STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey 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	E 0000		
E 0026 SS=C Bldg. --	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)(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), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(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 (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ryan Levengood	Executive Director	03/25/2024

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24, a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review the ED	E 0026	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure the Emergency Preparedness Plan (EPP) included the role of the LTC facility under a waiver declared by the Secretary, in accordance with	04/02/2024

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	stated that they could not locate this paperwork. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24.		section 1135 of the Act. **Corrective Action for resident(s) found to have deficiency:** The 1135 waiver was placed in the EPP Binders on 3/18/2024. **Identify other residents having the same potential deficiency:** An audit was conducted of 6 of 6 Cottages EEP Binders. The audit identified that all 6 EEP Binders were missing the 1135 waiver. All EEP Binders now have the 1135 waiver. **Measures put into place or systemic changes:** As of 3/18/2024 all EPP Binders include the 1135 waiver Plan to monitor performance to maintain compliance: No monitoring required as the deficiency is corrected. Executive Director will review EPP 1x per year to ensure 1135 waiver is included in EPP Binder.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.			

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	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in			

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	this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.			

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	(x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24.	E 0041	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** 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 they are scheduled to come this week to correct the issue. No other issues were identified.	04/02/2024

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			Identify other residents having 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 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 they are scheduled to come this week to correct the issue. No other issues were identified. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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 to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be	

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			submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/07/24 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility	K 0000		

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	services were sprinklered, with exception of a separate detached administration building. Building 01 is identified as Cottage #2. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General 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 failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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	K 0211	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s)**	04/02/2024

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	buildings and stated that this would be corrected. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		**found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was relocated. **Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed “No Parking Signs” on the 6 Cottage garage doors. During daily rounds anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

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K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not 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. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6 buildings. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door assemblies at the Oxygen Transfilling rooms. No concerns	04/02/2024

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	listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually. Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power	K 0918	**Disclaimer:** This Plan of Correction constitutes	04/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 01 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** 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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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 the past 36 months and found that none of the generators were in compliance with this regulation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 01 B. WING	03/08/2024

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K 0000			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 they are scheduled to come this week to correct the issue. No other issues were identified with the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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 to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 02 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/07/24 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 72 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 02 is identified as Cottage #3. The cottage has a capacity of 12 and had a census of 11 at the time of this survey. This Cottage serves as the Memory Care building for this facility.	K 0000		

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	155846	A. BUILDING 02 B. WING	03/08/2024

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	Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General 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 failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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 buildings and acknowledged that this would be corrected. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on	K 0211	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s) found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was relocated.	04/02/2024

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	03/08/24. 3.1-19(b)		**Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed “No Parking Signs” on the 6 Cottage garage doors. During daily rounds anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0271 SS=F Bldg. 02	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to			

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	155846	A. BUILDING 02 B. WING	03/08/2024

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	changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 3 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect all 12 residents. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/08/24 at approximately 11:30 a.m. the Cottage #3 exit discharge from the garage exit door, marked a facility exit had a large gap in the concrete and was uneven where the sections seamed together. Based on interview at the time of observation, the MD and ED acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of trip hazards leading to the common way. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)	K 0271	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements 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 discharge path from the garage exit door had a large gap in the concrete and was uneven where the sections seamed together. **Corrective Action for resident(s) found to have deficiency:** On 4/2/2024 a company will inspect Cottage #3 exit discharge path from the garage exit door. On or before 5/15/2024 the identified exit discharge path located outside of Cottage #3 will be corrected and will have a level walking surface. **Identify other residents having the same potential deficiency:** On 3/19/2024 the Maintenance	04/02/2024

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			Director audited all exit discharge paths to ensure all exit discharge paths had a level walking surface. The audit identified an exit path in front of Cottage #2 that had a nonlevel walking surface. The nonlevel walking path in front of Cottage #2 will be corrected on or before 5/15/2024. All other exits were found to be in compliance. **Measures put into place or systemic changes:** The Maintenance Director placed a Quarterly task in TELS System to inspect all exit discharge paths to ensure a level walking surface. Any identified concerns related to level walking surfaces will be corrected. Plan to monitor performance to maintain compliance: The Maintenance Director or designee will perform an audit Quarterly of the exit discharge paths to ensure they have a level walking surface. Results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0761 SS=F Bldg. 02	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of	04/02/2024

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	assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not 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. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf.		compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6 buildings. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door assemblies at the Oxygen Transfilling rooms. No concerns were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed	

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	(8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually. Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power			

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	source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1	K 0918	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists	04/02/2024

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	Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** 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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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 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	

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			generator. Buckey Power Systems was notified of the issue with Cottage #6's generator and they are scheduled to come this week to correct the issue. No other issues were identified with the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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 to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000		

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	155846	A. BUILDING 03 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Survey Dates: 03/07/24 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 03 is identified as Cottage #1. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 03	NFPA 101 Means of Egress - General Means of Egress - General			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	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 failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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 buildings and acknowledged that this would be corrected. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)	K 0211	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s) found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was relocated. **Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed "No Parking Signs" on the 6 Cottage garage doors. During daily rounds	04/02/2024

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			anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure 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.			

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	155846	A. BUILDING 03 B. WING	03/08/2024

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-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 N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 housekeeping storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could impact 2 staff in the garage area. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 between 3:45 p.m. and 4:15 p.m., the Cottage #1 Oxygen Transfilling storage room door (a hazardous area),	K 0321	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency: 1.** Failed to ensure Cottage #1 and Cottage #5 Oxygen Transfilling storage room door, located in the garage,	04/02/2024

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	located in the garage, was equipped with self-closing device but did not latch into the frame when tested. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		latched into the frame when tested. **Corrective Action for resident(s) found to have deficiency:** On 3/15/2024 Cottage #1 and Cottage #5 Transfilling storage room door was fixed by the Maintenance Director, so the door properly latches into the frame. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited all doors at the community to ensure they properly latch into the frame when tested and found no other deficiencies. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to check all facility doors Quarterly to ensure all doors in all Cottage's latch into the frame when tested. Plan to monitor performance to maintain compliance: The Maintenance Director or designee will perform an audit Quarterly of the Transfilling storage doors to ensure they latch into the frame when tested. The audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be	

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	155846	A. BUILDING 03 B. WING	03/08/2024

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			reviewed in QAPI meetings.	
K 0761 SS=F Bldg. 03	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not 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.	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6 buildings. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door	04/02/2024

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24.		assemblies at the Oxygen Transfilling rooms. No concerns were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually. Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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	3.1-19(b)			
K 0918 SS=F Bldg. 03	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

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	NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)	K 0918	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** 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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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	04/02/2024

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			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 they are scheduled to come this week to correct the issue. No other issues were identified with the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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 to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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K 0000 Bldg. 04	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/07/24 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 04 is identified as Cottage #4. The cottage has a capacity of 12 and had a census of	K 0000		

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	12 at the time of this survey. This Cottage serves as a Memory Care building for this facility. Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 04	NFPA 101 Means of Egress - General Means of Egress - General 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 failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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 buildings and acknowledged that this would be corrected. This finding was reviewed with the Executive	K 0211	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s) found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was	04/02/2024

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	Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		relocated. **Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed “No Parking Signs” on the 6 Cottage garage doors. During daily rounds anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0363 SS=E Bldg. 04	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility	K 0363	**Disclaimer:**	04/02/2024

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	failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 1 resident. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/08/24 at approximately 12:15 p.m. the following Cottage #4 corridor doors failed to latch positively into their respective door frames: a) The Mop Closet, equipped with a self-closing device. b) Resident Room "B" This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure Cottage #4 Mop Closet Door and Cottage #4 resident room B's door latch positively into their respective door frames. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director fixed Cottage #4 Mop Closet Door and Cottage #4 resident room "B's" door so they positively latch into their respective door frames. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited all doors at the community to ensure they properly latch into the frame when tested and found no other deficiencies. **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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			doors Quarterly to ensure all doors in all Cottage's latch into the frame when tested. **Plan to monitor performance to maintain compliance**: The Maintenance Director or designee will perform an audit Quarterly of all facility doors to ensure they latch into the frame when tested. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0761 SS=F Bldg. 04	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6	04/02/2024

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	specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not 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. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include:		buildings. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door assemblies at the Oxygen Transfilling rooms. No concerns were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually. Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks.	

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	Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0918 SS=F Bldg. 04	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include			

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	a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on	K 0918	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** On	04/02/2024

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	03/07/24 and 03/08/24 documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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 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 they are scheduled to come this week to correct the issue. No other issues were identified with the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder into our TELS System on 3/18/2024 to have a four-hour run	

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			test performed on all 6 of the generators every 36 months. **Plan to monitor performance to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0000 Bldg. 05	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/07324 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing	K 0000		

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	Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 05 is identified as Cottage #5. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 05	NFPA 101 Means of Egress - General Means of Egress - General 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 failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility.	K 0211	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	04/02/2024

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	Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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 buildings and acknowledged that this would be corrected. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s) found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was relocated. **Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed “No Parking Signs” on the 6 Cottage garage doors. During daily rounds anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The	

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			maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0321 SS=E Bldg. 05	NFPA 101 Hazardous Areas - Enclosure 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 field-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 N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)			

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	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 housekeeping storage rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could impact 2 staff in the garage area. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/08/24 at approximately 12:30 p.m., the Cottage #5 Oxygen Transfilling storage room door (a hazardous area), located in the garage, was equipped with self-closing device but did not latch into the frame when tested. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)	K 0321	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency: 1.** Failed to ensure Cottage #1 and Cottage #5 Oxygen Transfilling storage room door, located in the garage, latched into the frame when tested. **Corrective Action for resident(s) found to have deficiency:** On 3/15/2024 Cottage #1 and Cottage #5 Transfilling storage room door was fixed by the Maintenance Director, so the door properly latches into the frame. Identify other residents having the same potential deficiency: On	04/02/2024

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			3/18/2024 The Maintenance Director audited all doors at the community to ensure they properly latch into the frame when tested and found no other deficiencies. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to check all facility doors Quarterly to ensure all doors in all Cottage's latch into the frame when tested. Plan to monitor performance to maintain compliance: The Maintenance Director or designee will perform an audit Quarterly of the Transfilling storage doors to ensure they latch into the frame when tested. The audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0761 SS=F Bldg. 05	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	04/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 05 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not 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. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly		submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6 buildings. **Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door assemblies at the Oxygen Transfilling rooms. No concerns were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually.	

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	have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0918 SS=F Bldg. 05	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources	K 0918	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	04/02/2024

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	shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24, documentation of a four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		**Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** 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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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 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 they are scheduled to come this week to correct the issue. No other issues were identified with	

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			the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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 to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0927 SS=E Bldg. 05	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable			

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	containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 2 staff. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/08/24 at approximately 12:30 p.m. the Cottage #5 oxygen storage/transfer room in the garage contained large liquid oxygen tanks. The ventilation fan in the room was missing a cover and was unplugged and not functioning at the time of the survey. Based on interview at the time of observation, the MD stated the oxygen room fan was being worked on a few days prior to the survey and that a replacement fan was needing to be installed. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)	K 0927	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure Cottage #5 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. **Corrective Action for resident(s) found to have deficiency:** On 3/19/2024 Cottage #5 oxygen storage room's mechanical ventilation fan was replaced and is properly ventilating. Identify other residents having the same potential deficiency: On 3/19/2024 The Maintenance Director audited each of the 6-oxygen storage room mechanical ventilation fans to ensure proper ventilation. No other concerns were noted. **Measures put into place or systemic changes:** On	04/02/2024

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			3/18/2024 the Maintenance Director placed a Quarterly preventative maintenance reminder into our TELS System to inspect 6 of 6 oxygen storage room's mechanical ventilations systems to ensure they are properly functioning. **Plan to monitor performance to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0000 Bldg. 06	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/07324 and 03/08/24 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with	K 0000		

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 06 is identified as Cottage #6. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/12/24			
K 0211 SS=F Bldg. 06	NFPA 101 Means of Egress - General Means of Egress - General 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

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	failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was readily accessible at all times. This deficient practice could affect all residents in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 the exit discharge paths from the garage exit doors, marked facility exits, in each of the 6 facilities led to the driveway parking area in front of the garage, which in some cases had cars parked in the driveway and obstructed access to 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 buildings and acknowledged that this would be corrected. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 1 of 3 exit discharge paths that lead from the garage to the public way was always readily accessible. **Corrective Action for resident(s) found to have deficiency:** The vehicle identified obstructing the discharge path that leads from the garage to the public way was relocated. **Measures put into place or systemic changes:** On 3/19/2024 the maintenance director permanently affixed "No Parking Signs" on the 6 Cottage garage doors. During daily rounds anyone observed parking in the exit discharge paths that lead from the garage to the public way will immediately be asked to relocate their vehicle. On 3/20/2024 the Maintenance Director walked our facility grounds to audit/inspect if any of the exit discharge paths that lead from the garage to the	

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			public way was readily accessible and he found no other concerns. **Plan to monitor performance to maintain compliance**: The maintenance director or designee will audit the exit discharge paths that lead from the garage to the public way to ensure all are always readily accessible 5 x per week for 1 month, 3 x a week for 2 months, and 2 x a week for 3 months. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meetings.	
K 0761 SS=F Bldg. 06	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire	K 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure annual inspection for the fire door assembly at the Oxygen Transfilling rooms for each of the 6 buildings.	04/02/2024

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	door assemblies shall be inspected and tested not 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. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance		**Corrective Action for resident(s) found to have deficiency:** The Maintenance Director became certified to inspect fire door assemblies on 3/18/2024. Annual inspections for the fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings were conducted on 3/18/2024. Identify other residents having the same potential deficiency: On 3/18/2024 The Maintenance Director audited/inspected each of the 6 building's fire door assemblies at the Oxygen Transfilling rooms. No concerns were identified during the audit/inspection. **Measures put into place or systemic changes:** The Maintenance Director placed a preventative maintenance task into TELS System to inspect fire door assemblies at the Oxygen Transfilling rooms for each of the 6 buildings annually. Plan to monitor performance to maintain compliance: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be	

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	Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour each of the 6 buildings had a transfilling room located in the garage and each Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time 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. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	
K 0918 SS=F Bldg. 06	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 06 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all 12 residents. Findings include: Based on records review with the Maintenance Director (MD) and Executive Director (ED) on 03/07/24 and 03/08/24 documentation of a	K 0918	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure a four-hour run test for the emergency generator was conducted within the last 36 months. **Corrective Action for resident(s) found to have deficiency:** On 3/18/2024 The Maintenance	04/02/2024

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	four-hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director contacted the facilities contractor on each day of the survey but did not get a response and finally stated documentation of a four-hour continuous run conducted in the past 36 months was not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/08/24. 3.1-19(b)		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 they are scheduled to come this week to correct the issue. No other issues were identified. **Identify other residents having 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 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 they are scheduled to come this week to correct the issue. No other issues were identified with the other generators. **Measures put into place or systemic changes:** The maintenance director placed a preventative maintenance reminder 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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			generators every 36 months. **Plan to monitor performance to maintain compliance**: The Executive Director or designee will do a monthly audit of all required TELS preventative maintenance tasks x6 months to ensure 100% compliance of completion of preventative maintenance tasks. The results of the audit will be submitted to the QAPI Committee Quarterly. If any compliance trends are identified, they will be reviewed in QAPI meeting.	