STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING -- B. WING	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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: 11/14/23 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Emergency Preparedness survey, Carmel Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare Providers and Suppliers, 42 CFR 483.73 The facility has 188 certified beds and a census of 135. Quality Review completed on 11/16/23	E 0000	Event ID: 14FI21 Please find enclosed the Plan of Correction for the State Licensure Survey conducted on November 14, 2023. This letter is to inform you that the plan of correction attached is to serve as Carmel Health & Living Community credible allegation of compliance. We allege substantial compliance on December 1, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-445-0548 Sincerely, Alyssa Holliday, HFA Administrator Carmel Health and Living Submission of this plan of correction in no way constitutes an admission by Carmel Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State	

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

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			Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee 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: 11/14/23 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 483.90(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. 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 on all levels in the corridors and in all areas open to the 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	K 0000	Event ID: 14FI21 Please find enclosed the Plan of Correction for the State Licensure Survey conducted on November 14, 2023. This letter is to inform you that the plan of correction attached is to serve as Carmel Health & Living Community credible allegation of compliance. We allege substantial compliance on December 1, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-445-0548 Sincerely, Alyssa Holliday, HFA Administrator Carmel Health and Living Submission of this plan of correction in no way constitutes an admission by Carmel Health and Living or its management	

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	sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 188 and had a census of 135 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/16/23		company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of over 6 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 4 smoke compartments when occupied. Findings include:	K 0226	**K226** **1.The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** a K226 Horizontal Exits, Based on observation and interview, the facility failed to ensure 2 of over 6 horizontal exit fire door sets were arranged to automatically close and latch. Observation 1. the (1) 90-minute rated fire door set near the therapy	11/29/2023

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	Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., the (1) 90-minute rated fire door set near the therapy area did not self-close and latch due to one of the two doors sticking/rubbing on the floor. The (2) 90-minute rated fire door set between station 3 and the front entrance door #4 did not self-close and latch due to one the doors sticking on the carpet. When tested the aforementioned doors failed to latch into the frame due to the doors rubbing on the floor. This finding was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and Executive Director present. 3.1-19(b)		area did not self-close and latch due to one of the two doors sticking/rubbing on the floor. The (2) 90-minute rated fire door set between station 3 and the front entrance door #4 did not self-close and latch due to one the doors sticking on the carpet. When tested the aforementioned doors failed to latch into the frame due to the doors rubbing on the floor **2 The facility will identify other residents that may potentially be affected by the deficient practice.** a All residents and staff could be affected by this deficient practice. **3 The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** a There is a current TELS task to inspect all fire and smoke barrier door monthly to ensure they function properly. See attached task labeled “TELS Door Inspection Task” 4 **The facility will monitor the corrective action by implementing the following measures.** a The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities for the need to	

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			ensure that all fire and smoke barrier doors latch properly. They will monitor this documentation during their annual CQR. **5 Plan of Correction completion date.** a Therapy Door will be fixed by 11/29/23 Fire Rate door to station 3 has been fixed and no longer catch's on the floor when closing. See attached video labeled station 3 door and the front entrance door 4# video of the door shutting. Completed 11/22/23	
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of over 3 exit ramps met the slope requirement. LSC 7.2.5.2 states that existing ramps shall be provided with a slope not to exceed a 1:8 (1 inch of rise for every 8 inches of ramp) and approved existing ramps with a slope not to exceed 1:6 (1 inch of rise for every 6 inches of ramp). This deficient practice could affect 15 residents if exiting the station 4 exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23	K 0227	**K227** **1.The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** a K227 Ramps and Other Exits, Based on observation and interview, the facility failed to ensure 1 of over 3 exit ramps met the slope requirement. i Observation 1, Based on observations and interview during a tour of the facility the exit discharge ramp outside the	11/14/2023

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	between 12:20 p.m. and 4:30 p.m., the exit discharge ramp outside the Station 4 exit door near Room 442b had a concrete surface ramp which measured 100 inches in run length and 30 inches in elevation rise, as measured by the surveyor and the Maintenance Supervisor. Based upon these measurements, in order to achieve the least restrictive 1:6 slope requirement the run length of the ramp would need to be in excess of 180 inches. It was unclear at the time of the survey if the aforementioned door, marked as both a facility exit and not an exit, was a required exit. Additionally, there is a similar exit door at station 2, with a ramp measuring 108 inches of run length with 31 inches of elevation rise, (as measured by the surveyor and the Maintenance Supervisor). This door at station 2 is marked only NOT AN EXIT. It was unclear to the surveyor at the time of the survey why this exit door was so marked and why it was not a required exit. This finding and measurements was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and Executive Director present. 3.1-19(b)		Station 4 exit door near Room 442b had a concrete surface ramp which measured 100 inches in run length and 30 inches in elevation rise, **2 The facility will identify other residents that may potentially be affected by the deficient practice.** **a No staff or Residents have the potential to be affected by this due to the door being deemed not a exit.** **3 The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** a This Door was Deemed Not a Exit and had a sign on the Door stating it was not a exit. The facility is requesting IDR for this tag given the slope does not come into play for a door deemed Not a Exit. 4 **The facility will monitor the corrective action by implementing the following measures** a No Further monitoring needed given this exit was shown not to be a exit and was marked as Not a Exit (See attached image showing door marked as not a exit)	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING			

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	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of over 8 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., the exterior exit door near RR #442b was marked as a facility exit by an illuminated exit sign. However, the door glass was marked NOT AN EXIT. This condition is confusing and contradictory. Based on interview at the time of the observations, it could not be determined if the aforementioned door was a required facility exit. This finding was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and	K 0293	**K293** **1 The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** a Exit Signage, Based on observation and interview, the facility failed to ensure 1 of over 8 doors to the outside of the facility were not mistaken as a facility exit. Observation 1, the exterior exit door near RR #442b was marked as a facility exit by an illuminated exit sign. However, the door glass was marked NOT AN EXIT. This condition is confusing and contradictory. Based on interview at the time of the observations, it could not be determined if the aforementioned door was a required facility exit. **2 The facility will identify other residents that may potentially be affected by the deficient practice.** **a** All residents and staff could be affected by this deficient practice. **3 The facility will put into place the following systematic**	11/27/2023

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	Executive Director present. 3.1-19(b)		**changes to ensure that the deficient practice does not recur.** a The Exit sign above the door was removed and the illuminating exit sign that pointed to the Non Exit door was changed to show the correct direction to the exit. 4 **The facility will monitor the corrective action by implementing the following measures.** a All other Exit Signs are pointing to Exits and are not contradictory. No other monitoring needed. **5 Plan of Correction completion date.** a Completed on 11/27/23	
K 0321 SS=E Bldg. 01	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.			

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	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 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., the kitchen storage room, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this storage room was not equipped with a self-closing device. The Maintenance Supervisor stated that they recently converted the room into a kitchen/dietary storage room. This finding was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and	K 0321	**K321** **1 The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** a Hazardous Areas-Enclosure, Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents and staff. the kitchen storage room, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this storage room was not equipped with a self-closing	11/22/2023

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	Executive Director present. 3.1-19(b)		device. **2 The facility will identify other residents that may potentially be affected by the deficient practice.** a Only kitchen staff have the potential to be affected by this deficient practice. **3 The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** a Self-closing device was installed to door. No follow up needed as this is a permanent solution to the issue. (See Video Attachment labeled Kitchen Storage Self Closure for example of self-closure.) 4 **The facility will monitor the corrective action by implementing the following measures.** a The Maintenance Supervisor has been reeducated by CarDon Corporate Facilities to ensure that all rooms greater than 50 square feet that contains a number of combustible items are equipped with a self-closing device. **5 Plan of Correction completion date.**	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 1 staff in the Medical Directors Office. Findings include:	K 0920	**K920** **1 The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** a Electrical Equipment-Power Cords and Extension Cords, Based on observation and	11/22/2023

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	Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., in the Medical Directors Office area, an extension cord what was in use powering electron equipment. The Maintenance Supervisor agreed the black extension cord was in use. This finding was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and Executive Director present. 2. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., in RR 315 there were two power strips in use next to the resident's bed that did not meet 1363A or 60601-1 requirements. Furthermore, one on the two aforementioned power strips was dangling from the wall and was powering a high amp draw appliance. The second aforementioned power strip was concurrently powering medical and non-medical equipment. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use next to a resident bed and did not meet 1363A		interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. Observation 1, in the Medical Directors Office area, an extension cord what was in use powering electron equipment. The Maintenance Supervisor agreed the black extension cord was in use. Observation 2, the facility failed to ensure 2 of 2 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. **2 The facility will identify other residents that may potentially be affected by the deficient practice.** a Two staff members and two residents have the potential to be affected by this deficient practice. **3 The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** a Extension cord was removed from Medical Directors office. b Both Non Medical grade power strips were removed from resident rooms. Residents and families were educated on use of	

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR 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
	or 60601-1. This finding was acknowledged by the Maintenance Supervisor and Executive Director at the time of discovery and again at the exit conference with the Maintenance Supervisor and Executive Director present. 3.1-19(b)		power strips and not using non medical grade power strips. 4 **The facility will monitor the corrective action by implementing the following measures.** a The Maintenance Supervisor has been re-educated by CarDon Corporate Facilities the importance to keep extension cords out of the community. b Maintenance Supervisor will check each resident room weekly for non-medical grade power strips. A Newsletter was also placed in all new admission packets on non-medical grade power strip usage. **5 Plan of Correction completion date.** a Completed 11/22/23	