STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Emergency Preparedness survey, Restoracy of Carmel was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 72 certified beds. At the time of the survey, the census was 71. Quality Review completed on 03/20/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0004	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	03/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andi Denbo	Assist Administrator	04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	Based on record review on 03/18/25 at 09:10 a.m. with the facility Maintenance Director (M.D.) the facility had Emergency Preparedness documentation, but it was incomplete. The facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually. Based on an interview on 03/18/25 at 9:12 a.m., the M.D. agreed that the facility Emergency Preparedness documentation had not been reviewed or updated at least annually as the date of the last update was documented on 02/01/2022 in the Emergency Preparedness binder. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25.		submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to develop and implement emergency preparedness policies and procedures. **Corrective Action for deficiency:** The Emergency Preparedness binder has been reviewed and updated as of 2/1/2025. The incorrect binder was reviewed. The outdated emergency preparedness binder is no longer in the same section as updated binders. **Measures put into place or systemic changes:** Administrator will ensure the proper emergency preparedness binder is selected for review and updated accordingly annually. **Plan to monitor performance to maintain compliance**: Administrator will audit and update the emergency preparedness binder annually.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42	E 0013	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	CFR 482.15(b). This deficient practice could affect all occupants. Findings include: Based on record review on 03/18/25 at 09:10 a.m. with the facility Maintenance Director (M.D.) the facility had Emergency Preparedness documentation, but it was incomplete. The facility failed to develop and implement emergency preparedness policies and procedures that were reviewed and updated at least annually. Based on interview on 03/18/25 at 09:13 a.m. the M.D. acknowledged that the emergency preparedness plan failed to develop and implement policies and procedures that were reviewed or updated at least annually with the date of the last update as being done on 02/01/2022. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25.		Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to develop and implement emergency preparedness policies and procedures. **Corrective Action for deficiency:** The Emergency Preparedness binder has been reviewed and updated as of 2/1/2025. The incorrect binder was reviewed. The outdated emergency preparedness binder is no longer in the same section as updated binders. **Measures put into place or systemic changes:** Administrator will ensure the proper emergency preparedness binder is selected for review and updated accordingly annually. **Plan to monitor performance to maintain compliance**: Administrator will audit and update the emergency preparedness binder annually.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility	E 0029	**Disclaimer:**	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 482.15(c). This deficient practice could affect all occupants. Findings include: Based on record review on 03/18/25 at 09:10 a.m. with the facility Maintenance Director (M.D.) the facility had Emergency Preparedness documentation, but it was incomplete. The facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually. Based on interview on 03/18/25 at 09:15 a.m. the M.D. acknowledged that the emergency preparedness plan failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually with the date of the last update as being done on 02/01/2022. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25.		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to develop and implement emergency preparedness policies and procedures. **Corrective Action for deficiency:** The Emergency Preparedness binder has been reviewed and updated as of 2/1/2025. The incorrect binder was reviewed. The outdated emergency preparedness binder is no longer in the same section as updated binders. **Measures put into place or systemic changes:** Administrator will ensure the proper emergency preparedness binder is selected for review and updated accordingly annually. **Plan to monitor performance to maintain compliance**: Administrator will audit and update the emergency preparedness binder annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 482.15(d). This deficient practice could affect all occupants. Findings include: Based on record review on 03/18/25 at 09:10 a.m. with the facility Maintenance Director (M.D.) the facility had Emergency Preparedness documentation, but it was incomplete. The facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually Based on interview on 03/18/25 at 09:17 a.m. the M.D. acknowledged that the emergency preparedness plan failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually with the date of the last update being documented as 02/01/2022. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25.	E 0036	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to develop and implement emergency preparedness policies and procedures. **Corrective Action for deficiency:** The Emergency Preparedness binder has been reviewed and updated as of 2/1/2025. The incorrect binder was reviewed. The outdated emergency preparedness binder is no longer in the same section as updated binders. **Measures put into place or systemic changes:** Administrator will ensure the proper emergency preparedness binder is selected for review and updated accordingly annually. **Plan to monitor performance to maintain compliance**:	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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			Administrator will audit and update the emergency preparedness binder annually.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least biennially, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 03/18/25 at 09:10 a.m.	E 0039	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to conduct exercises to test the emergency plan. **Corrective Action for deficiency:** A tabletop exercise for a tornado procedure has been conducted with staff. **Measures put into place or systemic changes: Maintenance Director will conduct these exercises biannually.** **Plan to monitor performance to maintain compliance**: Administrator will audit emergency plan biannually to ensure the facility has conducted proper	03/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	with the facility Maintenance Director (M.D.) the facility had Emergency Preparedness documentation, but it was incomplete. The facility failed to participate in a community-based or individual, facility-based full-scale exercise. Based on interview on 03/18/25 at 09:19 a.m. the M.D. acknowledged that the facility failed to conduct a full-scale exercise that is community-based or an individual, facility-based exercise. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25.		exercises for emergency procedures.	
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: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 01 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 01 is identified as Cottage #2. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for**	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 01 B. WING	03/18/2025

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RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 11:55 a.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #1 Cottage #2. Based on an interview on 03/17/25 at 11:56 a.m. the M.D. acknowledged there was no written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)		**deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting. **Measures put into place or systemic changes: We h**ave reached out to contracted services to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	
K 0000 Bldg. 02	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).	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 02 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	Survey Dates: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 02 is identified as Cottage #3. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 02 B. WING	03/18/2025

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	Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 12:18 p.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #2 Cottage #3. Based on an interview on 03/17/25 at 12:19 p.m. the M.D. acknowledged there was no	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting. **Measures put into place or systemic changes: We h**ave reached out to contracted services to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 02 B. WING	03/18/2025

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	written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)			
K 0000 Bldg. 03	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: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 03 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 03 is identified as Cottage #1. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting.	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 03 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 10:15 a.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #3 Cottage #1. Based on an interview on 03/17/25 at 10:16 a.m. the M.D. acknowledged there was no written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)		**Measures put into place or systemic changes: We h**ave reached out to contracted services to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	
K 0000 Bldg. 04	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: 03/17/25 and 03/18/25 Facility Number: 013753	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 04 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 04 is identified as Cottage #4. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. This Cottage serves as a Memory Care building for this facility. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 04 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 1:26 p.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #4 Cottage #4. Based on an interview on 03/17/25 at 1:27 p.m. the M.D. acknowledged there was no written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey.		compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting. **Measures put into place or systemic changes: We h**ave reached out to contracted services to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 04 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)			
K 0000 Bldg. 05	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: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 05 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY 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
	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 05 is identified as Cottage #5. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 05	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting. **Measures put into place or systemic changes: We h**ave reached out to contracted services	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 05 B. WING	03/18/2025

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RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 2:22 p.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #5 Cottage #5. Based on an interview on 03/17/25 at 2:23 p.m. the M.D. acknowledged there was no written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)		to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	
K 0363 SS=E Bldg. 05	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 72 sets of Resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect as many as 12 residents, 6 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director (M.D.) on	K 0363	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and	03/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 05 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	03/18/25 at 11:51 a.m., the corridor door in Cottage #5, resident room J, failed to fully close and latch into the doorframe. Based on an interview at 11:53 a.m. with the M.D., he agreed that the resident room J door to the corridor failed to fully close and latch into the doorframe adding that he would have the door looked at as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on 03/18/25. 3.1-19(b)		federal law. **Alleged deficiency:** Failed to ensure 1 of 72 sets of resident room doors to the corridor would close completely and latch into the door frame. **Corrective Action for deficiency:** The Maintenance Director added extra screws to the hinge and inserted a wooden shim to prop the door up correctly. **Measures put into place or systemic changes:** Maintenance Director will ensure all resident room doors latch completely into the door frame. **Plan to monitor performance to maintain compliance**: Maintenance Director will perform routine audits to ensure the doors close and latch completely.	
K 0000 Bldg. 06	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: 03/17/25 and 03/18/25 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 06 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	At this Life Safety Code survey, Restoracy of Carmel 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. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 06 is identified as Cottage #6. The cottage has a capacity of 12 and had a census of 11 at the time of this survey. Quality Review completed on 03/20/25			
K 0353 SS=F Bldg. 06	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA	K 0353	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 06 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices to be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the facilities quarterly sprinkler system inspection records entitled "Inspection and Testing Report" on 03/17/25 at 3:28 p.m. with the Maintenance Director (M.D.) present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2024 for Building #6 Cottage #6. Based on an interview on 03/17/25 at 3:29 p.m. the M.D. acknowledged there was no written documentation available for review in regards to a second quarter sprinkler system inspection available as of the time of this survey. This finding was reviewed with the Executive Director and Maintenance Director at the time of discovery and again during the exit conference on		or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to inspect and test the sprinkler system every quarter. **Corrective Action for deficiency: To upgrade our contracting services to provide quarterly** sprinkler system testing and inspecting. **Measures put into place or systemic changes: We h**ave reached out to contracted services to upgrade our contract to fulfill 4 quarters of sprinkler system testing and inspecting. Will have contracts signed by the end of April. 1st quarter inspection is complete. **Plan to monitor performance to maintain compliance**: Our contracted services will test and inspect quarterly with documentation recorded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 06 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	03/18/25. 3.1-19(b)			