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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/23/2012 |
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| NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032 |
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| K0000 | <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/23/12</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Carmel Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p> | K0000 | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the 700 and 800 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 229 and had a census of 157 at the time of this visit.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered with the exceptions noted at K-56. The facility had one detached building providing facility services including a generator housed in a wood frame shed which was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | | | |

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| K0050 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 1 of 4 fire drills conducted prior to 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" documentation with the Director of Maintenance from 9:40 a.m. to 12:10 p.m. on 07/23/12, documentation for the second shift fire drill conducted on 05/10/12 at 8:00 p.m. did not include the transmission of the fire alarm signal. Written documentation of the fire drill stated "No, Silent Drill" in response to</p> | K0050 | <p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8-22-12.</p> <p>K050 NFPA 101 Life Safety Code Standard 1. No resident was identified as being immediately affected by this deficient practice. 2. No other residents were identified as being immediately affected by this deficient practice. 3. A. The Fire Drill Report Form has been updated to include a fire alarm signal received section to be</p> | 08/22/2012 | | | |

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| | "Did alarm company receive the signal from the facility fire alarm system". Based on interview at the time of record review, the Director of Maintenance acknowledged documentation of the second shift fire drill conducted on 05/10/12 at 8:00 p.m. did not include transmission of the fire alarm signal. 3.1-19(b) | | completed by the associate completing the drill.B. Maintenance associates will be educated and inserviced on 8/13/12 in regards to documentation of transmission of the fire alarm signal as part of the written fire drill record.4. Maintenance Director or his designee will audit fire drills documentation monthly. All findings will be presented in the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee. | | |

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| K0056 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide sprinkler coverage for 4 of 13 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect residents, staff and visitors using the Manor House main entrance, exit by Room 207, exit by Room 221 and the employee exit.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during the tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, the exterior canopy at the Manor House main entrance measured</p> | K0056 | <p>K056 NFPA 101 Life Safety Code Standard</p> <p>1. No resident was identified as being immediately affected by this deficient practice.</p> <p>2. No other residents were identified as being immediately affected by this deficient practice. A contractor was immediately contacted to prepare quotes for sprinkler installation coverage to all identified areas.</p> <p>3.</p> <p>A. Sprinkler heads will be installed in the identified areas. B. Due to the complexity of the installation, sprinkler heads will be installed no later than 9/21/2012. C. Maintenance Director will</p> | 08/22/2012 |

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| | <p>eight feed wide, the exterior canopies at the exit by Room 207, by Room 221 and the employee exit each measured five wide. Each canopy was not provided with automatic sprinklers and was of wood construction. Based on interview at the time of the observations, the Director of Maintenance acknowledge the aforementioned canopy locations were each greater than four feet wide, were of wood construction and were not provided with automatic sprinklers.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinklers were installed in 1 of 2 basement elevator rooms to provide sprinkler coverage for all portions of the building. NFPA 13 at 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. This deficient practice could affect staff and visitors in the vicinity of the Main Elevator Machine Room in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during the tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, the Main Elevator Machine Room in the</p> | | <p>review NFPA 101 guidelines in an effort to make certain all areas of facility are in compliance.</p> <p>4. NFPA 101 regulations will be added to the monthly preventative maintenance audits conducted by the Maintenance Director or his designee. All findings will be presented in the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee.</p> | | | | |

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| | <p>basement did not have sprinklers installed in the room. Based on interview at the time of the observation, the Director of Maintenance acknowledged the Main Elevator Machine Room in the basement did not have sprinklers installed in the room.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>3. Based on observation and interview, the facility failed to ensure sprinklers were installed in 1 of 1 basement cable rooms to provide sprinkler coverage for all portions of the building. NFPA 13 at A-5-13.9.2 requires sprinklers in closets in nursing homes. This deficient practice could affect staff and visitors in the vicinity of the basement cable room closet.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during the tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, the basement cable room closet did not have sprinklers installed in the room.</p> <p>Based on interview at the time of the observation, the Director of Maintenance acknowledged the basement cable room closet did not have sprinklers installed in the room.</p> | | | | | | |

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| | 3.1-19(b) 3.1-19(ff) | | | |

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| K0067 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 149 of 149 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during the tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, all resident rooms and facility support offices were using the egress corridor as a return air system. Based on interview at the time of the observations, the Director of Maintenance acknowledged all resident rooms and</p> | K0067 | <p>LSC Waiver requested; see attached form.</p> <p>Addendum:</p> <p>Carmel Health & Living does not feel that a waiver would affect the resident health and safety. Strict compliance would impose an unreasonable financial hardship. Please find the following per your correspondence dated August 31, 2012:</p> <p>1. Please find attached floor plan (Exhibit "A"). All 100% of the resident rooms that are represented on the floor plan would be affected, 160 out of 160 rooms.</p> <p>Please find the attached quote from JMI Mechanical Services, Inc. for \$205,500 (Exhibit "B"). This cost only represents labor and material and does not include any costs associated with disruption of services or the relocation of residents.</p> <p>Strict compliance would impose a</p> | 08/22/2012 | | | |

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| | <p>facility support offices were using the egress corridor as a return air system.</p> <p>3.1-19(b)</p> | | <p>financial hardship to the facility based upon the inconvenience to residents and families, costs associated with the scope of work, the lack of available financing, the fact that the building is over 35 years old, and waivers have been approved to date.</p> <p>2. The Life Safety Code deficiency does not pose a hazard to occupants due to the following:</p> <p>a. Facility operates an addressable fire alarm system manufactured by the Notifier Corporation.</p> <p>b. Each of the HVAC units operates within its own smoke zone.</p> <p>c. Each of the HVAC units have smoke detectors located downstream of the air filter and ahead of any branch connections of the air supply systems that when the products of combustion are detected by the individual detectors the fire alarm panel is notified which sound the horns and strobes, notifies the fire department and completes all the other tasks required by the life safety code.</p> <p>d. Currently there are 56 HVAC units located at Carmel Health and Living Community. 50 of these units are tied to the fire alarm panel with</p> | | |

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| | | | <p>a shut off module that caused the unit to shut down in the event there is smoke detected in either the return air or the air plenum that offers treated air to the building. 6 units are not connected to the shut off module. These 6 HVAC Units will be connected to the shut off module within a two week period by 9/21/12 (Exhibit "C").</p> <p>e. All fire dampers were cleaned, inspected, and tested in March of 2009 by JMI Mechanical Services, Inc., which is currently on a 4 year cycle to clean, inspect and test.</p> | | |

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| K0144 SS=C | <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure for 1 of 3 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during the tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, a remote manual stop for the emergency generator identified as Generator II was not installed. Based on interview at the time of observation, the Director of Maintenance acknowledged a remote manual stop was not installed for Generator II.</p> | K0144 | <p>K144 NFPA 101 Life Safety Code Standard 1. No resident was identified as being immediately affected by this deficient practice. 2. No other residents were identified as being immediately affected by this deficient practice. A contractor has been contacted to prepare quotes for a remote stop to be installed. 3. A. A remote manual stop will be installed for the identified generator. 4. Maintenance Director will research the NFPA website once a quarter to identify any regulatory updates changes. All findings will be presented in the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee.</p> | 08/22/2012 | | | |

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| K9999 | <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) The facility must be designed, constructed and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This State Rule has not been met as evidenced by: Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning battery operated smoke detectors in 85 of 85 resident sleeping rooms. This deficient practice could affect 85 residents in the facility.</p> <p>Findings include:</p> <p>Based on review of "Tels: Monthly Smoke Detector Log" documentation with the Director of Maintenance from 9:40 a.m. to 12:10 p.m. on 07/23/12, cleaning of battery operated smoke detectors in resident sleeping rooms was not documented for the twelve month period of 07/01/11 through 06/01/12. Based on</p> | K9999 | <p>K9999 State Findings</p> <p>1. No resident was identified as being immediately affected by this deficient practice.</p> <p>2. No other residents were identified as being immediately affected by this deficient practice. The smoke detectors identified have been cleaned using the manufacturer recommended cleaning method.</p> <p>3.</p> <p>A. A "Smoke Detector Cleaning Form" audit will be conducted by the maintenance director or designee monthly.</p> <p>B. Maintenance associates will be educated and inserviced on 8/13/12 regarding documentation of smoke detector cleaning and the manufacturers recommended cleaning method for the smoke detectors.</p> <p>4.</p> <p>Maintenance Director or his designee will complete the smoke detector cleaning form monthly. All findings will be presented in the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee.</p> | 08/22/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/23/2012 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032 | | |
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| | <p>interview at the time of record review, the Director of Maintenance stated cleaning of battery operated smoke detectors is not performed by the facility and acknowledged documentation of cleaning battery operated smoke detectors in resident rooms was not available for review. Based on observations with the Director of Maintenance Supervisor during a tour of the facility from 1:20 p.m. to 4:40 p.m. on 07/23/12, the manufacturer's recommendation printed on the backing of First Alert battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall stated "clean by vacuum or compressed air".</p> <p>3.1-19(ff)</p> | | | | |