STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 06/29/15 & 06/30/15 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 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. This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered except for the partial walkout exit discharge area for staff below the Station 8 discharge balcony. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has	K 0000	Please accept the Plan of Correction to the annual LifeSafety Code Recertification and State Licensure Survey conducted on June 29 andJune 30, 2015. The official Plan of Correction, 2567, is to serve as Carmel Health & Living's credible allegation of compliance. We allege compliance on July 30, 2015. We are requesting a desk review for this planof correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 188 and had a census of 130 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observation and interview, the facility failed to ensure openings through 3 of 26 smoke barrier walls were protected to maintain the fire resistance	K 0025	**K025** **I. The corrective actions to be accomplished forthose**	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 60 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 8:45 a.m. to 10:15 a.m. on 06/30/15, the following was noted: a. a four foot by two foot hole in the Station 7 attic smoke barrier wall was noted above the corridor door set by Room 722. The aforementioned attic smoke barrier wall consisted of three layers of five-eighths inch thick drywall on one side of the wall studs and two layers of five-eighths inch thick drywall on the other side of the stud. b. the three inch annular space surrounding a one inch in diameter sprinkler pipe which penetrated the Station 8 attic smoke barrier wall above the corridor door set by Room 817 was filled with foam which is not an approved material for maintaining the smoke resistance of a smoke barrier. A four		**residents found to have been affected by the deficient practice.** 70 residents could be affected by the deficientpractice. 1.The Maintenance staffrepaired the attic smoke barrier walls, the areas around the pipes, and theceiling barriers with fire resistant caulk which provides a minimum of a halfan hour fire rating. 2.The Maintenance staffrepaired the ceiling holes with fire resistant materials which maintain a minimumof one and a half hour rating. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Facility Maintenance Staff were re-educated onensuring that areas around pipes, barrier walls and ceilings are sealed withcorrect fire resistant foam. The Maintenance Director and/ or Corporate Facilities Staff will physically inspect areas that have beenaddressed by an outside	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	inch by three inch hole for the passage of a one inch in diameter conduit and a four inch long by one inch wide hole for the passage of one cable was also noted in the aforementioned Station 8 attic smoke barrier wall. The attic smoke barrier wall consisted of two layers of five-eighths inch thick drywall on each side of the wall studs. c. the four inch annular space surrounding a two inch in diameter sprinkler pipe and four separate one inch in diameter holes were noted in the smoke barrier wall above the suspended ceiling at the corridor door set by Room 201. Based on interview at the time of the observations, the Environmental Supervisor stated he was unaware of the fire resistance rating of foam used in the Station 8 attic smoke barrier wall and acknowledged the openings in the aforementioned smoke barrier walls did not maintain the fire resistance rating of the smoke barrier wall. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors.		vendor after completion of a job to ensure no holes oropenings are left in smoke compartments. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** All vendor repairs to thephysical plant will be reviewed at the facility daily stand up meeting betweenthe Administrator and Maintenance Director. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** All vendor repairs to thephysical plant will be reviewed at the facility QAPI meeting monthly to ensurerepairs have been checked by the Maintenance Director or Corporate Facilities. Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed. **V. Plan of Correction completion date.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15 and from 8:45 a.m. to 10:15 a.m. on 06/30/15, the following was noted: a. a three inch hole in the ceiling of the natural gas furnace closet in the Rehab Transitional Department was filled with expandable foam. In addition, a six inch in diameter hole in the floor for the passage of ten cables was not firestopped. The floor of the natural gas furnace room serves as the ceiling for the space below on the lower level. b. a one foot by six foot hole and two one inch in diameter holes were noted in the ceiling of the cable room on the lower level. Based on interview at the time of the observations, the Environmental Director stated he was unaware of the UL rating of the expandable foam used in the natural gas furnace closet and acknowledged the aforementioned holes in the ceiling smoke barriers did not maintain at least a one half hour fire resistance rating. 3.1-19(b)		Plan of Completion date is July 30, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 27 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the natural gas furnace closet in the Rehab Transitional Department. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15, a three inch hole in the ceiling of the natural gas furnace closet in the Rehab Transitional Department was filled with expandable foam. In addition, a six inch in diameter hole in the floor for the passage of ten cables was not firestopped. The floor of the natural gas	K 0029	**K029** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 10 residents could be affected by the deficientpractice. TheMaintenance staff repaired the attic smoke barrier walls, the areas around thepipes, and the ceiling barriers with fire resistant rated foam which provides aminimum of a half an hour fire rating. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.**	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	furnace room serves as the ceiling for the space below on the lower level. Based on interview at the time of the observations, the Environmental Director stated he was unaware of the UL rating of the expandable foam used in the natural gas furnace closet and acknowledged the aforementioned holes in the natural gas furnace closet in the Rehab Transitional Department did not separate this hazardous from other spaces by smoke resistant partitions. 3.1-19(b)		The facility Maintenance staff were re-educated onensuring that areas around pipes, barrier walls and ceilings are sealed withcorrect fire resistant caulk. The Maintenance Director and/ or Corporate Facilities Staff will physically inspect areas that have beenaddressed by an outside vendor after completion of a job to ensure no holes oropenings are left in smoke compartments. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** All vendor repairs to thephysical plant will be reviewed at the facility daily stand up meeting betweenthe Administrator and Maintenance Director. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** All vendor repairs to thephysical plant will be reviewed at the facility QAPI meeting monthly to ensurerepairs have been checked by the Maintenance Director or Corporate Facilities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is July 30, 2015.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 4 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily	K 0038	**K038** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 80 residents could be affected by the deficientpractice. 1.The Maintenance staff postedthe exit codes immediately. 2.A vendor has been contractedto install the new sidewalk at Station 4 exit discharge area.	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	unlock such doors at all times. This deficient practice could affect 65 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15 and from 8:45 a.m. to 10:15 a.m. on 06/30/15, the Main Entrance, the entrance by Room 501, the entrance for long term care and the employee entrance were each marked as a facility exit with an exit sign. Each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Environmental Director stated the Main Entrance is supervised by reception staff who can unlock the door until 7:00 p.m. after which time it is not supervised. In addition, the Environmental Director stated not all residents in each smoke compartment have a clinical diagnosis requiring specialized security measures and acknowledged the four digit code was not posted at each of the aforementioned four facility exits. The Administrator confirmed at the exit interview at 10:30 a.m. on 06/30/15 not all residents in each smoke compartment have a clinical diagnosis requiring		**II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff andfacility managers were educated on the requirement of posting the exit codes ateach exit on July 17, 2015. The maintenance staff wereeducated on the importance of ensuring external exits are level and have aclear path. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The Maintenance staff and facility managers makedaily rounds and will monitor the exit code postings to ensure they are posted. The Maintenance staff make daily external rounds andwill ensure all exit sidewalks that are not level are reported to theAdministrator for repair. The vendor will install a level sidewalk from theStation 4 exit. **IV Thefacility will monitor the corrective action by implementing the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	specialized security measures. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a level walking surface was provided for 1 of 11 exits. LSC 7.1.6.3 states walking surfaces in the means of egress shall be nominally level. This deficient practice could affect 15 residents, staff and visitors using the Station 4 exit. Findings include: Based on observation with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15, a ten foot length in the northerly path of the outside walking surface at the Station 4 exit discharge measured one foot higher from the building side to the side with a storm water drain. Based on interview at the time of observation, the Environmental Director stated the facility has had issues with storm water not draining properly at the Station 4 exit discharge area and recently reconfigured the walking surface and installed two storm water drains in		**followingmeasures.** An audit form will be usedto ensure the exit codes remained posted 24/7 at each facility exit. An audit for will be usedto monitor the external exit egress to ensure they remain level. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is July 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	the concrete walking surface. The Environmental Director acknowledged the Station 4 exit discharge walking surface was not level due to a storm water drain installed in the northerly path of the walking surface at the Station 4 exit discharge area. 3.1-19(b)			
K 0050 SS=C Bldg. 01	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 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters and on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Direct Supply TELS	K 0050	**K050** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** All residents could be affected by the deficientpractice. Thefacility has implemented an annual calendar to track random times for fire drills. They will	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Logbook Documentation: Fire Drills" and "Fire Alarm Drill" documentation with the Environmental Director during record review from 8:55 a.m. to 11:10 a.m. on 06/29/15, second shift (3:00 p.m. to 11:00 p.m.) fire drills conducted on 08/26/14, 11/28/14, 02/27/15 and 05/29/15 were conducted at, respectively, 4:00 p.m., 3:30 p.m., 3:20 p.m. and 3:30 p.m. In addition, third shift (11:00 p.m. to 7:00 a.m.) fire drills conducted on 09/29/14, 12/27/14 and 03/22/15 were conducted at, respectively, 6:30 a.m., 6:30 a.m. and 6:50 a.m. Based on interview at the time of record review, the Environmental Director acknowledged the aforementioned second and third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)		occur every month and rotateshifts. Each shift fire drill will occur2 hours apart from the last fire drill. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on importance of holding fire drills at off times and the newcalendar for random times. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The Maintenance staff will use the calendar toensure the fire drills are completed at the correct time. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form CorporateFacilities will be used to ensure the fire drills are at random times andshifts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is July 30, 2015.	
K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 14 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	K 0056	**K056** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.**	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	practice could affect 24 residents, staff and visitors if needing to exit the facility from the Station 8 emergency exit. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15 and from 8:45 a.m. to 10:15 a.m. on 06/30/15, the Station 8 emergency exit discharge is a wooden balcony attached to the building and measuring eight feet wide by forty feet long. The wooden balcony serves as a canopy for the partial walkout lower level exit discharge area below. The area underneath the wooden balcony was not provided with automatic sprinklers. Based on interview at the time of the observations, the Environmental Director acknowledged the aforementioned canopy extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)		24 residents could be affected by the deficientpractice. Thefacility will have automatic sprinklers installed at the station 8 exit underthe wooden balcony. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on importance ensuring that all exterior canopies are sprinkled if4 feet in width. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The Maintenance staff will make daily externalrounds and ensure all areas 4 feet in width are sprinkled and if not willreport to Administrator. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form will be usedto ensure the automatic sprinklers are in place on canopies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			measuring 4 feet inwidth. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is July 30, 2015.	
K 0067 SS=E Bldg. 01	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 Based on record review, 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 3 of over 150 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	K 0067	**K067** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 36 residents could be affected by the deficientpractice. Thefacility has a bid to install return air ducts in the sited areas. Bid is currently under Corporate review tomake sure it addresses all areas of concern.	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	could affect 36 residents, staff and visitors Findings include: Based on review of Deem Mechanical and Electrical Company's "Proposal" letter dated 10/21/13 and their subsequent "Invoice" dated 02/28/14 with the Environmental Director during record review from 8:55 a.m. to 11:10 a.m. on 06/29/15, the initial installation of return air ducting in rooms in Station 2, 3, 4, 5, 7 and 8 was completed by 02/28/14. Based on observations with the Environmental Director during a tour of the facility from 8:45 a.m. to 10:15 a.m. on 06/30/15, the Doctor's Office and the Clean Utility room in Station 7 and the Pantry in Station 8 were each provided with supply air from the HVAC system and were using the egress corridor as a return air system. Based on interview at the time of the observations, the Environmental Director acknowledged the aforementioned rooms were using the egress corridor as a return air system and were not included in the initial return air duct installation project completed by 02/28/14. 3.1-19(b)		**II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on importance of ensuring return air ducts are available tofacility rooms. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The vendor will install the appropriate air returnsto meet the requirement. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form will be usedby corporate maintenance to ensure the facility has the appropriate returnsthroughout the facility. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			completion date. Plan of Completion date is July 30, 2015.	
K 0130 SS=C Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 5 of 5 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 11:10 a.m. to 3:45 p.m. on 06/29/15 and from 8:45 a.m. to 10:15 a.m. on 06/30/15, four of five fuel fired water heaters, identified as Registration # 296400, #297025, #304618 and #313965 each had the expiration date of 02/05/15 listed on posted Certificate of Inspection documentation from the State of Indiana. In addition, one of five fuel fired water heaters identified as Registration	K 0130	**K130** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** All residents could be affected by the deficientpractice. Thefacility contacted the vendor immediately for an inspection. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on timeliness of boiler/water heater inspections. The inspections werecompleted on July 2, 2015. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.**	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	#321890 had the expiration date of 02/21/15 listed on the posted Certificate of Inspection documentation from the State of Indiana. Current Certificate of Inspection documentation from the State of Indiana was not posted at each of the fuel fired water heater locations. Based on interview at the time of the observations, the Environmental Director stated each water heater had a recent pressure vessel inspection but acknowledged recent pressure vessel inspection documentation and current Certificate of Inspection documentation was not available for review. 3.1-19(b)		The facility insurance carrier is responsible forthe annual inspections. The maintenancestaff will monitor the date the inspection is due. The due date has been added to the TEL'sreporting system as a task due. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit from CorporateFacilities will be used to ensure the inspections are completed prior to theexpiration date of the inspection. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is July 30, 2015.	