STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING -- B. WING	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF CARMEL	12315 PENNSYLVANIA STREET CARMEL, IN 46032

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/12/23 Facility Number: 013444 Provider Number: 155833 AIM Number: 201294880 At this Emergency Preparedness survey, Wellbrooke of Carmel was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 74 certified beds. At the time of the survey, the census was 51. Quality Review completed on 12/14/23	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on December 12th, 2023. Upon completion of this POC and submittal of supporting documentation or photographic evidence of completion we respectfully request that a desk review be obtained and or granted.	
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 Date: 12/12/23 Facility Number: 013444 Provider Number: 155833 AIM Number: 201294880	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to	

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

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	At this Life Safety Code survey, Wellbrooke of Carmel was found not in compliance with Requirements for Participation 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 facility located on the first floor of a two-story building was determined to be of Type V (111) construction and fully sprinklered. A 2-hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first-floor healthcare occupancy and the second-floor residential occupancy is provided by a 2-hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2-hour rated construction. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 51 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/14/23		respond to the allegation of noncompliance cited during the survey visit with exit on December 12th, 2023. Upon completion of this POC and submittal of supporting documentation or photographic evidence of completion we respectfully request that a desk review be obtained and or granted.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following			

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	special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised			

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	automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents. Findings include: Based on observation and interview with the Director of Plant Operations and Corporate Facilities Support Representative during a facility tour on 12/12/23 between 11:00 a.m. and 12:15 p.m., the exit door marked as a facility exit, leading into the Assisted Living area, on the Brookshire	K 0222	**K222 – Egress Doors.** **Immediate Intervention** The signage indicating delayed egress has been removed and access code for entrance has been posted to satisfy deficiency K222 this practice could affect 15 residents. **Exhibit A – Photo (attached)** **Compliance Date** **12-28-23** The Director of plant operations was educated by regional support on egress doors NFPA101 stating that doors in a required means of egress is in accordance with delayed egress locking arrangements or Access controlled egress locking arrangement. This is in accordance with 7.2.1.6.2, 18.2.2.2.4, 19.2.2.2.4	12/28/2023

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	Legacy Hall, was equipped with a working 15 second delayed egress locking mechanism however, the door lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the DOPO acknowledged the door was equipped with a delayed egress and lacked the proper signage. The aforementioned door was also equipped with a coded keypad which would release the magnetic locking mechanism. However, the code to release the mechanism was not posted. This finding was acknowledged at the time of discovery and again at the exit conference with both the Director of Plant Operations and Corporate Facilities Support Representative present. 3.1-19(b)		**Exhibit B – Inservice Documentation** The Director of plant operations will complete a visual inspection on the building for locking devices once a week x3 months then monthly x 3 months. **Exhibit C– Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
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			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 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 10 residents, as well as staff and visitors. Findings include: Based on observation and interview with the Director of Plant Operations and Corporate Facilities Support Representative during a facility tour on 12/12/23 between 11:00 a.m. and 12:15 p.m., the corridor door to the Health Services Directors office, greater than 50 square feet, contained a number of combustible items, such as, 15 large cardboard boxes, was not equipped with a self-closing device. Based on interview at the time of observation, the DOPO agreed the aforementioned office door was not equipped with a self-closing device.	K 0321	**K321- Hazardous Areas Immediate Intervention** Director of plant operations has removed the additional items from the office to remove the need for self-closure equipment to meet deficiency K321 this practice could affect 10 residents and staff. **Exhibit D - Photo (attached)** **Compliance date 12/28/2023** Director of plant operations was educated by the Regional Director of Plant operations on K321 NFPA 101 hazardous areas enclosure doors. Corridor doors and doors to rooms that containing flammable devices or combustible materials must have self-closure device and latching hardware.	12/28/2023

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	This finding was acknowledged at the time of discovery and again at the exit conference with both the Director of Plant Operations and Corporate Facilities Support Representative present. 3.1-19(b)		**Exhibit B- Inservice Documentation** Director of plant operations will visually inspect the required areas latch and do not require self-closure. With the door inspection within TELS. Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is			

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	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 5 residents. Findings include: Based on observation and interview with the Director of Plant Operations and Corporate Facilities Support Representative during a facility tour on 12/12/23 between 11:00 a.m. and 12:15 p.m., the Therapy door into the corridor, equipped with a self-closing device was propped open with a weight and which would not allow the door to self-close. Based on interview at the time of observation, the DOPO agreed the Therapy door would not self-close and latch due to the obstruction.	K 0363	**K363 – Corridor – Doors** **Immediate intervention** Removed the closer attached to the door that would have prevented keeping closed, had no impediment to closing, latching and would resist the passage of smoke that could affect 5 staff and residents to meet K363 deficiency. **Exhibit E - Photo (attached)** **Compliance date** **12/28/23** The Director of Plant Operations was educated by Regional Support on K363 corridor – doors protecting corridor openings in	12/28/2023

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	This finding was acknowledged at the time of discovery and again at the exit conference with both the Director of Plant Operations and Corporate Facilities Support Representative present. 3.1-19(b)		other than required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertains NFPA 101 in compliance with 7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.3, 42 CFR parts 403,418,460,482,483 and 485. **Exhibit B – Inservice Documentation** The Director of Plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit F - Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not			

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	stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 5 of 5 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding	K 0923	**K 923 – Gas equipment – Cylinder and Container storage** **Immediate Intervention** CO2 containers found loose were immediately secured to prevent falling to meet the deficiency that could affect the 3 staff members working in the kitchen. **Exhibit G - Photo (attached)** **Compliance date**	12/28/2023

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	cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 3 staff. Findings include: Based on observation and interview with the Director of Plant Operations and Corporate Facilities Support Representative during a facility tour on 12/12/23 between 11:00 a.m. and 12:15 p.m., 5 carbon dioxide cylinders were standing upright on the floor in the Kitchen Supply area and were not properly chained or supported in a proper cylinder stand or cart. The Director of Plant Operations stated he was unsure why they were being stored in this location. This finding was acknowledged at the time of discovery and again at the exit conference with both the Director of Plant Operations and Corporate Facilities Support Representative present. 3.1-19(b)		**12-28-2023** The Director of Dietary Services was educated by the Regional Facilities Support on NFPA 99 Health Care facilities Code, 2012 Edition in accordance with section 11.3.2.1 through 11.3.2.3 section 11.3.2.6 stating cylinder or container restraints shall comply with 11.6.2.3. **Exhibit B – Inservice Documentation** The director of Dietary Services will visually inspect proper security of cylinders weekly. **Exhibit H – Audit tool** The Executive Director will present the results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	