		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	A. BUI	A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/14/2023	
	ROVIDER OR SUPPLIER . HEALTH & LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 118 MEDICAL DR CARMEL, IN 46032					
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg	conducted by the In accordance with 42 Survey Dates: 11/14 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency Health & Living Cocompliance with Er Requirements for M Suppliers, 42 CFR 4 certified beds and a	4/23 00095 .55181 .90490 Preparedness survey, Carmel ommunity was found in mergency Preparedness Medicare Providers and 483.73 The facility has 188	E 00	00	Event ID: 14FI21 Please find enclosed the Plan Correction for the State Licens Survey conducted on Novemb 14, 2023. This letter is to inform you that the plan of correction attached is to serve as Carme Health & Living Community credible allegation of compliant We allege substantial compliant We allege substantial compliant on December 1, 2023. We are requesting paper compliance of this plan of correction. If you have any further questing please do not hesitate to containe at 317-445-0548 Sincerely, Alyssa Holliday, HFA Administrator Carmel Health and Living Submission of this plan of correction in no way constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or ot services provided in this facilit The Plan of Correction is prepand executed solely because required by Federal and State	sure per rm ll nce. nce e for ons, act is a the her y. ared it is		

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED	
		155181	B. WING 11/14/		11/14/		
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				118 MEDICAL DR			
CARMEL	HEALTH & LIVING	COMMUNITY		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	L	DATE
					Law.		
					This statement of deficiencies	and	
					plan of correction will be review	wed	
					at the Monthly Quality		
					Assurance/Assessment		
					Committee meeting.		
K 0000							
Bldg. 01							
	•	Recertification and State	K 0	000	Event ID: 14FI21		
		as conducted by the Indiana			Please find enclosed the Plan	of	
	-	th in accordance with 42 CFR			Correction for the State Licens	ure	
	483.90(a).				Survey conducted on Novemb	er	
					14, 2023. This letter is to infor	m	
	Survey Dates: 11/14	1/23			you that the plan of correction		
					attached is to serve as Carme		
	Facility Number: 00				Health & Living Community		
	Provider Number: 1				credible allegation of complian		
	AIM Number: 1002	90490			We allege substantial complia		
					on December 1, 2023. We are		
	-	Code survey, Carmel Health &			requesting paper compliance f	or	
		was found not in compliance			this plan of correction.		
	with Requirements						
		, 42 CFR Subpart 483.90(a),			If you have any further question		
	-	re and the 2012 Edition of the			please do not hesitate to conta	ect	
		etion Association (NFPA) 101,			me at 317-445-0548		
	•	SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.			Sincerely,		
	TT : 0 '1	s sa a a a					
	-	ity with a partial walkout lower					
		ed to be of Type V (111)			Alyssa Holliday, HFA		
		lly sprinklered. The facility			Administrator		
	•	tem with smoke detection on all			Carmel Health and Living		
		rs and in all areas open to the			Outrosia sia sa af II i di		
		y has smoke detectors hard			Submission of this plan of	_	
		rm system in resident sleeping			correction in no way constitute		
		d 800 Hall. The facility has			an admission by Carmel Healt	n	
	battery operated sm	oke detectors in resident			and Living or its management		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/14/2023
	ROVIDER OR SUPPLIER HEALTH & LIVING		118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	The facility has a cacensus of 135 at the	dents have customary access all areas providing facility stered.		company that the allegations contained in the survey repor true and accurate portrayal of provision of nursing care or o services provided in this facili. The Plan of Correction is prepand executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revied at the Monthly Quality Assurance/Assessment Committee meeting.	f the ther ty. pared it is
K 0226 SS=E Bldg. 01	with 7.2.4 and the through 18.2.2.5.7 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation failed to ensure 2 of sets were arranged that the LSC section assemblies in horizon automatic-closing Standard for Fire Deprotectives, section doors shall swing each equipped with a cloto close and latch expression.	used, are in accordance provisions of 18.2.2.5.1 f, or 19.2.2.5.1 through on and interview, the facility fover 6 horizontal exit fire door of automatically close and 7.2.4.3.10 requires all fire door ontal exits shall be self-closing g. In addition NFPA 80, the boors and Other Opening 6.1.4.2.1 states self-closing asily and freely and shall be using device to cause the door such time it is opened. This exit 40 residents in 4 smoke a occupied.	K 0226	K226 1.The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. a K226 Horizontal Exits, Based on observation and interview, the facility failed to ensure 2 of over 6 horizontal fire door sets were arranged automatically close and latch. Observation 1. the (1) 90-min rated fire door set near the th	exit to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	<u>01</u>	COMPLI	ETED
		155181	B. W	ING		11/14/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			EDICAL DR		
CARMEL	HEALTH & LIVING	G COMMUNITY			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ons and interview during a			area did not self-close and lat	ch	
	-	with the Maintenance			due to one of the two doors		
	Supervisor and Executive Director on 11/14/23 between 12:20 p.m. and 4:30 p.m., the (1) 90-minute				sticking/rubbing on the floor.		
					The (2) 90-minute rated fire d		
	rated fire door set near the therapy area did not				set between station 3 and the		
	self-close and latch due to one of the two doors				entrance door #4 did not self-		
	sticking/rubbing on the floor. The (2) 90-minute rated fire door set between station 3 and the front				and latch due to one the door	s	
					sticking on the carpet. When		
	entrance door #4 did not self-close and latch due				tested the aforementioned do failed to latch into the frame of		
	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				the doors rubbing on the floor The facility will identify		
	floor.				other residents that may		
	noor.				potentially be affected by th	_	
	This finding was a	cknowledged by the			deficient practice.		
	_	rvisor and Executive Director at			a All residents and staff co	uld	
	_	ry and again at the exit			be affected by this deficient	-ai-a	
		e Maintenance Supervisor and			practice.		
	Executive Director	-			'		
					3 The facility will put into		
	3.1-19(b)				place the following systema	tic	
					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	e	
					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 Super	visor	
					has been reeducated by Car[
					Corporate Facilities for the ne		

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181 A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 11/14/2023	
	ROVIDER OR SUPPLIER		118 M	ADDRESS, CITY, STATE, ZIP COD EDICAL DR IEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				ensure that all fire and smoke barrier doors latch properly. Twill monitor this documentation during their annual CQR. 5 Plan of Correction completion date. a Therapy Door will be fixed 11/29/23 Fire Rate door to station 3 has been fixed and no longer catcon the floor when closing. See attached video labeled station door and the front entrance do 4# video of the door shutting. Completed 11/22/23	They n ed by s h's e
K 0227 SS=E Bldg. 01	escapes, alternation of refuge are in accomprovisions 7.2.5 th 18.2.2.6 to 18.2.2. Based on observation failed to ensure 1 of slope requirement. ramps shall be proved a 1:8 (1 inch of rise approved existing resceed 1:6 (1 inch of ramp). This deficient residents if exiting the state of the s	Exits ageways, fire and slide ag tread devices, and areas cordance with the arough 7.2.12. 10 or 19.2.2.6 to 19.2.2.10 an and interview, the facility arover 3 exit ramps met the LSC 7.2.5.2 states that existing aded with a slope not to exceed for every 8 inches of ramp) and amps with a slope not to of rise for every 6 inches of at practice could affect 15	K 0227	1.The corrective actions to accomplished for those residents found to have been affected by the deficient practice. a K227 Ramps and Other Exits, Based on observation a interview, the facility failed to ensure 1 of over 3 exit ramps the slope requirement. i Observation 1, Based on observations and interview du tour of the facility the exit	n ind met
	_	with the Maintenance cutive Director on 11/14/23		tour of the facility the exit discharge ramp outside the	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/14/2023
	ROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032	
CARMEL (X4) ID PREFIX TAG	summary second and again at the extractive Direct and postpropers of the survey of the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION and 4:30 p.m., the exit side the Station 4 exit door d a concrete surface ramp 0 inches in run length and 30 rise, as measured by the aintenance Supervisor. Based ments, in order to achieve the slope requirement the run would need to be in excess of inclear at the time of the survey and door, marked as both a an exit, was a required exit. is a similar exit door at station suring 108 inches of run length evation rise, (as measured by a Maintenance Supervisor). 2 is marked only NOT AN are to the surveyor at the time of exit door was so marked and quired exit.	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Station 4 exit door near Room 442b had a concrete surface r which measured 100 inches in length and 30 inches in elevatrise, 2 The facility will identify other residents that may potentially be affected by the deficient practice. a No staff or Residents had 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 N Exit and had a sign on the Doos stating it was not a exit. The facility is requesting IDR for the tag given the slope does not controlly into play for a door deemed N Exit. 4 The facility will monitor the corrective action by implementing the following measures a No Further monitoring needed given this exit was she	amp n run ion e ve y ic Not a or is ome ot a
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING			not to be a exit and was marked as Not a Exit (See attached in showing door marked as not a exit)	nage

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155181		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/14/2023	
CARMEL	ROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP COD EDICAL DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
TAG	Exit and directional accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of eased on observation failed to ensure 1 of the facility were not LSC 7.10.8.3.1 states stairway that is neith access and that is look likely to be mistake by a sign that reads EXIT sign shall have inches high, with a and the word EXIT such sign is an approdeficient practice of Findings include: Based on observation of the facility we supervisor and Exelection of the facility we supervisor and Exelection of the facility of the f	al signs are displayed in an another travel is obvious.) The estory existing less than 30 occupants exit travel is obvious.) The another travel is obvious. The another travel is o	K 0293	K293 1 The corrective actions to be accomplished for those residents found to have bee affected by the deficient practice. a Exit Signage, Based on observation and interview, the facility failed to ensure 1 of oxidoors to the outside of the factive were not mistaken as a facility exit. Observation 1, the exterior exidoor near RR #442b was man as a facility exit by an illuminate exit sign. However, the door of was marked NOT AN EXIT. To condition is confusing and contradictory. Based on intervation the time of the observation 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.	DATE 11/27/2023 o n e e ver 8 cility y cit cked glass chis view s, it e e
	the time of discover	y and again at the exit Maintenance Supervisor and		3 The facility will put into place the following systema	tic

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155181	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/14/2023
	PROVIDER OR SUPPLIER		118 MI	ADDRESS, CITY, STATE, ZIP CO	DD
CARMEL	. HEALTH & LIVING	GOMMUNITY	CARM	EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) DULD BE COMPLETION PROPRIATE DATE
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automatioption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 0.7.1 or 19.3.5.9. When the cic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4.		changes to ensure that deficient practice does recur. a The Exit sign above was removed and the ill exit sign that pointed to Exit door was changed to the correct direction to the corrective action by implementing the follow measures. a All other Exit Signs pointing to Exits and are contradictory. No other inneeded. 5 Plan of Correction completion date. a Completed on 11/2	e the door uminating the Non to show he exit. onitor y wing s are e not monitoring

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155181	B. W	ING		11/14	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			EDICAL DR		
CARMEL	_ HEALTH & LIVING	3 COMMUNITY			EL, IN 46032		
OAINILL				OARWIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	N/A					
	a. Boiler and Fuel-Fired Heater Rooms						
	, -	er than 100 square feet)					
	•	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)	_					
	e. Trash Collectio						
	(exceeding 64 ga	•					
		orage Rooms/Spaces					
	(over 50 square for	,					
	,	classified as Severe					
	Hazard - see K32	•	17.0	201	14004		11/22/2022
		on and interview, the facility	K 0	321	K321	_	11/22/2023
		f over 10 hazardous area doors,			1 The corrective actions to	3	
	_	ms, were provided with elf-closing devices. This			be accomplished for those residents found to have bee	_	
		ould affect more than 5				П	
	residents and staff.	outd affect more than 3			affected by the deficient		
	residents and starr.				practice.		
	Findings include:				a Hazardous		
	I mumgs meruue				Areas-Enclosure, Based on		
	Based on observati	ons and interview during a			observation and interview, the	۵	
		with the Maintenance			facility failed to ensure 1 of ov		
		ecutive Director on 11/14/23			hazardous area doors, such a		
	_	and 4:30 p.m., the kitchen			storage rooms, were provided		
	_	ter than 50 square feet			properly working self-closing		
		r of combustible items, such as,			devices. This deficient practic	е	
		cardboard boxes. The corridor			could affect more than 5 resid		
		room was not equipped with a			and staff.		
	_	. The Maintenance Supervisor					
		ently converted the room into			the kitchen storage room, gre	ater	
	a kitchen/dietary st				than 50 square feet contained		
					number of combustible items,		
	This finding was a	cknowledged by the			such as, paper, plastic, and		
		visor and Executive Director at			cardboard boxes. The corrido	r	
	the time of discove	ry and again at the exit			door to this storage room was	not	
		e Maintenance Supervisor and			equipped with a self-closing		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155181	B. WI	NG		11/14	/2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
CARMEL	. HEALTH & LIVIN	G COMMUNITY			EL, IN 46032		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Executive Directo	r present.			device.		
		•					
	3.1-19(b)				2 The facility will identify		
	, ,				other residents that may		
					potentially be affected by the)	
					deficient practice.		
					a Only kitchen staff have th	ne	
					potential to be affected by this		
					deficient practice.		
					·		
					3 The facility will put into		
					place the following systemat	ic	
					changes to ensure that the		
					deficient practice does not		
					recur.		
					1.00		
					a Self-closing device was		
					installed to door. No follow up		
					needed as this is a permanent	t	
					solution to the issue. (See Vide		
					Attachment labeled Kitchen		
					Storage Self Closure for exam	ple	
					of self-closure.)		
					4 The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					a The Maintenance Superv	visor	
					has been reeducated by CarD		
					Corporate Facilities to ensure		
					all rooms greater than 50 squa		
					feet that contains a number of		
					combustible items are equippe	z u	
					with a self-closing device.		1

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155181	B. WING			11/14/	2023
	PROVIDER OR SUPPLIER		11	18 ME	ddress, city, state, zip cod DICAL DR L, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	, T			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)	I E	DATE
					a Completed 11/22/23		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-terre do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3) 1. Based on observa failed to ensure 1 of as a substitute for fif 400.8 state unless sy flexible cords and cr as a substitute for fif	de electrical equipment les that have been diffied personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE OL 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was state conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 tition and interview, the facility of 1 flexible cords were not used exed wiring. NFPA-70/2011, pecifically permitted in 400.7 ables shall not be used for (1) exed wiring. This deficient	K 0920		K920 1 The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		11/22/2023
	practice could affect Directors Office. Findings include:	t up to 1 staff in the Medical			a Electrical Equipment-Por Cords and Extension Cords, Based on observation and	wer	

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Event ID:

14FI21

Facility ID: 000095

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155181	B. W	ING		11/14	/2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			EDICAL DR		
CARME	. HEALTH & LIVING	COMMUNITY			EL, IN 46032		
				O, (I VIVIL	, +0002		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					interview, the facility failed to		
Based on observations and interview during a				ensure 1 of 1 flexible cords we			
		with the Maintenance			not used as a substitute for fix	ed	
	Supervisor and Executive Director on 11/14/23				wiring.		
	-	and 4:30 p.m., in the Medical					
	Directors Office area, an extension cord what was in use powering electron equipment. The				Observation 1, in the Medical	:	
					Directors Office area, an exter		
	Maintenance Super extension cord was	visor agreed the black			cord what was in use powering	g	
	extension cord was	in use.			electron equipment. The	ad	
	This first are a should also the start				Maintenance Supervisor agree		
	This finding was acknowledged by the Maintenance Supervisor and Executive Director at				the black extension cord was	111	
	the time of discovery and again at the exit				Use.	nd to	
		Maintenance Supervisor and			Observation 2, the facility fail ensure 2 of 2 flexible cords po		
	Executive Director	-			strips in patient care locations		
	LACCULIVE DIFFEREN	present.			the required UL rating of 1363		
	2 Based on observe	ation and interview, the facility			60601-1. This deficient practic		
		f 2 flexible cords power strips			affects two residents.	,	
		ions met the required UL			and two residents.		
	-	60601-1. This deficient practice			2 The facility will identify		
	affects two resident	-			other residents that may		
					potentially be affected by the)	
	Findings include:				deficient practice.		
	-						
	Based on observation	ons and interview during a			a Two staff members and t	wo	
	tour of the facility v	with the Maintenance		residents have the potential to		be	
	Supervisor and Exe	ecutive Director on 11/14/23			affected by this deficient pract	ice.	
	between 12:20 p.m.	and 4:30 p.m., in RR 315 there					
	-	ips in use next to the resident's			3 The facility will put into		
		et 1363A or 60601-1			place the following systemat	ic	
	requirements.				changes to ensure that the		
	· ·	n the two aforementioned			deficient practice does not		
		ingling from the wall and was			recur.		
		np draw appliance. The second					
	_	wer strip was concurrently			a Extension cord was remo	oved	
	powering medical a	and non-medical equipment.			from Medical Directors office.		
	D 1				b Both Non Medical grade		
		at the time of observation, the			power strips were removed from		
		tor agreed a power strip was in			resident rooms. Residents and		
	Luse next to a recider	nt hed and did not meet 1363 A	1		families were educated on use	a ot	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPLETED		
		155181	B. WING			11/14/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD				
CADMEL LIEALTH & LIVING COMMUNITY			118 MEDICAL DR					
CARMEL HEALTH & LIVING COMMUNITY			CARMEL, IN 46032					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
	or 60601-1.				power strips and not using nor	n		
			medical grade power str		medical grade power strips.			
	This finding was ac							
	-	visor and Executive Director at			4 The facility will monitor			
		ry and again at the exit			the corrective action by			
		Maintenance Supervisor and			implementing the following			
	Executive Director	present.			measures.			
	3.1-19(b)				a The Maintenance Superv			
				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			
							[

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