be tested at least or that one was cited correctly. once within every three years. Where the This Plan of Correction is assigned class is greater than 4 hours, it shall be submitted to meet requirements permitted to terminate the test after 4 hours. established by the state and NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and federal law. Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 Alleged deficiency: Failed to generator sets. This deficient practice could ensure a four-hour run test for the affect all 12 residents. emergency generator was conducted within the last 36 Findings include: months. Based on records review with the Maintenance Corrective Action for resident(s) Director (MD) and Executive Director (ED) on found to have deficiency: On 03/07/24 and 03/08/24 documentation of a 3/18/2024 The Maintenance four-hour run test for the emergency generator Director performed a four-hour run conducted within the last 36 months was not test for the six emergency provided for review. Based on interview at the generators. An issue was time of records review, the Maintenance Director identified in Cottage #6's contacted the facilities contractor on each day of generator. Buckey Power the survey but did not get a response and finally Systems was notified of the issue stated documentation of a four-hour continuous with Cottage #6's generator and run conducted in the past 36 months was not they are scheduled to come this available for review at the time of the survey. week to correct the issue. No other issues were identified. This finding was reviewed with the Executive Director and Maintenance Director at the time of Identify other residents having discovery and again during the exit conference on the same potential deficiency: 03/08/24. On 3/18/2024 the Maintenance Director conducted an audit to 3.1-19(b) ensure 6 of 6 generators had a four-hour run test conducted within the past 36 months and found that none of the generators were in

compliance with this regulation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2024			
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD			
RESTOR	ACY OF CARMEL		616 GREEN HOUSE WAY CARMEL, IN 46032				
(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 APPROPRI DEFICIENCY)			
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	On 3/18/2024 The Maintenan Director performed a four-houtest for the six emergency generators. An issue was identified in Cottage #6's generator. Buckey Power Systems was notified of the is with Cottage #6's generator at they are scheduled to come to week to correct the issue. Not other issues were identified with eother generators.  Measures put into place or systemic changes: The maintenance director placed apreventative maintenance reminto our TELS System on 3/18/2024 to have a four-hout test performed on all 6 of the generators every 36 months.  Plan to monitor performance maintain compliance: The Executive Director or designed of a monthly audit of all required TELS preventative maintenant tasks x6 months to ensure 10 compliance of completion of preventative maintenance tase The results of the audit will be submitted to the QAPI Commance Quarterly. If any compliance trends are identifit they will be reviewed in QAPI meeting.	essue nd nis nith  a ninder run  e to e will red nce 0% ks. e ittee ed,		
K 0000							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155846	B. W	NG		03/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				EEN HOUSE WAY		
RESTORACY OF CARMEL					EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 02		D 10 1 10					
	-	Recertification and State	K 0	000			
	_	as conducted by the Indiana					
	Department of Health in accordance with 42 CFR 483.90(a).						
	Survey Dates: 03/0	7/24 and 03/08/24					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 2013	362150					
	At this Life Safety Code survey, Restoracy of						
	Carmel was found not in compliance with						
	Requirements for Pa	-					
		, 42 CFR Subpart 483.90(a),					
	-	re and the 2012 edition of the					
		etion Association (NFPA) 101,					
		SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Health Care Occupa	theres and 410 IAC 10.2.					
	The facility consists	of six buildings (01 through					
	_	s a one-story cottage					
	determined to be of	Type V (111) construction and					
	was fully sprinklere	d. Each cottage has a fire alarm					
	system with smoke	detection in the corridors,					
	areas open to the co	rridors and hard-wired smoke					
	detectors in the resid	dent rooms. The entire facility					
		and had a census of 72 at the					
	time of this survey.						
	All areas where resi	dents have customary access					
		d all areas providing facility					
	_	klered, with exception of a					
	_	dministration building.					
	Building 02 is ident	ified as Cottage #3. The					
		ty of 12 and had a census of					
		s survey. This Cottage serves					
	as the Memory Care	e building for this facility.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155846		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/08/2024	
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL	<del></del>	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIE IST BE PRECEDED BY FULL DENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E IATE	(X5) COMPLETION DATE	
Quality Review complete  K 0211  NFPA 101  Means of Egress - Gen  Aisles, passageways, or  discharges, exit location in accordance with Cha of egress is continuous all obstructions to full us emergency, unless mod through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1  Based on observation and failed to ensure 1 of 3 exi lead from the garage to th accessible at all times. Th could affect all residents in  Findings include:  Based on observation and of the facility with the Ma and Executive Director (E 03/08/24 the exit discharge exit doors, marked facility facilities led to the drivew of the garage, which in so parked in the driveway and the public way. The MD is believed NO PARKING is to prevent people from pa terminated into the drivey buildings and acknowledge corrected.  This finding was reviewed Director and Maintenance discovery and again during	eral eral orridors, exit ns, and accesses are pter 7, and the means ly maintained free of se in case of diffied by 18/19.2.2  interview, the facility t discharge paths that e public way was readily nis deficient practice in the facility.  interview during a tour aintenance Director (MD) ED) on 03/07/24 and ge paths from the garage y exits, in each of the 6 vay parking area in front one cases had cars and obstructed access to stated that in the past he signs had been installed rking where the sidewalk vay at each of the 6 ged that this would be  d with the Executive e Director at the time of	K 02	211	Disclaimer: This Plan of Correction consthis facility's written allegatio compliance for the deficiencicited. However, submission of Plan of Correction is not an admission that a deficiency or that one was cited correct. This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed the ensure 1 of 3 exit discharge that lead from the garage to public way was always readinaccessible.  Corrective Action for reside found to have deficiency: The vehicle identified obstructing discharge path that leads from garage to the public way was relocated.	n of es of this exists ly. ents  co paths the ly ent(s) he the m the	04/02/2024	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY  COMPLETED  03/08/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
RESTORACY OF CARMEL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  03/08/24.  3.1-19(b)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  Measures put into place or systemic changes: On 3/19/2024 the maintenance director permanently affixed Parking Signs" on the 6 Cott garage doors. During daily r anyone observed parking in exit discharge paths that lear the garage to the public way immediately be asked to relo their vehicle. On 3/20/2024 t Maintenance Director walked facility grounds to audit/insper any of the exit discharge pat that lead from the garage to public way was readily acces and he found no other conce	"No age rounds the d from will bocate he d our ect if hs the ssible erns.			
K 0271 SS=F Bldg. 02	=F Discharge from Exits			maintenance director or desi will audit the exit discharge public way to ensure all are always readily accessible 5 week for 1 month, 3 x a week months, and 2 x a week for 3 months.  The results of the audit will be submitted to the QAPI Commounterly. If any compliance trends are identified, they will reviewed in QAPI meetings.	paths the  k per k for 2 3 ee nittee		

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	T OF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2024	
NAME OF	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY				
RESTOR	RACY OF CARMEL			CARM	EL, IN 46032		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	changes in elevate free of obstruction discharge shall be travel surface.  18.2.7, 19.2.7  Based on observation failed to ensure 1 or walking surface, we constructed of hard surface in accordant Certification Letter could affect all 12 m.  Findings include:  Based on observation of the facility with the facility with the facility exit had a lawas uneven where the Based on interview MD and ED acknown in need of repair to surface that was free common way.  This finding was re Director and Mainter	R LSC IDENTIFYING INFORMATION ion and shall be maintained as. Additionally, the exit a hard packed all-weather on and interview, the facility of 3 exit discharges had a level ere free of obstructions, and packed all-weather travel ce with CMS Survey and 05-38. This deficient practice residents.  The Maintenance Director (MD) exter (ED) on 03/08/24 at 0 a.m. the Cottage #3 exit garage exit door, marked a large gap in the concrete and the sections seamed together. at the time of observation, the wledged that the walkway was have a complete level walking the of trip hazards leading to the viewed with the Executive enance Director at the time of a during the exit conference on	K 0	271	Disclaimer: This Plan of Correction constitution facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Facility failed to ensure 1 of 3 exit discharge paths had a level walking surface. Cottage #3 exit door had a large gap in the concrete and was uneven whethe sections seamed together.  Corrective Action for resider found to have deficiency: Or 4/2/2024 a company will inspect to the garage exit door. On before 5/15/2024 the identified discharge path located outside Cottage #3 will be corrected a will have a level walking surface.	tutes of es f this kists /. hts  nt(s) n ect h or d exit e of ind	04/02/2024

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Identify other residents having the same potential deficiency: On 3/19/2024 the Maintenance

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155846	B. W	ING		03/08/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R	616 GREEN HOUSE WAY				
RESTOR	ACY OF CARMEL		CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Director audited all exit discha		
					paths to ensure all exit discha	-	
					paths had a level walking surf		
					The audit identified an exit par		
					front of Cottage #2 that had a nonlevel walking surface. The		
					nonlevel walking surface. The nonlevel walking path in front		
					Cottage #2 will be corrected o		
					before 5/15/2024. All other ex		
					were found to be in compliand		
					Measures put into place or		
					systemic changes: The		
					Maintenance Director placed	a	
					Quarterly task in TELS Syster	n to	
					inspect all exit discharge path	s to	
					ensure a level walking surface		
					Any identified concerns relate	d to	
					level walking surfaces will be		
					corrected.		
					Plan to monitor performance t	0	
					maintain compliance:		
					The Maintenance Director or		
					designee will perform an audit		
					Quarterly of the exit discharge		
					paths to ensure they have a le		
					walking surface. Results of the	е	
					audit will be submitted to the	·	
					QAPI Committee Quarterly. If	•	
					compliance trends are identification that will be reviewed in OARI	ea,	
					they will be reviewed in QAPI meetings.		
					mocungs.		
K 0761 SS=F							
Bldg. 02							
	Based on observation	on, records review, and	K 0	761	Disclaimer:		04/02/2024
		ity failed to ensure annual			This Plan of Correction consti	tutes	
		ng of at least 1 fire door			this facility's written allegation	of	

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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. B	A. BUILDING <u>02</u>			COMPLETED	
		155846	B. W	ING	03/08/2024			
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8	616 GREEN HOUSE WAY					
RESTOR	ACY OF CARMEL				EL, IN 46032			
(VA) ID	OID B (A D.Y.	CTATEMENT OF DEFICIENCIE			1	ı	(VE)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
TAG		mpleted in accordance of LSC	+	TAG	compliance for the deficiencie		DATE	
		unicating openings in dividing			cited. However, submission of			
		d by 19.1.1.4.1 shall be			Plan of Correction is not an	i triis		
	_	orridors and shall be protected			admission that a deficiency ex	viete		
	1 -	osing fire door assemblies.			or that one was cited correctly			
		3.) LSC 8.3.3.1 Openings			This Plan of Correction is	′•		
	1	ire protection rating by Table			submitted to meet requiremen	nte		
	_	tected by approved, listed,			established by the state and	ii.		
	_	semblies and fire window			federal law.			
		r accompanying hardware,			logorariaw.			
		s, closing devices, anchorage,			Alleged deficiency: Failed to	,		
		nce with the requirements of			ensure annual inspection for t			
	NFPA 80, Standard for Fire Doors and Other				fire door assembly at the Oxy			
	i i	s, except as otherwise			Transfilling rooms for each of	-		
		de. NFPA 80 5.2.1 states fire			buildings.			
	_	all be inspected and tested not						
		and a written record of the			Corrective Action for resider	nt(s)		
	1	signed and kept for inspection			found to have deficiency: Th			
	_	80, 5.2.4.1 states fire door			Maintenance Director became			
		visually inspected from both			certified to inspect fire door			
	sides to assess the o	overall condition of door			assemblies on 3/18/2024. An	nual		
	assembly. NFPA 80	), 5.2.4.2 states as a minimum,			inspections for the fire door			
	the following items	shall be verified:			assemblies at the Oxygen			
	(1) No open holes o	or breaks exist in surfaces of			Transfilling rooms for each of	the 6		
	either the door or fr	ame.		buildings were conducted on				
	(2) Glazing, vision	light frames, and glazing beads			3/18/2024.			
		ely fastened in place, if so						
	equipped.				Identify other residents having	g the		
		, hinges, hardware, and			same potential deficiency: Or	1		
		eshold are secured, aligned,			3/18/2024 The Maintenance			
	and in working orde	er with no visible signs of			Director audited/inspected ea	ch of		
	damage.				the 6 building's fire door			
	(4) No parts are mis				assemblies at the Oxygen			
	1 1	do not exceed clearances			Transfilling rooms. No concert	ns		
	listed in 4.8.4 and 6				were identified during the			
		device is operational; that is,			audit/inspection.			
		pletely closes when operated						
	from the full open p				Measures put into place or			
	1 1	is installed, the inactive leaf			systemic changes:			
closes before the active leaf.					The Maintenance Director pla	ced		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/08/2024	
	PROVIDER OR SUPPLIER		616	EET ADDRESS, CITY GREEN HOUS RMEL, IN 46032	SE WAY	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC	X (EACH CORE CROSS-REFE	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(8) Latching hardward door when it is in the (9) Auxiliary hardward prohibit operation as frame. (10) No field modification have been performed (11) Gasketing and inspected to verify the This deficient practice residents.  Findings include:  Based on records residents.  Findings include:  Based on records residents.  Findings include:  Based on records residents.  Govern (MD) and 03/07/24 and 03/08 annual inspection for Oxygen Transfilling Based on observation 6 buildings had a tragarage and each Oxone 90-minute firest interview at the time observation, the MI inspection was not of for the Oxygen Rocom This finding was responded to Director and Mainton discovery and again 03/08/24.  3.1-19(b)	are operates and secures the second position.  For are items that interfere or re not installed on the door assembly at the respect of the record of the record of the respect to the record of the respect to the respect		a preventa into TELS door asser Transfilling buildings a Plan to mo maintain or Executive do a month TELS preventasks x6 m compliance preventation. The results submitted Quarterly, trends are	ative maintenance ta System to inspect fi mblies at the Oxyge g rooms for each of the annually.  In the performance to the compliance: The performance to the district of all requirements to ensure 100 and the completion of the maintenance tasks of the audit will be to the QAPI Commillary compliance identified, they will in QAPI meeting.	isk ire n the 6  e will red ce 0% ks.
K 0918 SS=F Bldg. 02	Electrical Systems System Maintena	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155846		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 03/08/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(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		
	of supplying service 10-second criterion monthly test, a programmal confirm the safety and critical and testing of the switches are performed in the switches are personned in the switches are complete simular automatic or manulated in the switches are personnel. Mainten in the switches are program for period components is estimated in the switches are program for period components is estimated in the switches are manufacturer required in the switches are manufactured in the s	ual transfer of all EES inducted by competent nance and testing of stored rces (Type 3 EES) are in IFPA 111. Main and feeder in inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits.					
	failed to maintain 1 Standby System in a Standard for Emerg Systems, Section 8. Health Care Faciliti	riew and interview, the facility of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1.	K 0918	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex	of s this		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY  COMPLETED  03/08/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  PREFIX  GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	Emergency Power Sonce within every the assigned class is greepermitted to termina NFPA 99 Section 6 Type 2 essential eleshall be classified a generator sets. This affect all 12 resident Findings include:  Based on records reduced Director (MD) and 03/07/24 and 03/08, four-hour run test for conducted within the provided for review time of records reviewed to the facilitation of the survey but did not stated documentation run conducted in the available for reviewed This finding was reduced to the survey but did not stated the facilitation of the survey but did not stated documentation run conducted in the available for reviewed This finding was reduced to the survey but did not stated documentation run conducted in the available for reviewed This finding was reduced to the survey but did not stated documentation run conducted in the available for reviewed This finding was reduced to the survey but did not stated documentation and	Systems shall be tested at least three years. Where the eater than 4 hours, it shall be atte the test after 4 hours.  4.1.1.6.1 states that Type 1 and actrical system power sources to Type 10, Class X, Level 1 and deficient practice could	TAG	or that one was cited correct. This Plan of Correction is submitted to meet requireme established by the state and federal law.  Alleged deficiency: Failed the ensure a four-hour run test for emergency generator was conducted within the last 36 months.  Corrective Action for reside found to have deficiency: Constitution of the six emergency generators. An issue was identified in Cottage #6's generator. Buckey Power Systems was notified of the inwith Cottage #6's generator. Buckey Power Systems was notified of the inwith Cottage #6's generator at they are scheduled to come week to correct the issue. Nother issues were identified.  Identify other residents have the same potential deficient on 3/18/2024 the Maintenan Director conducted an audit the ensure 6 of 6 generators had four-hour run test conducted the past 36 months and foun none of the generators were compliance with this regulation on 3/18/2024 The Maintenan Director performed a four-houtest for the six emergency generators. An issue was	porting cy: ce to I a within d that in on. nce		
ı	I		1	identified in Cottage #6's			

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155846		A. BUILDING B. WING	02	COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(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)	(X5) COMPLETION DATE
				generator. Buckey Power Systems was notified of the is with Cottage #6's generator a they are scheduled to come the week to correct the issue. No other issues were identified we the other generators.	nd nis
				Measures put into place or systemic changes: The maintenance director placed a preventative maintenance reninto our TELS System on 3/18/2024 to have a four-hour test performed on all 6 of the generators every 36 months.	ninder
				Plan to monitor performance maintain compliance: The Executive Director or designe do a monthly audit of all requi TELS preventative maintenant tasks x6 months to ensure 10 compliance of completion of preventative maintenance tas The results of the audit will be submitted to the QAPI Comm Quarterly. If any compliance trends are identifithey will be reviewed in QAPI meeting.	e will red oce 0% ks. e iittee
K 0000					
Bldg. 03	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		ľ	UILDING	nstruction  03	(X3) DATE COMPL 03/08/	ETED		
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Survey Dates: 03/0	7/24 and 03/08/24						
	Facility Number: 0 Provider Number: AIM Number: 201	155846						
	Carmel was found a Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code (I	Code survey, Restoracy of not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.						
	06). Each building determined to be of was fully sprinklere system with smoke areas open to the codetectors in the resi	s of six buildings (01 through is a one-story cottage. Type V (111) construction and ed. Each cottage has a fire alarm detection in the corridors, orridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the						
	were sprinklered an services were sprink	idents have customary access d all areas providing facility klered, with exception of a dministration building.						
	_	tified as Cottage #1. The ity of 12 and had a census of s survey.						
	Quality Review cor	mpleted on 03/12/24						
K 0211 SS=F Bldg. 03	NFPA 101 Means of Egress Means of Egress							

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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 03 B. WING 03/08/2024 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility K 0211 Disclaimer: 04/02/2024 failed to ensure 1 of 3 exit discharge paths that This Plan of Correction constitutes lead from the garage to the public way was readily this facility's written allegation of accessible at all times. This deficient practice compliance for the deficiencies could affect all residents in the facility. cited. However, submission of this Plan of Correction is not an Findings include: admission that a deficiency exists or that one was cited correctly. Based on observation and interview during a tour This Plan of Correction is of the facility with the Maintenance Director (MD) submitted to meet requirements and Executive Director (ED) on 03/07/24 and established by the state and 03/08/24 the exit discharge paths from the garage federal law. exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front Alleged deficiency: Failed to of the garage, which in some cases had cars ensure 1 of 3 exit discharge paths parked in the driveway and obstructed access to that lead from the garage to the the public way. The MD stated that in the past he public way was always readily believed NO PARKING signs had been installed accessible. to prevent people from parking where the sidewalk terminated into the driveway at each of the 6 Corrective Action for resident(s) buildings and acknowledged that this would be found to have deficiency: The corrected. vehicle identified obstructing the discharge path that leads from the This finding was reviewed with the Executive garage to the public way was Director and Maintenance Director at the time of relocated. discovery and again during the exit conference on 03/08/24. Measures put into place or systemic changes: On 3.1-19(b) 3/19/2024 the maintenance director permanently affixed "No Parking Signs" on the 6 Cottage garage doors. During daily rounds

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  IG 03	(X3) DATE SURVEY COMPLETED 03/08/2024		
	ROVIDER OR SUPPLIER		616	EET ADDRESS, CITY, STATE, ZIP COD 3 GREEN HOUSE WAY RMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPR	LD BE	(X5) COMPLETION DATE
				anyone observed parking exit discharge paths that the garage to the public wimmediately be asked to their vehicle. On 3/20/202 Maintenance Director wal facility grounds to audit/in any of the exit discharge that lead from the garage public way was readily act and he found no other compliance: To maintenance director or will audit the exit discharge that lead from the garage public way to ensure all a always readily accessible week for 1 month, 3 x a wimonths, and 2 x a week fronths.  The results of the audit wis submitted to the QAPI Co Quarterly. If any compliantereds are identified, they reviewed in QAPI meeting	lead from vay will relocate 24 the ked our spect if paths to the cessible neerns.  ance to he lesignee le paths to the re 5 x per veek for 2 or 3 ill be simmittee nee will be	
K 0321 SS=E Bldg. 03	barrier having 1-he (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatoption is used, the from other spaces	- Enclosure are protected by a fire our fire resistance rating				

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039			
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	03	COMPLETED				
155846		B. WING		03/08/2024				
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			616 GF	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
IAU	Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gall f. Combustible Stoto) (over 50 square feeg. Laboratories (if Hazard - see K322) Based on observation failed to ensure the housekeeping storagarea containing contains 50 square feet self-closing devices automatically close This deficient practigarage area.  Findings include:	f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in  Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops boms (exceeding 64 In Rooms lons) orage Rooms/Spaces set) classified as Severe	K 0321	Disclaimer: This Plan of Correction constitutis facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.	tutes of s f this tists			
		the Maintenance Director (MD)		Alloged deficiency: 4 Failed	l to			
	_	ctor (ED) on 03/07/24 between		Alleged deficiency: 1. Failed				
		p.m., the Cottage #1 Oxygen		ensure Cottage #1 and Cottage				
	5.45 p.m. and 4:15	p.m., me Conage #1 Oxygen		Oxygen Transfilling storage ro	OIII			

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Transfilling storage room door (a hazardous area),

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door, located in the garage,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/08/2024	
	PROVIDER OR SUPPLIER		616 G	FADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY MEL, IN 46032	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				latched into the frame when tested.	
	REGULATORY OR LSC IDENTIFYING INFORMATION  located in the garage, was equipped with self-closing device but did not latch into the frame			Corrective Action for reside found to have deficiency: 03/15/2024 Cottage #1 and 0 #5 Transfilling storage room was fixed by the Maintenance Director, so the door properly latches into the frame.  Identify other residents having same potential deficiency: 03/18/2024 The Maintenance Director audited all doors at community to ensure they properly latch into the frame tested and found no other deficiencies.  Measures put into place or systemic changes: The Maintenance Director placed preventative maintenance ta TELS System to check all fadoors Quarterly to ensure all in all Cottage's latch into the frame when tested.  Plan to monitor performance maintain compliance: The Maintenance Director or des will perform an audit Quarter the Transfilling storage doors ensure they latch into the frawhen tested. The audit will be submitted to the QAPI Commount Quarterly. If any compliance trends are identified, they will some tested and communication of the property of the pr	on ottage door see by see sto since see sto since see sto since see sto since see see sintee see si

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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	A. BUILDING 03  B. WING			COMPLETED	
		155846	B. W				/2024	
			-	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				REEN HOUSE WAY			
RESTOR	ACY OF CARMEL				EL, IN 46032			
WA ID	CVD G ( ) DV	THE TENTENT OF DEFICIENCIE	1		T		Q15)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	*	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
					reviewed in QAPI meetings.			
K 0761								
SS=F								
Bldg. 03								
J	Based on observation	on, records review, and	K 0	761	Disclaimer:		04/02/2024	
		ty failed to ensure annual	110	,01	This Plan of Correction constitutes		0 1/ 02/ 202 1	
	inspection and testing	ng of at least 1 fire door			this facility's written allegation	of		
	assemblies were con	mpleted in accordance of LSC			compliance for the deficiencies			
	19.1.1.4.1.1 commu	nicating openings in dividing			cited. However, submission of	this		
	fire barriers required	d by 19.1.1.4.1 shall be			Plan of Correction is not an			
	-	orridors and shall be protected			admission that a deficiency ex	ists		
	* * *	osing fire door assemblies.			or that one was cited correctly			
		3.) LSC 8.3.3.1 Openings			This Plan of Correction is			
	_	ire protection rating by Table			submitted to meet requiremen	ts		
	_	ected by approved, listed,			established by the state and			
		semblies and fire window			federal law.			
		r accompanying hardware,			l			
	_	s, closing devices, anchorage,			Alleged deficiency: Failed to			
		for Fire Degree and Other			ensure annual inspection for the			
	·	for Fire Doors and Other s, except as otherwise			fire door assembly at the Oxyg			
		de. NFPA 80 5.2.1 states fire			Transfilling rooms for each of	Tie o		
	_	all be inspected and tested not			buildings.			
		and a written record of the			Corrective Action for resider	nt/e\		
	-	signed and kept for inspection			found to have deficiency: Th			
	-	80, 5.2.4.1 states fire door			Maintenance Director became			
	-	visually inspected from both			certified to inspect fire door			
		verall condition of door			assemblies on 3/18/2024. An	nual		
	assembly. NFPA 80	), 5.2.4.2 states as a minimum,			inspections for the fire door			
	the following items	shall be verified:			assemblies at the Oxygen			
	(1) No open holes o	r breaks exist in surfaces of			Transfilling rooms for each of	the 6		
	either the door or fra				buildings were conducted on			
		light frames, and glazing beads			3/18/2024.			
		ely fastened in place, if so						
	equipped.				Identify other residents having			
		, hinges, hardware, and			same potential deficiency: On	1		
		eshold are secured, aligned,			3/18/2024 The Maintenance			
	_	er with no visible signs of			Director audited/inspected eac	ch of		
	damage.				the 6 building's fire door		1	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPLETED	
155846		B. W	B. WING 03/08/2		/2024		
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			REEN HOUSE WAY		
RESTORACY OF CARMEL					EL, IN 46032		
INLO I OF			_	CARIVIE	_L, IIN +00JZ		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(4) No parts are mi	2			assemblies at the Oxygen		
	` '	s do not exceed clearances			Transfilling rooms. No concer	ns	
	listed in 4.8.4 and 6				were identified during the		
		g device is operational; that is,			audit/inspection.		
		npletely closes when operated					
	from the full open p				Measures put into place or		
	1 1	is installed, the inactive leaf			systemic changes:		
	closes before the ac				The Maintenance Director pla		
	1 ' /	are operates and secures the			a preventative maintenance to		
	door when it is in the	-			into TELS System to inspect t		
		vare items that interfere or		door assemblies at the Oxygen			
	1	are not installed on the door or			Transfilling rooms for each of	the 6	
	frame.				buildings annually.		
	` '	fications to the door assembly					
	_	ed that void the label.			Plan to monitor performance to		
		edge seals, where required, are		maintain compliance: The			
		their presence and integrity.		Executive Director or designee will			
	_	tice could affect all 12		do a monthly audit of all required			
	residents.			TELS preventative maintenance			
					tasks x6 months to ensure 10	0%	
	Findings include:				compliance of completion of		
					preventative maintenance tas		
		eview with the Maintenance			The results of the audit will be		
	` ′	Executive Director (ED) on			submitted to the QAPI Comm	ittee	
		3/24 no documentation of an			Quarterly. If any compliance		
	_	or the fire door assembly at the			trends are identified, they will	be	
		g room was available for review.			reviewed in QAPI meeting.		
		on during the tour each of the					
	_	ansfilling room located in the					
		tygen Transfilling room has					
		door assembly. Based on					
		ne of records review and					
	observation, the MD stated an annual fire door						
	inspection was not completed within the last year						
	for the Oxygen Room door assembly.						
	TTI : C' 1:	t talat e					
		eviewed with the Executive					
		enance Director at the time of					
		n during the exit conference on					
	03/08/24.						İ

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155846		A. BUILDING B. WING	03	COM	COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIER		616 GR	ADDRESS, CITY, STATE, ZIP REEN HOUSE WAY EL, IN 46032	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-19(b)					
K 0918 SS=F Bldg. 03	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor- personnel. Mainte energy power sou accordance with N circuit breakers an program for period components is est manufacturer requiof maintenance ar and readily availat and circuits are maintenance ar and separate from Minimizing the pos- emergency power consideration for re-	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the poess shall be provided to his capability for the life branches. Maintenance generator and transfer armed in accordance with a inspected weekly, and 30 minutes 12 times a intervals, and exercised anths for 4 continuous hours. It der load conditions include the ted cold start and and transfer of all EES aducted by competent anance and testing of stored arces (Type 3 EES) are in a inspected annually, and a lically exercising the ablished according to be inspected annually. Written records and testing are maintained be. EES electrical panels arked, readily identifiable, normal power circuits. Sasibility of damage of the source is a design				

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03/27/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 03/08/2024 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility K 0918 Disclaimer: 04/02/2024 failed to maintain 1 of 1 Emergency Power This Plan of Correction constitutes Standby System in accordance with NFPA 110, this facility's written allegation of Standard for Emergency and Standby Power compliance for the deficiencies Systems, Section 8.4.9, as required by NFPA 99 cited. However, submission of this Health Care Facilities Code, Section 6.4.1.1.6.1. Plan of Correction is not an NFPA 110 Section 8.4.9 states that all Level 1 admission that a deficiency exists Emergency Power Systems shall be tested at least or that one was cited correctly. once within every three years. Where the This Plan of Correction is assigned class is greater than 4 hours, it shall be submitted to meet requirements permitted to terminate the test after 4 hours. established by the state and NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and federal law. Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 Alleged deficiency: Failed to generator sets. This deficient practice could ensure a four-hour run test for the affect all 12 residents. emergency generator was conducted within the last 36 Findings include: months. Based on records review with the Maintenance Corrective Action for resident(s) Director (MD) and Executive Director (ED) on found to have deficiency: On 03/07/24 and 03/08/24 documentation of a 3/18/2024 The Maintenance four-hour run test for the emergency generator Director performed a four-hour run conducted within the last 36 months was not test for the six emergency provided for review. Based on interview at the generators. An issue was time of records review, the Maintenance Director identified in Cottage #6's contacted the facilities contractor on each day of generator. Buckey Power the survey but did not get a response and finally Systems was notified of the issue stated documentation of a four-hour continuous with Cottage #6's generator and run conducted in the past 36 months was not they are scheduled to come this available for review at the time of the survey. week to correct the issue. No other issues were identified. This finding was reviewed with the Executive Director and Maintenance Director at the time of Identify other residents having

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03/08/24.

3.1-19(b)

discovery and again during the exit conference on

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the same potential deficiency:

On 3/18/2024 the Maintenance Director conducted an audit to

ensure 6 of 6 generators had a four-hour run test conducted within

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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>03</u>			COMPLETED	
155846		B. WING			03/08/2024		
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIER	ę.		616 GF	REEN HOUSE WAY		
RESTOR	RACY OF CARMEL			CARME	EL, IN 46032		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					the past 36 months and found		
					none of the generators were in compliance with this regulation		
					On 3/18/2024 The Maintenand		
					Director performed a four-hou		
					test for the six emergency		
					generators. An issue was		
					identified in Cottage #6's		
					generator. Buckey Power		
					Systems was notified of the is		
					with Cottage #6's generator as		
					they are scheduled to come the		
					week to correct the issue. No other issues were identified wi		
					the other generators.	u i	
					the other generators.		
					Measures put into place or		
					systemic changes: The		
					maintenance director placed a		
					preventative maintenance rem	ninder	
					into our TELS System on		
					3/18/2024 to have a four-hour	run	
					test performed on all 6 of the generators every 36 months.		
					generators every 30 months.		
					Plan to monitor performance	to	
					maintain compliance: The		
					Executive Director or designed		
					do a monthly audit of all requir		
					TELS preventative maintenantasks x6 months to ensure 100		
					compliance of completion of	J /0	
					preventative maintenance task	KS.	
					The results of the audit will be		
					submitted to the QAPI Commi		
					Quarterly. If any		
					compliance trends are identifie	ed,	
					they will be reviewed in QAPI		
					meeting.		
Ī	I		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 03	CON	(X3) DATE SURVEY COMPLETED 03/08/2024	
	PROVIDER OR SUPPLIE		616 GR	ADDRESS, CITY, STATE, ZIP COL REEN HOUSE WAY EL, IN 46032	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 0000						
Bldg. 04	Licensure Survey v	e Recertification and State was conducted by the Indiana Ith in accordance with 42 CFR	K 0000			
	Facility Number: (Provider Number: AIM Number: 201	013753 155846				
	Carmel was found Requirements for F Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I	Code survey, Restoracy of not in compliance with Participation in 1, 42 CFR Subpart 483.90(a), are and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.				
	06). Each building determined to be of was fully sprinkler system with smoke areas open to the codetectors in the res	s of six buildings (01 through is a one-story cottage f Type V (111) construction and ed. Each cottage has a fire alarm detection in the corridors, orridors and hard-wired smoke ident rooms. The entire facility 2 and had a census of 71 at the				
	were sprinklered an services were sprin	idents have customary access and all areas providing facility klered, with exception of a didministration building.				
	1	tified as Cottage #4. The ity of 12 and had a census of				

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>04</u>	X3) DATE SURVEY COMPLETED 03/08/2024
	PROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR  12 at the time of thi as a Memory Care be  Quality Review core  NFPA 101  Means of Egress of Means of Egress of Aisles, passageward discharges, exit lower in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1  18.2.1, 19.2.1, 7.1  Based on observation failed to ensure 1 of lead from the garage accessible at all time could affect all resident from the facility with the control of the facility with the control of the facilities led to the control of the garage, which is a memory of the garage.	e LSC IDENTIFYING INFORMATION s survey. This Cottage serves building for this facility.  Impleted on 03/12/24  General General ays, corridors, exit cations, and accesses are in Chapter 7, and the means auously maintained free of full use in case of s modified by 18/19.2.2  110.1 but and interview, the facility f 3 exit discharge paths that the to the public way was readily es. This deficient practice			DATE  DATE  04/02/2024  utes of statistics sts  sthis
	believed NO PARK to prevent people fr terminated into the buildings and ackno- corrected.	MD stated that in the past he ING signs had been installed om parking where the sidewalk driveway at each of the 6 owledged that this would be viewed with the Executive		public way was always readily accessible.  Corrective Action for resident found to have deficiency: The vehicle identified obstructing the discharge path that leads from garage to the public way was	e e

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>04</u>		COMPLETED	
		155846	B. W	ING		03/08/2024	
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			REEN HOUSE WAY		
RESTOR	RACY OF CARMEL				EL, IN 46032		
	T				, 10002 I		
(X4) ID		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
		enance Director at the time of			relocated.		
		n during the exit conference on			<b></b>		
	03/08/24.				Measures put into place or		
	2.1.10(b)				systemic changes: On		
	3.1-19(b)				3/19/2024 the maintenance	No.	
					director permanently affixed "I		
					Parking Signs" on the 6 Cottag garage doors. During daily ro	-	
					anyone observed parking in the		
					exit discharge paths that lead		
					the garage to the public way v		
					immediately be asked to reloc		
					their vehicle. On 3/20/2024 the		
					Maintenance Director walked		
					facility grounds to audit/inspec		
					any of the exit discharge path		
					that lead from the garage to the	ne	
					public way was readily access	sible	
					and he found no other concer	ns.	
					Plan to monitor performance	e to	
					maintain compliance: The		
					maintenance director or desig		
					will audit the exit discharge pa		
					that lead from the garage to the	ne	
					public way to ensure all are		
					always readily accessible 5 x	-	
					week for 1 month, 3 x a week	tor 2	
					months, and 2 x a week for 3		
					months.		
					The results of the audit will be submitted to the QAPI Commi		
					Quarterly. If any compliance	iiiee	
					trends are identified, they will	he	
					reviewed in QAPI meetings.	DC	
					Toviewed in QALTITIEELINGS.		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 04	Corridor - Doors						
		corridor openings in other					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE A. BUILDING B. WING	construction  04	(X3) DATE COMPL 03/08/	ETED
	PROVIDER OR SUPPLIER		616 G	T ADDRESS, CITY, STATE, ZIP COD GREEN HOUSE WAY MEL, IN 46032		
(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller land CMS regulation. The apply to auxiliary selfammable or complying to a complying the doors complying the doors complying the door closed where the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be lated the the door closed where the permitted. Fixed allowed per 8.3. In there are no restring resistance of glass assemblies.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	Disclaimer:		04/02/2024
		, <b>,</b>	1 00 00			

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DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	04	COMPL	ETED
		155846	B. W	ING		03/08	/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			REEN HOUSE WAY		
RESTOR	ACY OF CARMEL				EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to ensure all	corridor doors had no			This Plan of Correction consti	tutes	
	impediment to closi	ing and latching into the door			this facility's written allegation	of	
	frame and would re	sist the passage of smoke.			compliance for the deficiencie		
		ice could affect 2 staff and 1			cited. However, submission of		
	resident.				Plan of Correction is not an		
					admission that a deficiency ex	cists	
	Findings include:				or that one was cited correctly		
					This Plan of Correction is	1.	
	Based on observation	on and interview during a tour			submitted to meet requiremen	ite	
		the Maintenance Director (MD)			established by the state and	11.5	
	-	ctor (ED) on 03/08/24 at			federal law.		
		5 p.m. the following Cottage #4			lederariaw.		
		d to latch positively into their			Alleged deficiency: Foiled to		
		-			Alleged deficiency: Failed to		
	respective door fram				ensure Cottage #4 Mop Close		
		et, equipped with a self-closing			Door and Cottage #4 resident		
	device.	WD.W			room B's door latch positively	into	
	b) Resident Room	n "B"			their respective door frames.		
	This finding was re	viewed with the Executive			Corrective Action for resider	nt(s)	
	Director and Mainte	enance Director at the time of			found to have deficiency: Th	e	
	discovery and agair	during the exit conference on			Maintenance Director fixed		
	03/08/24.				Cottage #4 Mop Closet Door a	and	
					Cottage #4 resident room "B's		
	3.1-19(b)				door so they positively latch in		
	` ,				their respective door frames.		
					Identify other residents having	the	
					same potential deficiency: On	•	
					3/18/2024 The Maintenance		
					Director audited all doors at th	ne	
					community to ensure they		
					properly latch into the frame w	hen	
					tested and found no other		
					deficiencies.		
							•

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Measures put into place or systemic changes: The Maintenance Director placed a preventative maintenance task into TELS System to check all facility

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	04	COMPLETED
		155846	B. WING		03/08/2024
	PROVIDER OR SUPPLIER		616 0	T ADDRESS, CITY, STATE, ZIP COD BREEN HOUSE WAY MEL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				doors Quarterly to ensure all d in all Cottage's latch into the frame when tested.	oors
K 0704				Plan to monitor performance maintain compliance: The Maintenance Director or designee will perform an audit Quarterly of all facility doors to ensure they latch into the fram when tested. The results of the audit will be submitted to the QAPI Committee Quarterly. If compliance trends are identified they will be reviewed in QAPI meetings.	ne e e any
K 0761 SS=F					
Bldg. 04					
	interview, the facili inspection and testing assemblies were considered in 19.1.1.4.1.1 commutation fire barriers require permitted only in compartment of the provided for the second of the second o	on, records review, and ty failed to ensure annual ing of at least 1 fire door impleted in accordance of LSC inicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, semblies and fire window or accompanying hardware,	K 0761	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.	of s this ists
	and sills in accorda	s, closing devices, anchorage, nce with the requirements of for Fire Doors and Other		Alleged deficiency: Failed to ensure annual inspection for the fire door assembly at the Oxygon	ne

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Opening Protectives, except as otherwise

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fire door assembly at the Oxygen

Transfilling rooms for each of the 6

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 04 COMPLETED B. WING 03/08/2024 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL. IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE specified in this Code. NFPA 80 5.2.1 states fire buildings. door assemblies shall be inspected and tested not less than annually, and a written record of the Corrective Action for resident(s) inspection shall be signed and kept for inspection found to have deficiency: The by the AHJ. NFPA 80, 5.2.4.1 states fire door Maintenance Director became assemblies shall be visually inspected from both certified to inspect fire door sides to assess the overall condition of door assemblies on 3/18/2024. Annual assembly. NFPA 80, 5.2.4.2 states as a minimum, inspections for the fire door the following items shall be verified: assemblies at the Oxygen (1) No open holes or breaks exist in surfaces of Transfilling rooms for each of the 6 either the door or frame. buildings were conducted on (2) Glazing, vision light frames, and glazing beads 3/18/2024. are intact and securely fastened in place, if so equipped. Identify other residents having the (3) The door, frame, hinges, hardware, and same potential deficiency: On noncombustible threshold are secured, aligned, 3/18/2024 The Maintenance and in working order with no visible signs of Director audited/inspected each of the 6 building's fire door (4) No parts are missing or broken. assemblies at the Oxygen (5) Door clearances do not exceed clearances Transfilling rooms. No concerns listed in 4.8.4 and 6.3.1.7. were identified during the (6) The self-closing device is operational; that is, audit/inspection. the active door completely closes when operated from the full open position. Measures put into place or (7) If a coordinator is installed, the inactive leaf systemic changes: closes before the active leaf. The Maintenance Director placed (8) Latching hardware operates and secures the a preventative maintenance task door when it is in the closed position. into TELS System to inspect fire (9) Auxiliary hardware items that interfere or door assemblies at the Oxygen prohibit operation are not installed on the door or Transfilling rooms for each of the 6 frame. buildings annually. (10) No field modifications to the door assembly have been performed that void the label. Plan to monitor performance to (11) Gasketing and edge seals, where required, are maintain compliance: The inspected to verify their presence and integrity. Executive Director or designee will This deficient practice could affect all 12 do a monthly audit of all required

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residents.

Findings include:

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TELS preventative maintenance tasks x6 months to ensure 100%

compliance of completion of preventative maintenance tasks.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	î ´	JILDING	onstruction  04	(X3) DATE : COMPL 03/08/	ETED
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
(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)	ΓE	(X5) COMPLETION DATE
	Director (MD) and 03/07/24 and 03/08/annual inspection for Oxygen Transfilling Based on observation 6 buildings had a tragarage and each Ox one 90-minute fire of interview at the time observation, the MI inspection was not of for the Oxygen Root.  This finding was red Director and Mainton	view with the Maintenance Executive Director (ED) on 724 no documentation of an or the fire door assembly at the groom was available for review. on during the tour each of the ansfilling room located in the ygen Transfilling room has door assembly. Based on e of records review and 0 stated an annual fire door completed within the last year m door assembly.  viewed with the Executive enance Director at the time of during the exit conference on			The results of the audit will be submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will I reviewed in QAPI meeting.		
K 0918 SS=F Bldg. 04	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo	s - Essential Electric Syste s - Essential Electric Ince and Testing other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the provided to the capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised on the for 4 continuous hours.					

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>04</u>		COMPLETED	
		155846	B. W	B. WING		03/08/2024	
	PROVIDER OR SUPPLIER		•	616 GR	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	<u>,                                      </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	loads, and are cor personnel. Mainte energy power sou	ual transfer of all EES nducted by competent enance and testing of stored urces (Type 3 EES) are in NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
	1 ' -	tablished according to					
	manufacturer requ	uirements. Written records					
		nd testing are maintained					
	I	ble. EES electrical panels					
		arked, readily identifiable,					
	1	n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r	new installations. (NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
		view and interview, the facility	$ _{K0}$	918	Disclaimer:		04/02/2024
		of 1 Emergency Power	110	<i>)</i> 10	This Plan of Correction consti	tutes	0 1/ 02/ 202 1
		accordance with NFPA 110,			this facility's written allegation		
	Standard for Emerg	gency and Standby Power			compliance for the deficiencie	:S	
	Systems, Section 8.	4.9, as required by NFPA 99			cited. However, submission of	f this	
		ies Code, Section 6.4.1.1.6.1.			Plan of Correction is not an		
		8.4.9 states that all Level 1			admission that a deficiency ex		
		Systems shall be tested at least			or that one was cited correctly	<i>1</i> .	
	1	hree years. Where the			This Plan of Correction is		
	"	eater than 4 hours, it shall be			submitted to meet requiremen	its	
	1 -	ate the test after 4 hours.  3.4.1.1.6.1 states that Type 1 and			established by the state and federal law.		
		ectrical system power sources			icucialiaw.		
		t Type 10, Class X, Level 1			Alleged deficiency: Failed to	)	
		s deficient practice could			ensure a four-hour run test for		
	affect all 12 residen	-			emergency generator was conducted within the last 36		
	Findings include:				months.		
		eview with the Maintenance			Corrective Action for resider		
	Director (MD) and	Executive Director (ED) on			found to have deficiency: Or	1	

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>04</u>	(X3) DATE SURVEY COMPLETED 03/08/2024
	PROVIDER OR SUPPLIER	2	616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	03/07/24 and 03/08 four-hour run test for conducted within the provided for review time of records review contacted the facility the survey but did not stated documentation run conducted in the available for review.  This finding was represented the provided provided the provided p	/24 documentation of a per the emergency generator are last 36 months was not as Based on interview at the ew, the Maintenance Director ries contractor on each day of not get a response and finally on of a four-hour continuous are past 36 months was not at the time of the survey.  Viewed with the Executive enance Director at the time of a during the exit conference on		3/18/2024 The Maintenance Director performed a four-hou test for the six emergency generators. An issue was identified in Cottage #6's generator. Buckey Power Systems was notified of the is with Cottage #6's generator at they are scheduled to come the week to correct the issue. Not other issues were identified.  Identify other residents have the same potential deficience On 3/18/2024 the Maintenance Director conducted an audit the ensure 6 of 6 generators had four-hour run test conducted the past 36 months and found none of the generators were incompliance with this regulation On 3/18/2024 The Maintenance Director performed a four-hou test for the six emergency generators. An issue was identified in Cottage #6's generator. Buckey Power Systems was notified of the is with Cottage #6's generator at they are scheduled to come they are scheduled to c	ssue and his b a within d that n on. ce ur run  ssue and his b rith

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	OF CORRECTION	IDENTIFICATION NUMBER  155846	A. BUILDING B. WING	04	COMPLETED 03/08/2024
	ROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(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
				test performed on all 6 of the generators every 36 months.	
				Plan to monitor performance maintain compliance: The Executive Director or designed do a monthly audit of all required. TELS preventative maintenant tasks x6 months to ensure 10 compliance of completion of preventative maintenance tast. The results of the audit will be submitted to the QAPI Comminguarterly. If any compliance trends are identified they will be reviewed in QAPI meeting.	e will red ce 0% ks.
K 0000					
Bldg. 05	Licensure Survey w Department of Healt 483.90(a).  Survey Dates: 03/0  Facility Number: 0 Provider Number: 1 AIM Number: 2013  At this Life Safety C Carmel was found n Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protect	13753 155846 362150 Code survey, Restoracy of not in compliance with	K 0000		

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	OF CORRECTION	IDENTIFICATION NUMBER  155846	A. BUILDING B. WING	05	COMPLETED 03/08/2024
	ROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=F	Health Care Occupation  The facility consists 06). Each building is determined to be of was fully sprinklere system with smoke areas open to the condetectors in the residual has a capacity of 72 time of this survey.  All areas where residuere sprinklered and services were spr	of six buildings (01 through s a one-story cottage Type V (111) construction and d. Each cottage has a fire alarm detection in the corridors, rridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the dents have customary access d all areas providing facility elered, with exception of a dministration building.  Iffied as Cottage #5. The try of 12 and had a census of s survey.	IAU		DATE
Bldg. 05	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of lead from the garage	ays, corridors, exit cations, and accesses are a Chapter 7, and the means uously maintained free of full use in case of a modified by 18/19.2.2 1	K 0211	Disclaimer: This Plan of Correction constitutis facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an	of s

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>05</u>	(X3) DATE SURVEY COMPLETED 03/08/2024
ROVIDER OR SUPPLIER		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
SUMMARY:  (EACH DEFICIEN REGULATORY OR Findings include:  Based on observation of the facility with the and Executive Directly of the garage, which parked in the drivery the public way. The believed NO PARK to prevent people from terminated into the buildings and acknown corrected.  This finding was resulted Director and Mainter	estatement of Deficiencie CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  on and interview during a tour the Maintenance Director (MD) ctor (ED) on 03/07/24 and scharge paths from the garage facility exits, in each of the 6 driveway parking area in front in in some cases had cars way and obstructed access to MD stated that in the past he ING signs had been installed om parking where the sidewalk driveway at each of the 6 owledged that this would be wiewed with the Executive enance Director at the time of in during the exit conference on	616 GI	REEN HOUSE WAY EL, IN 46032  PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  admission that a deficiency e or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure 1 of 3 exit discharge put that lead from the garage to the public way was always readily accessible.  Corrective Action for reside found to have deficiency: The vehicle identified obstructing discharge path that leads from garage to the public way was relocated.  Measures put into place or systemic changes: On 3/19/2024 the maintenance director permanently affixed "Parking Signs" on the 6 Cottagarage doors. During daily reanyone observed parking in the exit discharge paths that lead the garage to the public way immediately be asked to relocated the parage to the public way immediately be asked to relocated the parage to the public way immediately be asked to relocated the parage to the public way immediately be asked to relocated the parage to the public way immediately be asked to relocated the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediately be asked to relocate the parage to the public way immediat	xists y.  Ints  Date  xists y.  Ints  Date  A continue of the original orig
			public way was readily acces and he found no other concer Plan to monitor performanc maintain compliance: The	ns.

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY	
RESTORACY OF CARMEL CARMEL, IN 46032	
TRESTORACT OF CARWILL	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	(X5) COMPLETION DATE
maintenance director or designe will audit the exit discharge path that lead from the garage to the public way to ensure all are always readily accessible 5 x pe week for 1 months, and 2 x a week for 3 months.  The results of the audit will be submitted to the QAPI Committed Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.  K 0321  SS=E  Bldg. 05  Hazardous Areas - Enclosure  Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.  Doors shall be self-closing or automatic-closing and permitted to have nonrated or feld-applied protective plates that do not exceed 48 inches from the bottom of the door.  Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.  19.3.2.1, 19.3.5.9  Area Automatic Sprinkler  Separation NIA  a. Boller and Fuel-Fired Heater Rooms  b. Laundries (larger than 100 square feet)	ee ns er or 2

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>05</u> COMPL			
		155846	B. WING 03/08/2024			/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K32: Based on observatio failed to ensure the housekeeping stora area containing con than 50 square feet self-closing device automatically close This deficient pract garage area.  Findings include:  Based on observatio of the facility with t and Executive Direc approximately 12:3 Transfilling storage located in the garag self-closing device when tested.  This finding was re Director and Mainte	nance, and Paint Shops coms (exceeding 64  n Rooms lons) crage Rooms/Spaces cet) classified as Severe	K 0	TAG	CROSS-REFERENCED TO THE APPROPRIA	tutes of s f this dists dists f.  otts  ht(s) ttage loor	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/08/2024		
	PROVIDER OR SUPPLIE			616 GRI	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
K 0761	REGULATORTO	K LSC IDENTIFIEND IN ORMATION			3/18/2024 The Maintenance Director audited all doors at the community to ensure they properly latch into the frame we tested and found no other deficiencies.  Measures put into place or systemic changes: The Maintenance Director placed a preventative maintenance task TELS System to check all facility doors Quarterly to ensure all coin all Cottage's latch into the frame when tested.  Plan to monitor performance to maintain compliance: The Maintenance Director or design will perform an audit Quarterly the Transfilling storage doors ensure they latch into the fram when tested. The audit will be submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will reviewed in QAPI meetings.	a k into dility doors	DAIL
SS=F Bldg. 05	interview, the facil inspection and test assemblies were co 19.1.1.4.1.1 comm fire barriers require permitted only in c by approved self-co	on, records review, and ity failed to ensure annual ing of at least 1 fire door ompleted in accordance of LSC unicating openings in dividing and by 19.1.1.4.1 shall be orridors and shall be protected losing fire door assemblies.	K 076	51	Disclaimer: This Plan of Correction constitution facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is	of s f this	04/02/2024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 05 COMPLETED  155846 B. WING 03/08/2024	
155846 B. WING 03/08/2024	
00/00/2021	
OTDEET ADDRESS SITE OF THE COD	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD  CAC OFFEN HOUSE WAY	
616 GREEN HOUSE WAY	
RESTORACY OF CARMEL  CARMEL, IN 46032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID DROWDER'S DLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCE) TO THE APPROPRIATE (AS)	ON
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
required to have a fire protection rating by Table submitted to meet requirements	
8.3.4.2 shall be protected by approved, listed,  established by the state and	
labeled fire door assemblies and fire window federal law.	
assemblies and their accompanying hardware,	
including all frames, closing devices, anchorage,  Alleged deficiency: Failed to	
and sills in accordance with the requirements of ensure annual inspection for the	
NFPA 80, Standard for Fire Doors and Other fire door assembly at the Oxygen	
Opening Protectives, except as otherwise Transfilling rooms for each of the 6	
specified in this Code. NFPA 80 5.2.1 states fire buildings.	
door assemblies shall be inspected and tested not	
by the AHJ. NFPA 80, 5.2.4.1 states fire door  Maintenance Director became	
assemblies shall be visually inspected from both  certified to inspect fire door	
sides to assess the overall condition of door  assemblies on 3/18/2024. Annual	
assembly. NFPA 80, 5.2.4.2 states as a minimum, inspections for the fire door	
the following items shall be verified:  assemblies at the Oxygen	
(1) No open holes or breaks exist in surfaces of  Transfilling rooms for each of the 6	
either the door or frame.  buildings were conducted on	
(2) Glazing, vision light frames, and glazing beads  3/18/2024.	
are intact and securely fastened in place, if so	
equipped. Identify other residents having the	
(3) The door, frame, hinges, hardware, and same potential deficiency: On	
noncombustible threshold are secured, aligned,  3/18/2024 The Maintenance	
and in working order with no visible signs of  Director audited/inspected each of	
damage. the 6 building's fire door	
(4) No parts are missing or broken. assemblies at the Oxygen	
(5) Door clearances do not exceed clearances Transfilling rooms. No concerns	
listed in 4.8.4 and 6.3.1.7. were identified during the	
(6) The self-closing device is operational; that is, audit/inspection.	
the active door completely closes when operated	
from the full open position.  Measures put into place or	
(7) If a coordinator is installed, the inactive leaf systemic changes:	
closes before the active leaf.  The Maintenance Director placed	
(8) Latching hardware operates and secures the a preventative maintenance task	
door when it is in the closed position. into TELS System to inspect fire	
(9) Auxiliary hardware items that interfere or door assemblies at the Oxygen	
prohibit operation are not installed on the door or  Transfilling rooms for each of the 6	
frame. buildings annually.	
(10) No field modifications to the door assembly	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	l í	JILDING	nstruction <u>05</u>	(X3) DATE COMPL <b>03/08</b> /	ETED
	PROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY L, IN 46032		
(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
	(11) Gasketing and inspected to verify to This deficient practive residents.  Findings include:  Based on records reduction of Director (MD) and to 3/07/24 and 03/08/24 annual inspection for Oxygen Transfilling Based on observation 6 buildings had a tragarage and each Oxone 90-minute fire of interview at the time observation, the MI inspection was not of for the Oxygen Root This finding was reducted by the contraction of the Oxygen Root This	d that void the label. edge seals, where required, are heir presence and integrity. It is could affect all 12  view with the Maintenance Executive Director (ED) on (24 no documentation of an or the fire door assembly at the groom was available for review. On during the tour each of the ansfilling room located in the yegen Transfilling room has door assembly. Based on the of records review and D stated an annual fire door completed within the last year m door assembly.  viewed with the Executive enance Director at the time of a during the exit conference on			Plan to monitor performance to maintain compliance: The Executive Director or designed do a monthly audit of all requir TELS preventative maintenance tasks x6 months to ensure 100 compliance of completion of preventative maintenance task. The results of the audit will be submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	e will red ce 0% cs.	
K 0918 SS=F Bldg. 05	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm to	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the breess shall be provided to nis capability for the life branches. Maintenance					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155846	A. BUILDING <u>05</u> B. WING		COMPLETED 03/08/2024		
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	switches are performed NFPA 110.  Generator sets are exercised under to year in 20-40 day once every 36 monosed scheduled test under a complete simular automatic or manuloads, and are compersonnel. Mainten energy power sour accordance with the circuit breakers are program for period components is estimated to mainten and circuits are manufacturer required of maintenance and readily availared and circuits are mand separate from Minimizing the power consideration for the following set of the following set on t	ual transfer of all EES inducted by competent inance and testing of stored irces (Type 3 EES) are in inspected annually, and a dically exercising the itablished according to uirements. Written records ind testing are maintained ble. EES electrical panels arked, readily identifiable, in normal power circuits. Insight of damage of the is source is a design inew installations. Insight of the service of the serv	K 0918	Disclaimer: This Plan of Correction constitution facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.	of es f this xists y.		

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 B. WING 03/08/2024 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE shall be classified at Type 10, Class X, Level 1 Alleged deficiency: Failed to generator sets. This deficient practice could ensure a four-hour run test for the affect all 12 residents. emergency generator was conducted within the last 36 Findings include: months. Based on records review with the Maintenance Corrective Action for resident(s) Director (MD) and Executive Director (ED) on found to have deficiency: On 03/07/24 and 03/08/24, documentation of a 3/18/2024 The Maintenance four-hour run test for the emergency generator Director performed a four-hour run conducted within the last 36 months was not test for the six emergency provided for review. Based on interview at the generators. An issue was time of records review, the Maintenance Director identified in Cottage #6's contacted the facilities contractor on each day of generator. Buckey Power the survey but did not get a response and finally Systems was notified of the issue stated documentation of a four-hour continuous with Cottage #6's generator and run conducted in the past 36 months was not they are scheduled to come this available for review at the time of the survey. week to correct the issue. No other issues were identified. This finding was reviewed with the Executive Director and Maintenance Director at the time of Identify other residents having discovery and again during the exit conference on the same potential deficiency: 03/08/24. On 3/18/2024 the Maintenance Director conducted an audit to 3.1-19(b) ensure 6 of 6 generators had a four-hour run test conducted within the past 36 months and found that none of the generators were in compliance with this regulation. On 3/18/2024 The Maintenance Director performed a four-hour run test for the six emergency generators. An issue was identified in Cottage #6's generator. Buckey Power Systems was notified of the issue with Cottage #6's generator and

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they are scheduled to come this week to correct the issue. No other issues were identified with

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  05	(X3) DATE COMPI 03/08			
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE		
				Measures put into place systemic changes: The maintenance director plate preventative maintenance into our TELS System or 3/18/2024 to have a four test performed on all 6 or generators every 36 more plan to monitor perform maintain compliance: The Executive Director or deed to a monthly audit of all TELS preventative maintenance and tasks x6 months to ensure compliance of completion preventative maintenance. The results of the audit of the submitted to the QAPI Compliance trends are independently. If any compliance trends are indicated to the will be reviewed in the meeting.	e e e e e e e e e e e e e e e e e e e			
K 0927 SS=E Bldg. 05	Gas Equipment - Transfilling of oxyganother is in acco Transfilling of High Oxygen Used for any gas from one prohibited in patie to liquid oxygen containers over 50 under 11.5.2.3.1 (	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable 0 psi comply with conditions NFPA 99). Transfilling to rainers or to portable						

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) M			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU			COMPLE		
		155846	B. W	ING	_	03/08/2024		
NAME OF A	DDOVIDED OF GUIDN TEX			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	(			REEN HOUSE WAY			
	RACY OF CARMEL				EL, IN 46032			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE	
TAG		R LSC IDENTIFYING INFORMATION  50 psi comply with		TAG			DATE	
		11.5.2.3.2 (NFPA 99).						
	11.5.2.2 (NFPA 9	, ,						
		on and interview, the facility	K 0	927	Disclaimer: This Plan of Correction constitutes		04/02/2024	
	failed to ensure 1 or	f 1 oxygen storage room where						
	oxygen transferring	takes place, was provided			this facility's written allegation	of		
		ing mechanical ventilation.			compliance for the deficiencie	s		
		tion, 11.5.2.3.1 (2) requires			cited. However, submission of	f this		
		rooms to be mechanically			Plan of Correction is not an			
	ventilated. Section 9.3.7.5.3.1 requires mechanical				admission that a deficiency ex			
	exhaust to maintain a negative pressure in the space continuously. This deficient practice could				or that one was cited correctly	′.		
		. This delicient practice could			This Plan of Correction is	uto.		
	affect up to 2 staff.				submitted to meet requirement established by the state and	ils		
	Findings include:				federal law.			
	i manigs metade.				icaciai iaw.			
	Based on observation	on and interview during a tour			Alleged deficiency: Failed to	,		
		the Maintenance Director (MD)			ensure Cottage #5 oxygen storage			
	and Executive Dire	ctor (ED) on 03/08/24 at			room where oxygen transferri	-		
	approximately 12:3	0 p.m. the Cottage #5 oxygen			takes place, was provided with	h		
	_	m in the garage contained			properly working mechanical			
		tanks. The ventilation fan in			ventilation.			
		ng a cover and was unplugged						
	_	at the time of the survey.			Corrective Action for resider	` '		
		at the time of observation, the			found to have deficiency: Or			
		gen room fan was being worked to the survey and that a			3/19/2024 Cottage #5 oxygen			
		is needing to be installed.			storage room's mechanical ventilation fan was replaced a	nd is		
	Topiacomon fan wa	is needing to be instance.			properly ventilating.	iiu io		
	This finding was re	viewed with the Executive			proporty vortinging.			
	_	enance Director at the time of			Identify other residents having	the I		
	discovery and agair	n during the exit conference on			same potential deficiency: On			
	03/08/24.	-			3/19/2024 The Maintenance			
					Director audited each of the			
	3.1-19(b)				6-oxygen storage room			
					mechanical ventilation fans to			
					ensure proper ventilation. No			
					other concerns were noted.			
					Measures put into place or			
	1				systemic changes: On			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155846	A. BUILDING <u>05</u> B. WING			COMPLETED 03/08/2024	
		100040	<u> </u>				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RESTOR	ACY OF CARMEL		616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	3/18/2024 the Maintenance Director placed a Quarterly preventative maintenance rem into our TELS System to inspect of 6 oxygen storage room's mechanical ventilations system to ensure they are properly functioning.  Plan to monitor performance maintain compliance: The Executive Director or designed do a monthly audit of all requir TELS preventative maintenant tasks x6 months to ensure 100 compliance of completion of preventative maintenance tasl The results of the audit will be submitted to the QAPI Commit Quarterly. If any compliance	ninder ect 6 ms e to e will red ce 0% cs.	DATE
					trends are identified, they will reviewed in QAPI meeting.	be	
					<u>.</u>		
K 0000							
Bldg. 06	Licensure Survey w Department of Heal 483.90(a).  Survey Dates: 03/0 Facility Number: 0 Provider Number: AIM Number: 2013 At this Life Safety 0	13753 155846	K 00	00			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MUI A. BUII B. WIN	LDING	nstruction <u>06</u>	(X3) DATE : COMPL 03/08/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE		
K 0211 SS=F Bldg. 06	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupated The facility consists 06). Each building it determined to be of was fully sprinklere system with smoke areas open to the codetectors in the resistance of this survey.  All areas where resistance were sprinklered and services were sprinklered and services were sprinklered and services were sprinklered and services were sprinklered and services were sprinklered and services were sprinklered and Building 06 is identiced to the cottage has a capacity of the cot	and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  To f six buildings (01 through a one-story cottage Type V (111) construction and d. Each cottage has a fire alarm detection in the corridors, rridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the dents have customary access d all areas providing facility alered, with exception of a dministration building.  Tified as Cottage #6. The ty of 12 and had a census of s survey.  The deneral of General areas of General areas, corridors, exit						
	in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1	s modified by 18/19.2.2 1.	K 02	11	Disclaimer:		04/02/2024	

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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>06</u>			COMPLETED	
		155846	B. WING 03/08/2024			2024	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
DECTOR	AOV OF OADME				REEN HOUSE WAY		
RESTORACY OF CARMEL			CARINE	EL, IN 46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	failed to ensure 1 of	f 3 exit discharge paths that			This Plan of Correction constit	utes	
	lead from the garag	e to the public way was readily			this facility's written allegation	of	
		es. This deficient practice			compliance for the deficiencies		
	could affect all resid	-			cited. However, submission of		
		,			Plan of Correction is not an		
	Findings include:				admission that a deficiency ex	rists	
					or that one was cited correctly		
	Based on observation	on and interview during a tour			This Plan of Correction is	•	
		the Maintenance Director (MD)			submitted to meet requiremen	te	
	1	ctor (ED) on 03/07/24 and			established by the state and		
		scharge paths from the garage			federal law.		
		facility exits, in each of the 6			icuciai iaw.		
		driveway parking area in front			Alleged deficiency: Failed to		
		h in some cases had cars			ensure 1 of 3 exit discharge page		
		way and obstructed access to			that lead from the garage to the		
	_	e MD stated that in the past he			public way was always readily		
		ING signs had been installed			accessible.		
		om parking where the sidewalk			accessible.		
		driveway at each of the 6			Corrective Action for resider	nt/c)	
		owledged that this would be			found to have deficiency: Th		
	corrected.	Swiedged that this would be			vehicle identified obstructing the		
	corrected.				discharge path that leads from		
	This finding was re	viewed with the Executive			garage to the public way was	ı uıe	
		enance Director at the time of			relocated.		
		during the exit conference on			Telocaled.		
	03/08/24.	i during the exit conference on			Mossuros put into place or		
	03/00/27.				Measures put into place or systemic changes: On		
	3.1-19(b)				3/19/2024 the maintenance		
	3.1-17(0)				director permanently affixed "N	No	
					· · · · · · · · · · · · · · · · · · ·		
					Parking Signs" on the 6 Cottag		
					garage doors. During daily ro		
					anyone observed parking in th		
					exit discharge paths that lead		
					the garage to the public way w		
					immediately be asked to reloc		
					their vehicle. On 3/20/2024 the		
					Maintenance Director walked		
					facility grounds to audit/inspec		
					any of the exit discharge paths		
					that lead from the garage to th	ie	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		A. BUILDING <u>06</u> COMPLET		(X3) DATE SURVEY COMPLETED 03/08/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0761 SS=F Bldg. 06	interview, the facilitinspection and testin assemblies were con 19.1.1.4.1.1 commufire barriers required permitted only in compartment of the permitted only in compartment of the permitted only in compartment of the permitted only in compartment of the permitted only in compartment of the permitted on the permitted of the permitted on the permitted on the permitted of the permitted on the permitted of the permitted on the permitted on the permitted on the permitted of the permitted on the permi	on, records review, and ty failed to ensure annual ng of at least 1 fire door mpleted in accordance of LSC unicating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table ected by approved, listed, semblies and fire window r accompanying hardware, s, closing devices, anchorage, nce with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire	K 0761	public way was readily access and he found no other concerned.  Plan to monitor performance maintain compliance: The maintenance director or design will audit the exit discharge path that lead from the garage to the public way to ensure all are always readily accessible 5 x week for 1 month, 3 x a week months, and 2 x a week for 3 months.  The results of the audit will be submitted to the QAPI Comm Quarterly. If any compliance trends are identified, they will reviewed in QAPI meetings.  Disclaimer:  This Plan of Correction constitutis facility's written allegation compliance for the deficiencie cited. However, submission on Plan of Correction is not an admission that a deficiency experiment of the correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure annual inspection for infire door assembly at the Oxy Transfilling rooms for each of buildings.	gnee aths he per for 2 e ittee be 04/02/2024 etutes of es f this exists y.  on the gen	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 06 COMP				
		155846	B. W	'ING		03/08/2	2024	
MANGOTT	DROLUDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	t .		616 GF	REEN HOUSE WAY			
RESTOR	ACY OF CARMEL			CARMEL, IN 46032				
(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	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		all be inspected and tested not						
		and a written record of the			Corrective Action for resider			
	_	signed and kept for inspection			found to have deficiency: Th			
	1 -	80, 5.2.4.1 states fire door			Maintenance Director became	9		
		visually inspected from both			certified to inspect fire door	.		
		overall condition of door			assemblies on 3/18/2024. An	inuai		
		), 5.2.4.2 states as a minimum,			inspections for the fire door			
	the following items				assemblies at the Oxygen	41 0		
	either the door or fr	or breaks exist in surfaces of			Transfilling rooms for each of	uie o		
		ame. light frames, and glazing beads			buildings were conducted on 3/18/2024.			
					3/16/2024.			
	are intact and securely fastened in place, if so equipped.				Identify other residents having	n tho		
	(3) The door, frame, hinges, hardware, and				same potential deficiency: Or			
		eshold are secured, aligned,			3/18/2024 The Maintenance	'		
		er with no visible signs of			Director audited/inspected ea	ch of		
	damage.	or with he visitie signs of			the 6 building's fire door	011 01		
	(4) No parts are mis	ssing or broken.			assemblies at the Oxygen			
		do not exceed clearances			Transfilling rooms. No concer	ns		
	listed in 4.8.4 and 6				were identified during the			
		device is operational; that is,			audit/inspection.			
	1 ' '	pletely closes when operated						
	from the full open p				Measures put into place or			
		is installed, the inactive leaf			systemic changes:			
	closes before the ac	tive leaf.			The Maintenance Director pla	ced		
	(8) Latching hardward	are operates and secures the			a preventative maintenance to			
	door when it is in th	ne closed position.			into TELS System to inspect f	ire		
	(9) Auxiliary hardw	vare items that interfere or			door assemblies at the Oxyge	en		
	prohibit operation a	re not installed on the door or			Transfilling rooms for each of	the 6		
	frame.				buildings annually.			
	` ′	ications to the door assembly						
	_	ed that void the label.			Plan to monitor performance t	to		
		edge seals, where required, are			maintain compliance: The			
		their presence and integrity.			Executive Director or designe			
	_	ice could affect all 12			do a monthly audit of all requi			
	residents.				TELS preventative maintenan			
					tasks x6 months to ensure 10	0%		
	Findings include:				compliance of completion of			
					preventative maintenance tas			
	Based on records review with the Maintenance				The results of the audit will be	,		

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		IDENTIFICATION NUMBER  155846		ULTIPLE CONSTRUCTION  JILDING  ING		COMPLETED 03/08/2024		
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(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)	Ē.	(X5) COMPLETION DATE	
K 0918 SS=F Bldg. 06	03/07/24 and 03/08/annual inspection for Oxygen Transfilling Based on observation 6 buildings had a tragarage and each Oxyone 90-minute fire of interview at the time observation, the MD inspection was not of for the Oxygen Roo.  This finding was rev. Director and Mainted discovery and again 03/08/24.  3.1-19(b)  NFPA 101  Electrical Systems Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a programmally confirm the safety and critical and testing of the switches are perfoned in 20-40 day once every 36 more of the system of the sys	viewed with the Executive snance Director at the time of during the exit conference on the exit conference on the exit conference on the exit conference on the exit conference on the exit conference on the exit conference of the exit conference on the			submitted to the QAPI Commit Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2024			
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
	loads, and are corpersonnel. Mainteenergy power sour accordance with Noircuit breakers are program for period components is estimated and circuits are mand readily availal and circuits are mand separate from Minimizing the power consideration for moderation for	(NFPA 99), NFPA 110, 0 (NFPA 70) riew and interview, the facility of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least three years. Where the eater than 4 hours, it shall be attended the test after 4 hours. 4.1.1.6.1 states that Type 1 and actrical system power sources to Type 10, Class X, Level 1 is deficient practice could	K 0918	Disclaimer: This Plan of Correction constitution facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency experience or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure a four-hour run test for emergency generator was conducted within the last 36 months.  Corrective Action for resider found to have deficiency: Or 3/18/2024 The Maintenance	of es f this kists /. hts or the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>06</u>			COMPLETED		
155846		B. WI	NG		03/08/2024		
NAME OF	DDOVIDED OD SLIDDI IE	P	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
	NAME OF PROVIDER OR SUPPLIER				REEN HOUSE WAY		
RESTOR	RACY OF CARMEL			CARME	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CC CC	OMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		for the emergency generator			Director performed a four-hou	r run	
		he last 36 months was not			test for the six emergency		
	1 ^	v. Based on interview at the			generators. An issue was		
		iew, the Maintenance Director		identified in Cottage #6			
		ties contractor on each day of not get a response and finally			generator. Buckey Power		
	1	on of a four-hour continuous			Systems was notified of the is		
		ne past 36 months was not			with Cottage #6's generator a they are scheduled to come the		
		w at the time of the survey.			week to correct the issue. No		
	available for review	wat the time of the survey.			other issues were identified.	·	
	This finding was re	eviewed with the Executive			other issues were identified.		
	_	tenance Director at the time of			Identify other residents havi	na	
		n during the exit conference on			the same potential deficienc	-	
	03/08/24.				On 3/18/2024 the Maintenance	_	
					Director conducted an audit to		
	3.1-19(b)				ensure 6 of 6 generators had		
					four-hour run test conducted v		
					the past 36 months and found	l that	
					none of the generators were i	n	
					compliance with this regulatio	n.	
					On 3/18/2024 The Maintenan	се	
					Director performed a four-hou	r run	
					test for the six emergency		
					generators. An issue was		
					identified in Cottage #6's		
					generator. Buckey Power		
					Systems was notified of the is		
					with Cottage #6's generator a		
					they are scheduled to come the		
					week to correct the issue. No		
					other issues were identified w	ith	
					the other generators.		
					Measures put into place or		
					systemic changes: The		
					maintenance director placed a	, l	
					preventative maintenance ren		
					into our TELS System on		
					3/18/2024 to have a four-hour	· run	
					test performed on all 6 of the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2024	
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΤE	(X5) COMPLETION DATE
					Plan to monitor performance maintain compliance: The Executive Director or designed to a monthly audit of all requirements asks x6 months to ensure 100 compliance of completion of preventative maintenance task. The results of the audit will be submitted to the QAPI Comminguarterly. If any compliance trends are identified they will be reviewed in QAPI meeting.	e will red ce 0% ks.	

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