STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155846	B. WING	<u></u>	03/18/2025	
			CTDEET	Γ ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L		REEN HOUSE WAY		
RESTOR	ACY OF CARMEL			MEL, IN 46032		
I LOTON	ACT OF CARNIEL		_ J GARN	ILE, II TOOOZ		
(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 APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg						
		paredness Survey was	E 0000			
	_	diana Department of Health in				
	accordance with 42 CFR 483.73.					
	Survey Dates: 03/17	7/25 and 03/18/25				
	E 112 37 1 04	12752				
	Facility Number: 01 Provider Number: 1					
	AIM Number: 2013	002130				
	At this Emergency l	Pranaradness survey				
	At this Emergency Preparedness survey, Restoracy of Carmel was found in substantial					
	-	nergency Preparedness				
	_	ledicare and Medicaid				
	-	lers and Suppliers, 42 CFR				
	483.73	,				
	The facility has 72 of	certified beds. At the time of				
	the survey, the cens					
	Quality Review con	npleted on 03/20/25				
	_	42 CFR, Subpart 483.73 is NOT				
	MET as evidenced b	by:				
E 0004	, ,	4(a), 418.113(a), 441.1				
SS=C	•	Review and Update				
Bldg	Annually				00/40/2025	
		view and interview, the facility	E 0004	Disclaimer:	03/18/2025	
	_	d maintain an emergency		This Plan of Correction consti		
		hat was reviewed and updated		this facility's written allegation		
	-	accordance with 42 CFR cient practice could affect all		compliance for the deficiencie		
	occupants.	erem practice could affect all		cited. However, submission of Plan of Correction is not an	i uno	
	оссиранів.			admission that a deficiency ex	viete	
	Findings include:			or that one was cited correctly		
	i maniga metude.			This Plan of Correction is	·	
				This hair of Conection is		

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

TITLE (X6) DATE

Andi Denbo Assist Administrator 04/08/2025

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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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846		JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/18/2025	
	ROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	with the facility Ma facility had Emerge	view on 03/18/25 at 09:10 a.m. intenance Director (M.D.) the ency Preparedness it was incomplete. The facility			submitted to meet requiremen established by the state and federal law.	ts	
	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				Alleged deficiency: Failed to develop and implement emergoreparedness policies and procedures.	ency	
	annually as the date	of the last update was 01/2022 in the Emergency			Corrective Action for deficiency: The Emergency Preparedness binder has been reviewed and updated as of 2/1/2025. The incorrect binder		
	Director and Mainte	viewed with the Executive enance Director at the time of a during the exit conference on			reviewed. The outdated emerg preparedness binder is no long in the same section as update binders.	ger	
					Measures put into place or systemic changes: Administrativill ensure the proper emerged preparedness binder is selected for review and updated accordannually.	ncy ed	
					Plan to monitor performance maintain compliance: Administrator will audit and up the emergency preparedness binder annually.		
E 0013 SS=C Bldg	• •	4(b), 418.113(b), 441.1 P Policies and Procedures					
	failed to develop an preparedness polici- policies and proced	view and interview, the facility dimplement emergency es and procedures. The ures must be reviewed and anally in accordance with 42	E 0	013	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of	of S	03/18/2025

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/18/2025
	PROVIDER OR SUPPLIER	3	616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROPE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	CFR 482.15(b). The all occupants.  Findings include:  Based on record rewith the facility Market facility had Emerged documentation, but failed to develop are preparedness policite reviewed and update interview on 03/18/acknowledged that plan failed to develop procedures that were annually with the didone on 02/01/2022.  This finding was represented by the company of the company	it was incomplete. The facility and implement emergency es and procedures that were used at least annually. Based on (25 at 09:13 a.m. the M.D. the emergency preparedness op and implement policies and the reviewed or updated at least atte of the last update as being	TAG	Plan of Correction is not an admission that a deficiency e or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to develop and implement emer preparedness policies and procedures.  Corrective Action for deficiency: The Emergency Preparedness binder has beer reviewed and updated as of 2/1/2025. The incorrect binder reviewed. The outdated emer preparedness binder is no lor in the same section as updated binders.  Measures put into place or systemic changes: Administ will ensure the proper emerge preparedness binder is select for review and updated accordantially.  Plan to monitor performance maintain compliance: Administrator will audit and up the emergency preparedness binder annually.	xists // ints  gency  en r was gency iger ed  rator ency ed dingly  e to  odate
E 0029 SS=C Bldg		4(c), 418.113(c), 441.1 Communication Plan			
	Based on record rev	view and interview, the facility	E 0029	Disclaimer:	03/18/2025

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Facility ID: 013753

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/18/2025	
	ROVIDER OR SUPPLIER		616 G	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY IEL, IN 46032	
(X4) ID PREFIX TAG	summary:  (EACH DEFICIEN REGULATORY OR failed to develop an preparedness comm with Federal, State, and updated at least 42 CFR 482.15(c).' affect all occupants  Findings include:  Based on record rev with the facility Ma facility had Emerge documentation, but failed to develop an preparedness comm with Federal, State, and updated at least on 03/18/25 at 09:1 that the emergency maintain an emerge communication plan State, and local law least annually with being done on 02/0  This finding was re Director and Mainton	riew on 03/18/25 at 09:10 a.m. intenance Director (M.D.) the ncy Preparedness it was incomplete. The facility d maintain an emergency unication plan that complies and local laws was reviewed annually. Based on interview 5 a.m. the M.D. acknowledged preparedness plan failed to ncy preparedness in that complies with Federal, is was reviewed and updated at the date of the last update as			itutes it of es if this es if this  gency en er was egency ed et  rator ency ted dingly e to  pdate
				binder annually.	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G	COMP	(X3) DATE SURVEY COMPLETED 03/18/2025	
	ROVIDER OR SUPPLIER		616	EET ADDRESS, CITY, STATE, ZIP COI 5 GREEN HOUSE WAY RMEL, IN 46032	)	
(X4) ID PREFIX TAG E 0036	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 4(d), 418.113(d), 441.1	ID PREFI TAG	CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
SS=C Bldg	EP Training and T	. ,				
Blag	failed to develop an preparedness training was reviewed and use accordance with 42 practice could affect Findings include:  Based on record reward with the facility Massacility had Emerged documentation, but failed to develop an preparedness training was reviewed and use on interview on 03/acknowledged that the plan failed to develop preparedness training was reviewed and use the date of the last use 02/01/2022.  This finding was reviewed and Mainter the date of the last use of the last us	riew on 03/18/25 at 09:10 a.m. intenance Director (M.D.) the	E 0036	Disclaimer: This Plan of Correction of this facility's written alleg compliance for the deficicited. However, submiss Plan of Correction is not admission that a deficier or that one was cited corrise Plan of Correction is submitted to meet requirestablished by the state federal law.  Alleged deficiency: Fail develop and implement of preparedness policies are procedures.  Corrective Action for deficiency: The Emerge Preparedness binder has reviewed and updated as 2/1/2025. The incorrect be reviewed. The outdated of preparedness binder is rein the same section as unbinders.  Measures put into place systemic changes: Admivilliensure the proper empreparedness binder is so for review and updated a annually.	encies ion of this an acy exists rectly. s ements and ed to emergency and ency s been s of binder was emergency no longer pdated e or aninistrator anergency selected accordingly	03/18/2025
				maintain compliance:		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155846				JILDING	onstruction 	COMPL 03/18/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					Administrator will audit and up- the emergency preparedness binder annually.	date	
E 0039 SS=C Bldg	403.748(d)(2), 416 EP Testing Requir	5.54(d)(2), 418.113(d)( ements					
	failed to conduct explan at least biennia staff drills using the LTC facility must diparticipate in a full-community-based of exercise is not access facility-based. If the actual natural or marequires activation of LTC facility is exencommunity-based of full-scale exercise for the actual event; (ii) exercise that may in following: (A) a secommunity-based of a tabletop exercise the discussion led by a clinically relevanter of problem statement prepared questions of emergency plan; (iii) response to and main drills, tabletop exercise the LTC needed in accordance. Findings include:	iew and interview, the facility ercises to test the emergency lly, including unannounced emergency procedures. The o all of the following: (i) scale exercise that is r when a community-based stible, an individual, a LTC facility experiences an in-made emergency that of the emergency plan, the npt from engaging in a r individual, facility-based for 1 year following the onset of conduct an additional clude, but is not limited to the ond full-scale exercise that is r individual, facility-based. (B) that includes a group facilitator, using a narrated, mergency scenario, and a set at the directed messages, or designed to challenge an analyze the LTC facility's intain documentation of all cises, and emergency events, facility's emergency plan, as the with 42 CFR 483.73(d)(2). In the condition of the	E 00	039	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly. This Plan of Correction is submitted to meet requirement 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 be conducted with staff.  Measures put into place or systemic changes: Maintenance Director will conduct these exercises biannually.  Plan to monitor performance maintain compliance: Administrator will audit emerge plan biannually to ensure the facility has conducted proper	of sthis ists	03/24/2025

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155846				JILDING	INSTRUCTION	COMPL 03/18/	ETED
	ROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE	ID ID				(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION DATE
K 0000	with the facility Mar facility had Emerger documentation, but failed to participate individual, facility-bon interview on 03/2 acknowledged that t full-scale exercise the individual, facility-bon This finding was rev Director and Mainter	intenance Director (M.D.) the ncy Preparedness it was incomplete. The facility in a community-based or based full-scale exercise. Based 18/25 at 09:19 a.m. the M.D. the facility failed to conduct a nat is community-based or an			exercises for emergency procedures.		
Bldg. 01							
Š	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 0	000			
	Survey Dates: 03/17	7/25 and 03/18/25					
	Facility Number: 01 Provider Number: 1 AIM Number: 2013	55846					
	Carmel was found n Requirements for Pa Medicare/Medicaid, Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa	the and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing and 410 IAC 16.2.					
	-	of six buildings (01 through s a one-story cottage					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  03/18/2025
	PROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	determined to be of was fully sprinklere system with smoke areas open to the codetectors in the resi has a capacity of 72 time of this survey.  All areas where resi were sprinklered an services were sprinklered an services were sprinklered and a Building 01 is ident cottage has a capacity at the time of thi Quality Review corn.  NFPA 101  Sprinkler System and the sprinkler System are detected and 4.6.12.1 requires an required for complimaintained in accorn requirements. Sprinkler Sprinkler System and the sprinkler sprink	Type V (111) construction and d. Each cottage has a fire alarm detection in the corridors, orridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the detection have customary access d all areas providing facility stered, with exception of a dministration building.	K 0353	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requiremen established by the state and federal law.  Alleged deficiency: Failed to inspect and test the sprinkler system every quarter.  Corrective Action for	tutes of s f this dists .

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	OF CORRECTION	IDENTIFICATION NUMBER  155846	A. BUILDING B. WING	01	COMPLETED 03/18/2025
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY	
RESTOR	ACY OF CARMEL		CARMEL, IN 46032		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	results, and the date	. NFPA 25, 5.2.5 requires that		deficiency: To upgrade our	
		vices shall be inspected		contracting services to prov	
		hey are free of physical		quarterly sprinkler system tes	sting
		5.3.3.1 requires the mechanical		and inspecting.	
		vices including, but not limited gs, shall be tested quarterly.		Measures put into place or	
	5.3.3.2 requires van			systemic changes: We have reached out to contracted ser	
	_	ow alarm devices to be tested		to upgrade our contract to fulf	
		deficient practice could affect		quarters of sprinkler system	''' <del>'</del>
	_	and visitors in the facility.		testing and inspecting. Will ha	ive
	,,	,		contracts signed by the end o	•
	Findings include:			April. 1st quarter inspection is	•
				complete.	
		the facilities quarterly			
		pection records entitled		Plan to monitor performance	e to
	_	ting Report" on 03/17/25 at		maintain compliance: Our	
		Maintenance Director (M.D.)		contracted services will test a	nd
	_	o quarterly sprinkler system		inspect quarterly with	
		ailable for the second quarter		documentation recorded.	
		ne) of 2024 for Building #1			
	-	on an interview on 03/17/25 at			
		acknowledged there was no on available for review in			
		quarter sprinkler system			
		as of the time of this survey.			
	•	·			
	_	viewed with the Executive			
		enance Director at the time of			
		during the exit conference on			
	03/18/25.				
	3.1-19(b)				
	>(=)				
K 0000					
Bldg. 02					
	_	Recertification and State	K 0000		
		as conducted by the Indiana			
	*	th in accordance with 42 CFR			
	483.90(a).				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	l í	UILDING	nstruction  02	(X3) DATE COMPL 03/18/	ETED
	ROVIDER OR SUPPLIER	2	-	616 GR	DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Survey Dates: 03/1	7/25 and 03/18/25					
	Facility Number: 0 Provider Number: 1 AIM Number: 2013	155846					
	Carmel was found a Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code (I	Code survey, Restoracy of not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	06). Each building determined to be of was fully sprinklere system with smoke areas open to the codetectors in the resi	s of six buildings (01 through is a one-story cottage. Type V (111) construction and ed. Each cottage has a fire alarm detection in the corridors, orridors and hard-wired smoke dent rooms. The entire facility 2 and had a census of 71 at the					
	were sprinklered an services were sprink	idents have customary access and all areas providing facility klered, with exception of a dministration building.					
	_	tified as Cottage #3. The ity of 12 and had a census of s survey.					
IV 0050	•	mpleted on 03/20/25					
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System	- Maintenance and Testing					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846		UILDING	DISTRUCTION 02	(X3) DATE COMPI 03/18	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
	failed to provide we evidence the sprink been inspected and 4.6.12.1 requires ar required for compli maintained in according requirements. Spring maintained in according the Inspection, water-Based Fire Parameters and shall an according the Inspections, tests, a components and shall authority having juring requires that recording performed (e.g., instance) the organization that results, and the date waterflow alarm dequarterly to verify the damage. NFPA 25, waterflow alarm deto, water motoring on 5.3.3.2 requires var switch-type waterflow alarm deto, water motoring on 5.3.3.2 requires var switch-type waterflow alarm deto, water motoring on 5.3.3.2 requires var switch-type waterflow alarm deto, water motoring on 5.3.3.2 requires var switch-type waterflow all residents, staff, a Findings include:  Based on review of sprinkler system instance in spection and Testance in the present, there was reinspection report averaged to the present, there was reinspection report averaged to the present, there was reinspection for the present and Jurian and Jurian Based of the present a	riew and interview, the facility ritten documentation or other ler system components had tested for 1 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA kler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 is shall indicate the procedure pection, test, or maintenance), at performed the work, the standard respective shall be inspected they are free of physical 5.3.3.1 requires the mechanical vices including, but not limited gs, shall be tested quarterly. The e-type and pressure ow alarm devices to be tested deficient practice could affect and visitors in the facility.  The facilities quarterly spection records entitled sting Report" on 03/17/25 at Maintenance Director (M.D.) to quarterly sprinkler system railable for the second quarter and on 13/17/25 at a caknowledged there was no		0353	Disclaimer: This Plan of Correction consthis facility's written allegation compliance for the deficiency cited. However, submission Plan of Correction is not an admission that a deficiency or that one was cited correct This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed inspect and test the sprinkle system every quarter.  Corrective Action for deficiency: To upgrade our contracting services to product to contract to product to contracted services will be a contracted service of sprinkler system testing and inspecting. We have reached out to contracted service to upgrade our contract to further testing and inspecting. Will be contracted signed by the end April. 1st quarter inspection complete.  Plan to monitor performant maintain compliance: Our contracted services will test inspect quarterly with documentation recorded.	on of ies of this exists tly. ents  ovide esting e ervices alfill 4 nave of is	04/30/2025

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	, ,	UILDING	NSTRUCTION 02	(X3) DATE COMPL 03/18/	ETED
	PROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	regards to a second inspection available  This finding was re  Director and Mainto	ion available for review in quarter sprinkler system e as of the time of this survey.  viewed with the Executive enance Director at the time of a during the exit conference on					
K 0000 Bldg. 03							
Bidg. US	Licensure Survey w Department of Heal 483.90(a).  Survey Dates: 03/1/ Facility Number: 0 Provider Number: 1 AIM Number: 2013  At this Life Safety of Carmel was found in Requirements for P Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupant The facility consists 06). Each building in determined to be of was fully sprinklere system with smoke	13753 155846 362150 Code survey, Restoracy of not in compliance with	K 0	000			

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Event ID:

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Facility ID: 013753

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 03  B. WING			(X3) DATE COMPL <b>03/18</b> /	ETED			
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0353 SS=F	has a capacity of 72 time of this survey.  All areas where rest were sprinklered an services were sprinklered at Building 03 is ident cottage has a capacita at the time of thi Quality Review cor	•					
Bldg. 03	failed to provide we evidence the sprink been inspected and 4.6.12.1 requires an required for compli maintained in accor requirements. Sprin maintained in accor for the Inspection, Water-Based Fire P 4.3.1 requires recor inspections, tests, a components and she authority having jur requires that record performed (e.g., inst the organization that results, and the date waterflow alarm de quarterly to verify to	riew and interview, the facility ritten documentation or other ler system components had tested for 1 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA kler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure pection, test, or maintenance), at performed the work, the s. NFPA 25, 5.2.5 requires that vices shall be inspected hey are free of physical 5.3.3.1 requires the mechanical	K 0	353	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement 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 provinguarterly sprinkler system testand inspecting.	of s this ists . ts	04/30/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

303P21

Facility ID: 013753

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIE		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
waterflow alarm do to, water motor go 5.3.3.2 requires va switch-type waterf semiannually. This all residents, staff, Findings include:  Based on review of sprinkler system in "Inspection and Te 10:15 a.m. with the present, there was inspection report at (April, May, and J. Cottage #1. Based 10:16 a.m. the M.I. written documentate regards to a second inspection available. This finding was redirector and Main	evices including, but not limited angs, shall be tested quarterly. In the angle of the state of the facilities quarterly and visitors in the facility.  If the facilities quarterly aspection records entitled esting Report" on 03/17/25 at the Maintenance Director (M.D.) and quarterly sprinkler system and visitors will be for the second quarter and of 2024 for Building #3 on an interview on 03/17/25 at the D. acknowledged there was no tion available for review in a quarter sprinkler system the as of the time of this survey.  Eviewed with the Executive tenance Director at the time of an during the exit conference on		Measures put into place or systemic changes: We have reached out to contracted sent oupgrade our contract to fulf 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 maintain compliance: Our contracted services will test a inspect quarterly with documentation recorded.	vices ill 4 ive f
K 0000				
Licensure Survey		K 0000		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155846		A. BUILDING B. WING	04	COMPLETED 03/18/2025
	ROVIDER OR SUPPLIER  ACY OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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 constitution this facility's written allegation	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		UILDING	onstruction 04	(X3) DATE : COMPL 03/18/	ETED	
	ROVIDER OR SUPPLIER	3	616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	been inspected and 4.6.12.1 requires ar required for compli maintained in accor requirements. Sprin maintained in accor for the Inspection, Water-Based Fire P 4.3.1 requires recor inspections, tests, a components and sha authority having jur requires that record performed (e.g., insthe organization that results, and the date waterflow alarm de quarterly to verify the damage. NFPA 25, waterflow alarm de to, water motor gon 5.3.3.2 requires var switch-type waterfl semiannually. This all residents, staff, a Findings include:  Based on review of sprinkler system instruction and Test 1:26 p.m. with the Inpresent, there was reinspection report av (April, May, and Ju Cottage #4. Based of 1:27 p.m. the M.D. written documentat regards to a second	tested for 1 of 4 quarters. LSC by device, equipment or system ance with this Code be redance with applicable NFPA deler systems shall be properly redance with NFPA 25, Standard Testing, and Maintenance of Protection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure repection, test, or maintenance), at performed the work, the s. NFPA 25, 5.2.5 requires that vices shall be inspected they are free of physical 5.3.3.1 requires the mechanical vices including, but not limited types, shall be tested quarterly. The facilities quarterly spection records entitled sting Report" on 03/17/25 at Maintenance Director (M.D.) The quarterly sprinkler system railable for the second quarter and of 2024 for Building #4 on an interview on 03/17/25 at acknowledged there was no ion available for review in quarter sprinkler system	TAG	compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement 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 provi quarterly sprinkler system test and inspecting.  Measures put into place or systemic changes: We have reached out to contracted service to upgrade our contract to fulfit 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 maintain compliance: Our contracted services will test an inspect quarterly with documentation recorded.	this ists	DATE
	_	e as of the time of this survey.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155846			lì í	UILDING	nstruction 04	CON	TE SURVEY MPLETED 18/2025
	ROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP EEN HOUSE WAY L, IN 46032	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Director and Mainte	viewed with the Executive enance Director at the time of a during the exit conference on					
K 0000							
Bldg. 05	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 03/17 Facility Number: 01 Provider Number: 1 AIM Number: 2013	13753 55846 62150	K 0	0000			
	Carmel was found r Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L	Code survey, Restoracy of not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	06). Each building is determined to be of was fully sprinklere system with smoke areas open to the condetectors in the residual to the con	s of six buildings (01 through s a one-story cottage Type V (111) construction and d. Each cottage has a fire alarm detection in the corridors, rridors and hard-wired smoke dent rooms. The entire facility and had a census of 71 at the					

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Event ID:

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Facility ID: 013753

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` ´		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	05	COMPLETED	
		155846	B. WING 03/18/2		2025		
	ROVIDER OR SUPPLIER			616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032		
(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	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
K 0353 SS=F Bldg. 05	were sprinklered an services were sprink separate detached as Building 05 is ident cottage has a capaci 12 at the time of thi Quality Review components and the sprinkler System - Based on record revidence the sprinkler of the s	dents have customary access d all areas providing facility stered, with exception of a dministration building.  diffied as Cottage #5. The sty of 12 and had a census of s survey.  Inpleted on 03/20/25  - Maintenance and Testing  A wiew and interview, the facility street documentation or other street der system components had tested for 1 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA kler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the sisdiction upon request. 4.3.2 is shall indicate the procedure pection, test, or maintenance), at performed the work, the supplies the mechanical vices including, but not limited gs, shall be tested quarterly. e-type and pressure	K 0	353	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exor that one was cited correctly This Plan of Correction is submitted to meet requirement 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 proving quarterly sprinkler system test and inspecting.  Measures put into place or systemic changes: We have reached out to contracted services.	of s f this sists tts	04/30/2025

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155846		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>05</u>	(X3) DATE SURVEY  COMPLETED  03/18/2025	
	PROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
140	switch-type waterfle semiannually. This all residents, staff, a Findings include:  Based on review of sprinkler system ins "Inspection and Tes 2:22 p.m. with the Market present, there was n inspection report av (April, May, and Ju Cottage #5. Based of 2:23 p.m. the M.D. written documentative regards to a second inspection available.  This finding was reported to the present of t	ow alarm devices to be tested deficient practice could affect and visitors in the facility.  the facilities quarterly spection records entitled sting Report" on 03/17/25 at Maintenance Director (M.D.) on quarterly sprinkler system ailable for the second quarter nee) of 2024 for Building #5 on an interview on 03/17/25 at acknowledged there was no ston available for review in quarter sprinkler system as of the time of this survey.  Viewed with the Executive enance Director at the time of a during the exit conference on	TAU	to upgrade our contract to fulf quarters of sprinkler system testing and inspecting. Will ha contracts signed by the end of April. 1st quarter inspection is complete.  Plan to monitor performance maintain compliance: Our contracted services will test a inspect quarterly with documentation recorded.	ill 4  ive f
K 0363 SS=E Bldg. 05	NFPA 101 Corridor - Doors				
,	failed to ensure 1 of doors to the corrido latch into the door f could affect as many visitors.  Findings include:  Based on observation	on and interview, the facility 6.72 sets of Resident room r would close completely and frame. This deficient practice by as 12 residents, 6 staff and 2 ons made during a tour of the intenance Director (M.D.) on	K 0363	Disclaimer: This Plan of Correction constitution this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency export that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and	of ss f this cists

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE ( A. BUILDING B. WING	O5	(X3) DATE SURVEY COMPLETED 03/18/2025
	ROVIDER OR SUPPLIER		616 G	FADDRESS, CITY, STATE, ZIP COD FREEN HOUSE WAY MEL, 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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	#5, resident room J, into the doorframe. a.m. with the M.D., room J door to the cand latch into the dohave the door looke  This finding was rev Director and Mainte	m., the corridor door in Cottage failed to fully close and latch Based on an interview at 11:53 he agreed that the resident corridor failed to fully close corframe adding that he would d at as soon as possible.  Viewed with the Executive chance Director at the time of during the exit conference on		Alleged deficiency: Failed to ensure 1 of 72 sets of reside room doors to the corridor will close completely and latch in the door frame.  Corrective Action for deficiency: The Maintenance Director added extra screws hinge and inserted a woode to prop the door up correctly  Measures put into place or systemic changes: Mainter Director will ensure all reside room doors latch completely the door frame.  Plan to monitor performant maintain compliance: Maintenance Director will per routine audits to ensure the	ent yould nto  ce s to the n shim y nance ent y into  ce to
K 0000				close and latch completely.	
Bldg. 06	Licensure Survey w	3753 55846	K 0000		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>06</u> COMPLETED B. WING 03/18/2025				
155846							
	ROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	Code survey, Restoracy of not in compliance with					
	Requirements for P	•					
	-	, 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the					
		ction Association (NFPA) 101,					
		SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	The facility consists	s of six buildings (01 through					
	•	is a one-story cottage					
		Type V (111) construction and					
		ed. Each cottage has a fire alarm					
		detection in the corridors,					
	-	orridors and hard-wired smoke					
		dent rooms. The entire facility and had a census of 71 at the					
	time of this survey.						
	time of time survey.						
	All areas where resi	idents have customary access					
	_	d all areas providing facility					
	-	klered, with exception of a					
	separate detached a	dministration building.					
	Building 06 is ident	tified as Cottage #6. The					
	-	ity of 12 and had a census of					
	11 at the time of thi	-					
	Quality Review con	npleted on 03/20/25					
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 06							
		view and interview, the facility	K 0.	353	Disclaimer:		04/30/2025
	-	ritten documentation or other ler system components had			This Plan of Correction constitution allocation		
	-	tested for 1 of 4 quarters. LSC			this facility's written allegation compliance for the deficiencie		
	•	y device, equipment or system			cited. However, submission of		
	•	ance with this Code be			Plan of Correction is not an	<del>-</del>	
		dance with applicable NFPA			admission that a deficiency ex	rists	

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE ( A. BUILDING B. WING	Onstruction  06	(X3) DATE SURVEY COMPLETED 03/18/2025
	PROVIDER OR SUPPLIER		616 G	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY IEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	maintained in according for the Inspection, Water-Based Fire P 4.3.1 requires recordinspections, tests, a components and shauthority having jui	Aller systems shall be properly redance with NFPA 25, Standard Festing, and Maintenance of Protection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure		or that one was cited correct.  This Plan of Correction is submitted to meet requireme established by the state and federal law.  Alleged deficiency: Failed to inspect and test the sprinkler system every quarter.	nts
	performed (e.g., ins the organization that results, and the date waterflow alarm de quarterly to verify the damage. NFPA 25,	ppection, test, or maintenance), at performed the work, the e. NFPA 25, 5.2.5 requires that vices shall be inspected hey are free of physical 5.3.3.1 requires the mechanical vices including, but not limited		Corrective Action for deficiency: To upgrade our contracting services to proquarterly sprinkler system to and inspecting.	vide
	to, water motor gon 5.3.3.2 requires var switch-type waterfl semiannually. This all residents, staff, a	ogs, shall be tested quarterly. te-type and pressure ow alarm devices to be tested deficient practice could affect and visitors in the facility.		Measures put into place or systemic changes: We have reached out to contracted se to upgrade our contract to ful quarters of sprinkler system testing and inspecting. Will h contracts signed by the end of	rvices Ifill 4 ave of
	sprinkler system ins "Inspection and Tes 3:28 p.m. with the I present, there was r	the facilities quarterly spection records entitled sting Report" on 03/17/25 at Maintenance Director (M.D.) no quarterly sprinkler system		April. 1st quarter inspection i complete.  Plan to monitor performance maintain compliance: Our contracted services will test a inspect quarterly with	ee to
	(April, May, and Ju Cottage #6. Based of 3:29 p.m. the M.D. written documentat regards to a second	railable for the second quarter time) of 2024 for Building #6 on an interview on 03/17/25 at acknowledged there was no ion available for review in quarter sprinkler system e as of the time of this survey.		documentation recorded.	
	Director and Maint	viewed with the Executive enance Director at the time of a during the exit conference on			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>06</u>			COMPLETED	
	155846 B. WING			03/18/2025				
	PROVIDER OR SUPPLIE			616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY 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 APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	03/18/25. 3.1-19(b)							

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