PRINTED: 11/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING			COMPLETED	
		155846	B. WI	B. WING			10/20/2021	
				CTREET	ADDRESS SITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
CDEEN		S OF CARMEL			REEN HOUSE WAY			
GREEN HOUSE COTTAGES OF CARMEL		S OF CARMEL		CARME	EL, IN 46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTI			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
		paredness Survey was	E 00	000	Preparation and/or execution			
	•	ndiana Department of Health			this plan of correction in			
	in accordance with	42 CFR 483.73.			general, or this corrective			
					action in particular, does not			
	Survey Dates: 10/1	19/21 and 10/20/21			constitute an admission or			
					agreement by this facility of			
	Facility Number: 0				facts alleged or conclusions	set		
	Provider Number:				forth in this statement of			
	AIM Number: 201362150				deficiencies. The plan of			
At this Emergency Preparedness survey, Green				correction and specific	_			
				corrective actions are prepar				
	_	Carmel was found not in			and/or executed in complian	ce		
		mergency Preparedness			with state and federal laws.			
	_	Medicare and Medicaid			This plan of correction			
		ders and Suppliers, 42 CFR			constitutes a written allegation			
	483.73				of substantial compliance wi Federal Medicare and Medica			
	The facility has 72	contified hade. At the time of				aiu		
	the survey, the cens	certified beds. At the time of			requirements. This facility is requesting paper compliance			
	the survey, the cens	sus was 55.			for all cited deficiencies.	;		
	Quality Paviany cor	mpleted on 10/26/21			lor all cited deliciencies.			
	Quality Review col	impleted on 10/20/21						
E 0004	403.748(a), 416.5	54(a), 418,113(a).						
SS=C	441.184(a), 482.1	, ,						
Bldg	483.73(a), 484.10							
	485.68(a), 485.72							
	486.360(a), 491.1							
	, ,	Review and Update						
	Annually	·						
	§403.748(a), §416	6.54(a), §418.113(a),						
	§441.184(a), §460	0.84(a), §482.15(a),						
	§483.73(a), §483.	.475(a), §484.102(a),						
	§485.68(a), §485.	.625(a), §485.727(a),						
		6.360(a), §491.12(a),						
	§494.62(a).							
	The [facility] must	comply with all applicable						
			1				1	

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

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING COMPLETE B. WING 10/20/202			
		155846	B. W			10/20/	2021
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
ODEENII	HOUSE COTTAGE	C OF CARMEL			EEN HOUSE WAY		
GREEN HOUSE COTTAGES OF CARMEL				CARME	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG		d local emergency		TAG	DEFICIENCE		DATE
	l '	uirements. The [facility]					
	1	ablish and maintain a					
	comprehensive er	mergency preparedness					
		ts the requirements of this					
		rgency preparedness					
	1 ' -	lude, but not be limited to,					
	the following elem	icino.					
	(a) Emergency Pla	an. The [facility] must					
		tain an emergency					
		n that must be [reviewed],					
	and updated at least every 2 years. The plan						
	must do all of the following:						
	* [For hospitals at	§482.15 and CAHs at					
		ergency Plan. The [hospital					
		nply with all applicable					
	Federal, State, an	d local emergency					
	1 ' '	uirements. The [hospital or					
	CAH] must develo	•					
		nergency preparedness ts the requirements of this					
	1	n all-hazards approach.					
		аа а. а.р а.а					
	* [For LTC Facilitie	es at §483.73(a):]					
		The LTC facility must					
		tain an emergency					
	and updated at lea	n that must be reviewed,					
	and updated at lea	ast armuany.					
	* [For ESRD Facil	ities at §494.62(a):]					
	l =	The ESRD facility must					
	· ·	tain an emergency					
	1 ' '	n that must be [evaluated],					
	and updated at lea	ast every 2 years.					
	Based on record rev	view and interview, the	E 0	004	E004		11/16/2021
		velop and maintain an		-	·What corrective action(s)		
	1		1		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155846	B. WING		10/20/2021		
			CTD	EFT ADDRESS OF STATE TO SODE			
NAME OF I	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE				
			616 GREEN HOUSE WAY				
GREEN	HOUSE COTTAGE	S OF CARMEL	CARMEL, IN 46032				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT PROVIDER'S		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	G CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE		
		dness plan that was reviewed		will be accomplished for th	OSA		
		t annually in accordance with		residents found to have be			
	_	This deficient practice could		affected by the deficient	511		
		-					
	affect all occupants	·		practice.			
	E' 1' ' 1 1			The facility has developed a	la		
	Findings include:			implemented an emergency			
				preparedness plan that is	-4		
		the facility's Emergency		reviewed and updated at lea	SI		
	_	entitled "Emergency		annually.			
		EOP) on 10/19/21 between					
		p.m. with the Executive					
Director, documentation that the (EOP) was				·How other residents hav			
	· ·	cility within the most recent		the potential to be affected	-		
		od was not available for		the same deficient practice	will		
		nterview at the time of record		be identified and what			
		ve Director stated that this		corrective action(s) will be			
	I -	day in the facility, and he had		taken.			
		ortunity to review the EOP or		All elders, staff, and visitors	l l		
	even check to see it	f it had been updated within		the potential to be affected b	y this		
	the last twelve mon	ths. During the exit		alleged deficient practice. T	his		
	conference with the	e Executive Director on		facilities emergency			
	10/20/21 at 12:15 p	o.m., no additional		preparedness policies and			
	information or evid	lence could be provided		ted to			
	contrary to this def	icient finding.		the			
				emergency preparedness pl	an.		
				·What measures will be p	ut		
				into place or what systemic	;		
				changes will be made to er			
				that the deficient practice of	l l		
				not recur.			
				This facility will continue to re	eview		
				and update the emergency			
				preparedness plan at least			
				annually.			
				armaany.			
				·How the corrective actio	n(e)		
			1	will be monitored to ensure	; trie		

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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	NSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	DATE		
E 0013 SS=C Bldg	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §485.727(b), §485.68(b), §485.625(b), §485.727(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.		deficient practice will not reci.e., what quality assurance program will be put into place and The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns ar noted during maintenance checks, they will be remedied immediately.	re;		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G	COM	TE SURVEY MPLETED 20/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	and procedures. I develop and imple preparedness poli based on the eme paragraph (a) of the assessment at paragraph (c) of the and procedures mupdated at least a *Additional Requires ESRD Facilities: *[For PACE at §46 procedures. The develop and imple preparedness poli based on the eme paragraph (a) of the assessment at paragraph (c) of the and procedures more more more more more more more more	cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this communication plan at his section. The policies ust be reviewed and nnually. ements for PACE and 60.84(b):] Policies and PACE organization must ement emergency cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this communication plan at his section. The policies ust address management him edical emergencies, imited to: Fire; equipment, illure; care-related natural disasters likely to hi or safety of the or the public. The policies ust be reviewed and very 2 years. cies at §494.62(b):] edures. The dialysis						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	section, and the coparagraph (c) of the and procedures mupdated at least elemergencies inclustifice, equipment or care-related emerginterruption, and noccur in the facility Based on record reviacility failed to devemergency prepared procedures. The polareviewed and update accordance with 42 deficient practice confacility. Findings include: Based on review of Preparedness Plan elemergency preparedness Plan elemergency operations Plan" (Elemergency operations Plan" (Elemergency operations Plan elemergency operations plan elemerg	gencies, water supply atural disasters likely to be a geographic area. It is and interview, the relop and implement liness policies and icies and procedures must be red at least annually in CFR 483.73(b). This rould affect all residents in the state of the facility's Emergency opportunitied "Emergency opportunitied "Emergency opportunitied "Emergency opportunities at complete EOP failty within the most recent did was not available for terview at the time of recordive Director stated that this and in the facility, and he had retunity to review the EOP or it had been updated within this. During the exit Executive Director on m., no additional rence could be provided	E 0	013	E013 ·What corrective action(s) will be accomplished for thoresidents found to have been affected by the deficient practice. The facility has developed and implemented emergency preparedness policies that are reviewed and updated at least annually. ·How other residents having the potential to be affected by the same deficient practice where identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. This facilities emergency preparedness plan has been updated to include the annual review of the facility policies a procedures. ·What measures will be put	g y vill ave this s	11/16/2021

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		DENTIFICATION NUMBER: 155846	A. BUILDING B. WING	onstruction 	COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER	OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				into place or what systemic changes will be made to ensith the deficient practice donot recur. This facility will continue to upon and review emergency preparedness policy and procedures at least annually.	oes		
				·How the corrective action will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla and The emergency preparednes policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns a noted during maintenance checks, they will be remedied immediately.	the cur, ce; s		
E 0018 SS=C Bldg	(ii) and (v), 441.184 483.475(b)(2), 483. 485.920(b)(1), 486 Procedures for Tra Patients §403.748(b)(2), §4 (6)(ii) and (v), §441 (2), §482.15(b)(2),	16.54(b)(1), §418.113(b) .184(b)(2), §460.84(b) §483.73(b)(2), 85.625(b)(2), §485.920(b)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/20/2021		
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		TE	(X5) COMPLETION DATE	
	must develop and preparedness polloased on the emergangraph (a) of the assessment at paragraph (c) of the assessment at paragraph (c) of the and procedures mupdated at least end to the least end to the location of the reconstruction of the location of the location of the location of the location. *[For Inpatient Hornal of the location of t	ragraph (a)(1) of this ommunication plan at his section. The policies nust be reviewed and every 2 years [annually for a minimum, the policies nust address the following:] If the to track the location of sheltered patients in the ring an emergency. If sheltered patients are he emergency, the [facility] he specific name and eiving facility or other 141.184(b), LTC at Ds at §483.475(b), PACE policies and procedures. (2) the location of on-duty staff idents in the [PRTF's, LTC, care during and after anormal duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name are receiving facility or other						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		155846	B. WING		10/20/2021			
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY					
GREEN	HOUSE COTTAGE	S OF CARMEL	CARMEL, IN 46032					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	ICY 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			
	transportation; ide	entification of evacuation						
	location(s) and pr	imary and alternate means						
	of communication	with external sources of						
	assistance.							
	, ,	ack the location of hospice						
	• •	ty and sheltered patients in						
		e during an emergency. If						
		yees or sheltered patients						
		ng the emergency, the						
	· ·	ument the specific name						
and location of the receiving facility or other								
	location.							
*[For CMHCs at §485.920(b):] Policies and								
		afe evacuation from the						
	. , ,	udes consideration of care						
		eds of evacuees; staff						
		ansportation; identification						
	-	ation(s); and primary and						
		of communication with						
	external sources							
	*[For OPOs at § 4	86.360(b):] Policies and						
	procedures. (2) A	system of medical						
	documentation that	at preserves potential and						
	actual donor infor	mation, protects						
	confidentiality of p	otential and actual donor						
	information, and s	secures and maintains the						
	availability of reco	ords.						
	*IE =000 : : :	104 00(L) 1 D						
	-	194.62(b):] Policies and						
		afe evacuation from the						
	dialysis facility, wh							
		nd needs of the patients.	F 0010	E018	11/1/2001			
		view and interview, the	E 0018		11/16/2021			
	-	sure emergency preparedness ures include a system to track		 What corrective action(s) will be accomplished for the 				
	_	luty staff during and after an		residents found to have bee				
		uty staff and sheltered		affected by the deficient	"			
		-		practice.				
residents are relocated during the emergency, the			1	practice.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MUL A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	and location of the location in accordar	ocument the specific name receiving facility or other ace with 42 CFR 483.73(b) ractice could affect all			The facility has developed and implemented an emergency preparedness plan that include system to track the location of on-duty staff during and after a emergency.	e a	
	Based on review of Preparedness Plan e Operations Plan" (E 10:30 a.m. to 12:00 Director, no documensuring the emerge and procedures inclocation of on-duty emergency. If on-duresidents are relocated LTC facility must d and location of the plocation. Based on i record review, the E this was only his six	OP) on 10/19/21 between p.m. with the Executive entation could be found ency preparedness policies ude a system to track the staff during or after an any staff and sheltered during the emergency, the ocument the specific name receiving facility or other interview at the time of executive Director stated that with day in the facility, and he			·How other residents havin the potential to be affected by the same deficient practice we be identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. This facilities emergency preparedness plan has been updated to include a system to track the location of on-duty standard and after an emergency	y vill ave this s	
	or even check to see the last twelve mon- conference with the 10/20/21 at 12:15 p	Executive Director on .m., no additional ence could be provided			·What measures will be put into place or what systemic changes will be made to ensithat the deficient practice do not recur. This facility will continue to upon the emergency preparedness to include a system to track the location of on-duty staff during and after an emergency. ·How the corrective action(ure es date plan e	
					will be monitored to ensure t deficient practice will not red i.e., what quality assurance		

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	A. BUILDING B. WING		COM	PLETED 20/2021		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY					
GREEN I	HOUSE COTTAGES	S OF CARMEL		IEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
E 0024 SS=C Bldg	441.184(b)(6), 482.483.73(b)(6), 484.485.68(b)(4), 485.491.12(b)(4), 494.Policies/Procedure §403.748(b)(6), §4(4), §441.184(b)(6), §482.15(b)(6), §4(6), §484.102(b)(5), §485.625(b)(6), §4(5), §491.12(b)(4), [(b) Policies and pmust develop and preparedness polibased on the eme paragraph (a) of the assessment at paragraph (b) of the and procedures mupdated at least e LTC facilities]. At a	es-Volunteers and Staffing 116.54(b)(5), §418.113(b)), §460.84(b)(7), 83.73(b)(6), §483.475(b)), §485.68(b)(4), 185.727(b)(4), §485.920(b) §494.62(b)(5). rocedures. The [facilities] implement emergency cies and procedures, rgency plan set forth in		program will be purand The emergency prepolicy and procedur maintained by main personnel, monitore administrator, and report of QAPI monthly. If conoted during maintachecks, they will be immediately.	eparedness re will be ntenance ed by the reported to oncerns are enance			

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` ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155846	B. WING 10/20/2021			2021	
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
			616 GREEN HOUSE WAY				
GREEN	GREEN HOUSE COTTAGES OF CARMEL			CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other						
		g strategies, including the					
		for integration of State and					
	Federally designa	_					
		ddress surge needs during					
	an emergency.						
	*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an						
	emergency. *[For Hospice at §418.113(b):] Policies and						
		he use of hospice					
		emergency and other					
		g strategies, including the					
	-	for integration of State and					
	Federally designa						
	an emergency.	ddress surge needs during					
		view and interview, the	E 0	024	E024		11/16/2021
		sure emergency preparedness		021	What corrective action(s) wil	I	11/10/2021
	•	ures include the use of			be accomplished for those		
		ergency or other emergency			residents found to have beer	1	
		ncluding the process and role			affected by the deficient		
	_	tate or Federally designated			practice.		
	_	onals to address surge needs			The facility has developed and	i	
		ey in accordance with 42 CFR deficient practice could			implemented an emergency	o tha	
	affect all occupants	•			preparedness plan that include use of volunteers in the event		
	arreet air occupants	•			an emergency.		
	Findings include:				How other residents having t	he	
					potential to be affected by th		
		the facility's Emergency			same deficient practice will be		
	_	entitled "Emergency			identified and what correctiv	e	
	-	EOP) on 10/19/21 between p.m. with the Executive			action(s) will be taken. All elders, staff, and visitors ha	ave	
		-			the potential to be affected by		
	Director, the facility's EOP provided did not						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		l í		INSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155846	B. W	ING		10/20/	2021
	ROVIDER OR SUPPLIER		•	616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
				<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
	Based on interview the Executive Direct his sixth day in the tan opportunity to re to see if it had addressort. During the exit Executive Director on additional inform	olunteers in an emergency. at the time of record review, tor stated that this was only facility, and he had not yet had view the EOP or even check essed the use of volunteers or conference with the on 10/20/21 at 12:15 p.m., nation or evidence could be of this deficient finding.			alleged deficient practice. This facilities emergency preparedness plan has been updated to include the use of volunteers in the event of an emergency. What measures will be put in place or what systemic changes will be made to ensithat the deficient practice do not recur. This facility will continue to upout the emergency preparedness to include the use of volunteer the event of an emergency. How the corrective action(s) will be monitored to ensure the deficient practice will not recipie, what quality assurance program will be put into place and The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	to ure es date plan s in he ur,	
E 0026 SS=C Bldg	(C)(iv), 441.184(b) 483.475(b)(8), 483 485.920(b)(7), 494 Roles Under a Wa Secretary §403.748(b)(8), §4 (6)(C)(iv), §441.18	3.73(b)(8), 485.625(b)(8), 4.62(b)(7)					•

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND FLAIN	OF CORRECTION	155846	B. WING		10/20/2021		
		133040			10/20/2021		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY				
GREEN I	HOUSE COTTAGE	S OF CARMEL		EL, IN 46032			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	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		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	(8), §485.625(b)(8 §494.62(b)(7).), §485.920(b)(7),					
	[(b) Policies and promust develop and preparedness policies and preparedness policies and preparedness policies and procedures mupdated at least e LTC facilities]. At a and procedures mupdated at least e LTC facilities]. At a and procedures mupdated at least e LTC facilities]. At a and procedures mupdated at least e LTC facility] under a with Secretary, in according to the Act, in the procedures. (8) The a waiver declared accordance with seprovision of care a sidentified by emergency materials. Based on record reversible facility failed to enspolicies and procedures and procedures. (8) The according to the Act, in the provision of care and according to the Act, in the provision and procedures.	implement emergency cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this communication plan at his section. The policies must be reviewed and very 2 years [annually for a minimum, the policies must address the following:] (7), or (9)] The role of the aiver declared by the rdance with section 1135 provision of care and dernate care site identified magement officials. 403.748(b):] Policies and the role of the RNHCI under by the Secretary, in ection 1135 of Act, in the at an alternative care site gency management riew and interview, the mure emergency preparedness the awaiver declared by the lance with section 1135 of ision of care and treatment at the identified by emergency lis in accordance with 42 CFR	E 0026	E026 •What corrective action(s) will be accomplished for thor residents found to have beer affected by the deficient practice. The facility has developed and implemented an emergency	1		
I	affect all occupants.	deficient practice could		preparedness plan to providing the provision of care at an	9		

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	OF CORRECTION IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	DATE
	Findings include:		alternate care site in the event an emergency.	: of
	Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Operations Plan" (EOP) on 10/19/21 between 10:30 a.m. to 12:00 p.m. with the Executive Director, a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act could not be located. Based on interview at the time of record review, the Executive Director stated that this was only his sixth day in the facility, and he had not yet had an opportunity to review the EOP or even check to see if it contained information on the 1135 waiver or not. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding.		·How other residents having the potential to be affected by the same deficient practice whose identified and what corrective action(s) will be taken. All elders, staff, and visitors has the potential to be affected by alleged deficient practice. This facilities emergency preparedness plan has been updated to include providing the provision of care at an alternaticare site in the event of an emergency.	y vill ave this s
			·What measures will be put into place or what systemic changes will be made to ens that the deficient practice do not recur. This facility will continue to up the emergency preparedness to include providing the provis of care at an alternate care sit the event of an emergency. ·How the corrective action will be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place and The emergency preparedness	ure es date plan ion e in s) he eur,

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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 10/20/2021
	ROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
				policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns an noted during maintenance checks, they will be remedied immediately.	e
E 0029 SS=C Bldg	\$403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485. §485.920(c), §486 §494.62(c). (c) The [facility] m an emergency pre plan that complies local laws and mu	5(c), 483.475(c), 2(c), 485.625(c), 7(c), 485.920(c), 2(c), 494.62(c) communication Plan 5.54(c), §418.113(c), 1.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 5.360(c), §491.12(c), wust develop and maintain paredness communication with Federal, State and st be reviewed and updated			
	facilities]. Based on record revelopment facility failed to development facility failed to development facility failed to development facility failed to development facility	riew and interview, the velop and maintain an dness communication plan Federal, State, and local laws 42 CFR 483.73(c). This buld affect all occupants.	E 0029	E029 ·What corrective action(s) will be accomplished for tho residents found to have been affected by the deficient practice. The facility has developed and implemented an emergency preparedness plan to include emergency communication plants.	n d an

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(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/20/2021
STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032	
PREFIX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
How other residents had the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors the potential to be affected alleged deficient practice. facilities emergency preparedness plan has been updated to include an emercommunication plan. What measures will be into place or what system changes will be made to extend the deficient practice not recur. This facility will continue to the emergency preparednes to include the emergency communication plan. How the corrective active will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into pand The emergency preparednes policy and procedure will be maintained by maintenance personnel, monitored by the	e will e s have by this This en rgency put ic ensure does update ess plan on(s) re the recur, ce clace; elace; ess e
	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032 ID PROVIDERS PLAN OF CORRECTIVE GEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) - How other residents had the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors the potential to be affected alleged deficient practice. facilities emergency preparedness plan has bee updated to include an eme communication plan. - What measures will be into place or what system changes will be made to e that the deficient practice not recur. This facility will continue to the emergency preparedne to include the emergency communication plan. - How the corrective acti will be monitored to ensu deficient practice will not i.e., what quality assurance program will be put into p

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGE		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				noted during maintenance checks, they will be remedied immediately.	
E 0035 SS=C Bldg	§483.73(c)(8); §48 *[For LTC Facilitie [(c) The LTC facili maintain an emergon communication plane Federal, State and reviewed and upd communication plane following:] *[For ICF/IIDs at § [(c) The ICF/IID man emergency prepare determined is apposite of the emergency plane determined in the emergency plane determined is apposite of the emergency plane determined in the emergency plane	Sharing Plan with Patients 33.475(c)(8) Its at §483.73(c):] Ity must develop and gency preparedness an that complies with delocal laws and must be atted at least annually. The an must include all of the search s	E 0035	E035 •What corrective action(s) will be accomplished for the residents found to have bee	
	emergency plan that is appropriate with representatives in a	t the facility has determined residents and their families or ecordance with 42 CFR deficient practice could		affected by the deficient practice. The facility has developed an implemented an emergency preparedness plan that include	d

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	OF CORRECTION	IDENTIFICATION NUMBER:	· /	IULTIPLE CO UILDING	ONSTRUCTION 	COMPLE	
		155846	B. W	'ING		10/20/2	2021
	PROVIDER OR SUPPLIER		•	616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE
	Findings include:				method for sharing informatio from the emergency plan with elders, families, or		
	Preparedness Plan	the facility's Emergency entitled "Emergency COP) on 10/19/21 between			representatives.		
	10:30 a.m. to 12:00 Director, the EOP conclude a method for the emergency plant determined is approximately approx	p.m. with the Executive ommunication plan failed to or sharing information from that the facility has priate with residents and resentatives. Based on e of record review, the stated that this was only his lity, and he had not yet had an extra the EOP or even check to method for sharing e emergency plan that the ned is appropriate with families or representatives. Gerence with the Executive 1 at 12:15 p.m., no on or evidence could be			How other residents having the potential to be affected by the same deficient practice of the identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. The facilities emergency preparedness plan has been updated to include the method sharing information from the emergency plan with the elde families, or representatives.	ave this is	
	provided contrary to	o this deficient finding.			·What measures will be puinto place or what systemic changes will be made to ensith the deficient practice do not recur. This facility will continue to up the emergency preparedness to include the method for sharinformation from the emergen plan with the elders, families, representatives. ·How the corrective action will be monitored to ensure deficient practice will not recite, what quality assurance	date plan ring cy and	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	r í	JILDING	NSTRUCTION	(X3) DATE : COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	§441.184(d), §460 §483.73(d), §483.4 §485.68(d), §485.6 §485.920(d), §486 §494.62(d). *[For RNCHIs at § §416.54, Hospice §441.184, PACE at §482.15, HHAs at §485.68, CAHs at under 485.727, CN at §486.360, and I Training and testir develop and maining preparedness train that is based on the in paragraph (a) or	5(d), 483.475(d), 2(d), 485.625(d), 7(d), 485.920(d), 2(d), 494.62(d) esting 5.54(d), §418.113(d), 6.84(d), §482.15(d), 6.75(d), §484.102(d), 6.25(d), §485.727(d), 6.360(d), §491.12(d), 403.748, ASCs at at §418.113, PRTFs at at §460.84, Hospitals at §484.102, CORFs at §486.625, "Organizations" MHCs at §485.920, OPOs RHC/FHQs at §491.12:] (d) ag. The [facility] must tain an emergency ning and testing program the emergency plan set forth			program will be put into place and The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	î ´	UILDING	NSTRUCTION	(X3) DATE COMPI 10/20	LETED
	PROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY L, IN 46032	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	section, policies an paragraph (b) of the communication plasection. The train must be reviewed 2 years. *[For LTC facilities Training and testing and testing that is based on the in paragraph (a) or assessment at paragraph (b) of the communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plate (a) of this section, paragraph (a)(1) or procedures at paragraph (a)(1) or procedures at paragraph (a) of the communication plasection.	and procedures at his section, and the his section, and the his an at paragraph (c) of this hing and testing program and updated at least every at \$483.73(d):] (d) hig. The LTC facility must have an emergency hing and testing program he emergency plan set forth of this section, risk ragraph (a)(1) of this			CROSS-REFERENCED TO THE APPR		
	program must be i least every 2 years	reviewed and updated at s. The ICF/IID must meet or evacuation drills and					
	Training, testing, a dialysis facility mu	ies at §494.62(d):] and orientation. The st develop and maintain an redness training, testing					

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	MENT OF DEFICIENCIES AN OF CORRECTION	TION IDENTIFICATION NUMBER: A. BUILDING COMP		(X3) DATE SURVEY COMPLETED 10/20/2021	
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	on the emergency (a) of this section, paragraph (a)(1) of procedures at para and the community of this section. The orientation prograss updated at every Based on record restriction from the community of this section. The orientation prograss updated at every Based on record restriction from the construction of this deficient praction occupants. Findings include: Based on review of Preparedness Plans of Operations Plans (Includes of Preparedness Plans of Operations Plans (Includes of Preparedness Plans of Preparedness Pl	view and interview, the velop and maintain an dness training and testing eviewed and updated at least nce with 42 CFR 483.73(d).	E 0036	E036 ·What corrective action(will be accomplished for the residents found to have be affected by the deficient practice. The facility has developed a implemented an emergency preparedness training and the program that is reviewed an updated annually. ·How other residents has the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors the potential to be affected alleged deficient practice. Facilities emergency preparedness plan has been updated to include the train and testing program. ·What measures will be into place or what systems changes will be made to endorse the systems of the place or what systems changes will be made to endorse the systems of the place or what systems changes will be made to endorse the systems of the	hose een and / desting nd ving d by e will e s have by this This in ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLI	ETED	
		155846	B. WI	NG		10/20/	2021
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	HOUSE COTTAGE	S OF CARMEL			REEN HOUSE WAY EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
E 0039 SS=F Bldg	403.748(d)(2), 410 441.184(d)(2), 483 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requii §416.54(d)(2), §46 (2), §460.84(d)(2) §483.73(d)(2), §48 (2), §485.68(d)(2)	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d) , §482.15(d)(2), 83.475(d)(2), §484.102(d)		TAG	that the deficient practice do not recur. This facility will continue to upon the emergency preparedness to include a training and testin program that is reviewed annual. How the corrective action(will be monitored to ensure the deficient practice will not recipie, what quality assurance program will be put into plact and. The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	es date plan g ally. s) he e;	DATE
	(2), §494.62(d)(2)						

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846	A. BU	A. BUILDING B. WING		COMPLETED 10/20/2021	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	OPO, "Organization CMHCs at §485.93	ons" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]:		e			22
	exercises to test the	acility] must conduct ne emergency plan lity] must do all of the					
	community-based (A) When a community accessible, confunctional exercise (B) If the [facilinatural or man-marequires activation the [facility] is exently accompanied to the onset of the accompanied companied in the confunction of the accompanied con	nunity-based exercise is induct a facility-based every 2 years; or lity] experiences an actual de emergency that of the emergency plan, mpt from engaging in its munity-based or individual, tional exercise following extual event. ditional exercise at least exercise the year the lonal exercise under of this section is ay include, but is not wing: cale exercise that is					
	functional exercise (B) A mock disaste (C) A tabletop exe led by a facilitator discussion using a clinically-relevant of a set of problem so messages, or prep to challenge an en (iii) Analyze the [face	er drill; or rcise or workshop that is and includes a group narrated, emergency scenario, and tatements, directed pared questions designed					

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846			A. B. W	ETED //2021			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREEN I	HOUSE COTTAGE	S OF CARMEL			EEN HOUSE WAY L, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	the patient's home conduct exercises at least annually. following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emerg activation of the eis exempt from en full scale communindividual facility-befollowing the onse (ii) Conduct an acyears, opposite th functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop excled by a facilitator discussion using a clinically-relevant a set of problem s messages, or prepto challenge an er (3) Testing for hospitality and conduction to the conduction of the cond	spices that provide care in a to test the emergency plan. The hospice must do the a full-scale exercise that is every 2 years; or an unity based exercise is not contain the transfer of the every 2 years; or experiences a natural or ency that requires exercise or eased functional exercise or eased functional exercise or experiences and exercise or every 2 year the full-scale or every 2 years; or experiences a natural or exercise or every 2 years; or experiences a natural or every 2 years; or experiences a natural or every 2 years; or					
	care unechy. The	hospice must conduct					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´		INSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL		
		155846	B. W	TNG		10/20	/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	8			EEN HOUSE WAY			
GREEN I	HOUSE COTTAGE	S OF CARMEL	CARMEL, IN 46032					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	exercises to test t	he emergency plan twice						
		spice must do the following:						
		n annual full-scale						
		mmunity-based; or						
	(A) When a comm	nunity-based exercise is						
	, ,	nduct an annual individual						
	facility-based fund	tional exercise; or						
	(B) If the hospice	experiences a natural or						
	man-made emerg	ency that requires						
	activation of the e	mergency plan, the						
	hospice is exempt	from engaging in its next						
	required full-scale	community based or						
	•	tional exercise following						
	the onset of the e							
	, ,	dditional annual exercise						
	· ·	but is not limited to the						
	following:							
	, ,	scale exercise that is						
	-	or a facility based						
	functional exercise							
	(B) A mock disas							
		ercise or workshop led by a						
		udes a group discussion						
	using a narrated,	rio, and a set of problem						
		ed messages, or prepared						
	questions designe							
	emergency plan.	to challenge an						
] 0 , 1	ospice's response to and						
	. ,	ntation of all drills, tabletop						
		nergency events and revise						
		ergency plan, as needed.						
	*[For PRFTs at §4	41.184(d), Hospitals at						
	§482.15(d), CAHs	* *						
	- , ,	PRTF, Hospital, CAH] must						
	. ,	to test the emergency plan						
	twice per year. Ti	ne [PRTF, Hospital, CAH]						
	must do the follow	ving:						
			1				I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155846	B. W	ING		10/20	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			EEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES	ı	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		an annual full-scale		ING			DATE
	' '	ommunity-based; or					
		nunity-based exercise is					
	1 ' '	induct an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF, I						
	l ' '	ctual natural or man-made					
	I	equires activation of the					
	,	the [facility] is exempt from					
	1	xt required full-scale					
		or individual, facility-based					
	· ·	e following the onset of the					
	emergency event.	_					
		an [additional] annual					
		at may include, but is not					
	limited to the follo						
		scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and					
	a set of problem s	tatements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze t	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.						
	*IE DAGE (0.1)	20.04/-1\-1					
	*[For PACE at §46	· / =					
	1 ' '	ACE organization must					
		to test the emergency plan					
		The PACE organization					
	must do the follow	•					
		an annual full-scale					
	exercise that is co	ommunity-based; or					

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		155846	B. W	ING		10/20	/2021
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF F	PROVIDER OR SUPPLIEF	C		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	F.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	WIL	DATE
	(A) When a comm	nunity-based exercise is					
	not accessible, co	nduct an annual individual,					
	facility-based fund	tional exercise; or					
	(B) If the PACE ex	xperiences an actual					
	natural or man-ma	ade emergency that					
	-	n of the emergency plan,					
	the PACE is exem	npt from engaging in its next					
	1	community based or					
		based functional exercise					
	ı •	et of the emergency event.					
	, ,	n additional exercise every					
	1	he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to	· ·					
	1 ' '	scale exercise that is					
	1 -	or individual, a facility					
	based functional e						
	(B) A mock disas						
		ercise or workshop that is					
	· ·	and includes a group					
	discussion, using						
		emergency scenario, and					
		tatements, directed					
		pared questions designed					
	to challenge an er						
	l ' '	ACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise gency plan, as needed.					
	THE PACES emerg	gency plan, as needed.					
	*[For LTC Facilitie	os at 8.483 73(d)·1					
	_	ity] must conduct exercises					
	I ' '	ency plan at least twice per					
	_	announced staff drills					
	1 -	ncy procedures. The [LTC					
	"	ust do the following:					
		an annual full-scale					
		ommunity-based; or					
		nunity-based, or					
		idility-based exelcise is					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155846	B. W	ING		10/20	/2021
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF F	ROVIDER OR SUPPLIER			616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		onduct an annual individual,					
	facility-based fund						
	, , _	ility] facility experiences					
		or man-made emergency					
		ration of the emergency					
	•	lity is exempt from required a full-scale					
		or individual, facility-based					
	•	e following the onset of the					
	emergency event.						
		dditional annual exercise					
	, ,	but is not limited to the					
	following:						
	_	scale exercise that is					
	` '	or an individual, facility					
	based functional e						
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and					
	a set of problem s	statements, directed					
		pared questions designed					
	to challenge an er						
	, , -	LTC facility] facility's					
	-	naintain documentation of					
	-	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
	-	CF/IID must conduct					
	` '	he emergency plan at least					
		ie ICF/IID must do the					
	following:						
	•	n annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is					
	not accessible, co	nduct an annual individual,					
	facility-based fund	ctional exercise; or.					
			1				I

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		î ´		DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155846	B. W	ING		10/20	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES	<u> </u>	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		experiences an actual		mo			DATE
	1 ' '	ade emergency that					
		n of the emergency plan,					
		mpt from engaging in its					
		scale community-based or					
		based functional exercise					
	I -	et of the emergency event.					
	_	ditional annual exercise					
		but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
	l ` '	ercise or workshop that is					
		and includes a group					
	discussion, using	~ .					
	clinically-relevant	emergency scenario, and					
	a set of problem s	statements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	mergency plan.					
	(iii) Analyze the IC	CF/IID's response to and					
		ntation of all drills, tabletop					
	exercises, and en	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	#r== 11114	14.400					
	*[For HHAs at §48	-					
		e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	full scale eversion that is					
	community-based	full-scale exercise that is					
	1	ommunity-based exercise					
	, ,	conduct an annual					
		based functional exercise					
	every 2 years; or.	based fullotional excluse					
	1 .	A experiences an actual					
	1 ' '	ade emergency that					
		n of the emergency plan,					
	Toquilos activation	To the emergency plant,					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155846	B. W	ING		10/20	/2021
NAME OF I	DROWINED OF CLIEBLICA		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	X.		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ot from engaging in its next					
	•	community-based or					
		based functional exercise					
	_	et of the emergency event.					
	' '	ditional exercise every 2					
		e year the full-scale or					
	of this section is c	e under paragraph (d)(2)(i) onducted, that may					
		limited to the following:					
		full-scale exercise that is					
	community-based						
	_	ctional exercise; or					
	·	isaster drill; or					
	` '	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and					
	a set of problem s	tatements, directed					
		pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*(For ODOs at \$4)	26.2601					
	*[For OPOs at §48	e OPO must conduct					
	` ' ' '	he emergency plan. The					
	OPO must do the						
		er-based, tabletop exercise					
		ast annually. A tabletop					
	•	a facilitator and includes a					
	-	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemen	its, directed messages, or					
	prepared question	ns designed to challenge an					
	emergency plan. I	f the OPO experiences an					
		nan-made emergency that					
	-	n of the emergency plan,					
	the OPO is exemp	ot from engaging in its next					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		155846	B. WING		10/20/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPERTION OF T				
TAG	required testing exof the emergency (ii) Analyze the Ofmaintain documer exercises, and emithe [RNHCl's and as needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paperat least annually. It is group discussion in narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and emithe RNHCl's emergency plan at lunannounced staff or procedures. The LT following: (i) Participate in an that is community-based function. If the LTC facility natural or man-mad activation of the emit facility is exempt for required full-scale of the content of the emit facility is exempt for required full-scale of the content of the content of the emit facility is exempt for required full-scale of the content of the content of the emit facility is exempt for required full-scale of the content of the emit facility is exempt for required full-scale of the content of the emit facility is exempt for required full-scale of the content of the content of the emit facility is exempt for required full-scale of the content of the emit facility is exempt for required full-scale of the content of the emit facility is exempt for required full-scale of the content of the content of the emit facility is exempt for required full-scale of the content	PO's response to and ntation of all tabletop hergency events, and revise OPO's] emergency plan, 3.748]: Per RNHCI must conduct the emergency plan. The her following: Per-based, tabletop exercise and tabletop exercise is a feed by a facilitator, using a relevant emergency plan. The hergency plan and the property plan and the property plan and the property plan and the property plan, as needed. The property plan as needed and the property plan as needed. The property plan as needed and the property plan as needed. The property plan as needed and the property plan as needed. The property plan as needed and the property plan as needed and the property plan as needed. The property plan are property plan as needed and the plan as needed and the property plan as needed and the property plan as needed and the plan as needed	E 0039	E039 ·What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice. The facility has developed an implemented a plan to conduce exercises to test the emergen plan at least twice a year, including unannounced staff of using emergency procedures. ·How other residents having the potential to be affected by the same deficient practice.	d ct ccy chrills			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021				
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
	X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE	
	TAG	exercise for 1 year of actual event. (ii) Conduct an addinclude, but is not lia. A second full-sear community-based of functional exercise. b. A mock disaster of c. A tabletop exercial facilitator that inclusing a narrated, clisscenario, and a set of directed messages, designed to challeng (iii) Analyze the LT maintain documental exercises, and emer LTC facility's emergacordance with 42 deficient practice conformation. Based on review of Preparedness Plane of Operations Plane (E10:30 a.m. to 12:00 Director, the EOP conformation of at least two exercises to individual, facility-mock disaster drill, workshop that is led a group discussion, relevant emergency problem statements prepared questions emergency plan. Based frecord review, the	following the onset of the stional exercise that may mited to the following: le exercise that is r an individual, facility-based drill; or se or workshop that is led by ludes a group discussion, nically relevant emergency of problem statements, for prepared questions ge an emergency plan. To facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. the facility's Emergency entitled "Emergency cOP) on 10/19/21 between p.m. with the Executive ontained no documentation		TAG	be identified and what corrective action(s) will be taken. All elders, staff, and visitors had the potential to be affected by alleged deficient practice. The facility has developed and implemented a plan to conduct exercises to test the emergency plan at least twice a year, including unannounced staff of using emergency procedures. What measures will be purinto place or what systemic changes will be made to ensith at the deficient practice do not recur. The facility has developed and implemented a plan to conduct exercises to test the emergency plan at least twice a year, including unannounced staff of using emergency procedures. How the corrective actions will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place and The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during emergency plan	this e et cy rills tt ure es d ct cy rills	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	155846	B. WING	<u></u>		PLETED 20/2021
		100070		ADDRESS CITY OF THE ST		20,2021
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZI REEN HOUSE WAY	IP CODE	
GREEN I	HOUSE COTTAGES	S OF CARMEL		EL, IN 46032		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO T	ON SHOULD BE THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	tests, they will be re		DATE
		n opportunity to review the to see if it contained any type		immediately.	emealea	
		s. During the exit conference		miniculatory.		
		Director on 10/20/21 at				
	12:15 p.m., no addit	tional information or				
	-	rovided contrary to this				
	deficient finding.					
E 0041	482.15(e), 483.73((a) 485 625(a)				
SS=C		LTC Emergency Power				
Bldg	•	ion for Participation:				
J	- , ,	d standby power systems.				
	The hospital must	implement emergency and				
	• • •	stems based on the				
		et forth in paragraph (a) of				
	this section and in	the policies and et forth in paragraphs (b)				
	(1)(i) and (ii) of this					
		5 0000011.				
	§483.73(e), §485.6	625(e)				
		d standby power systems.				
	The [LTC facility a					
		ency and standby power				
	forth in paragraph	the emergency plan set				
	Torur in paragraph	(a) or tino occitori.				
	§482.15(e)(1), §48	33.73(e)(1), §485.625(e)				
	Emergency genera	ator location. The				
	generator must be	located in accordance				
		equirements found in the				
		ties Code (NFPA 99 and				
		Amendments TIA 12-2, TIA				
		A 12-5, and TIA 12-6), Life A 101 and Tentative				
		nts TIA 12-1, TIA 12-2, TIA				
		4), and NFPA 110, when a				
		uilt or when an existing				
	structure or buildir					
			1	1		1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING ING		COMPL	
		155846	D. W.			10/20/	12021
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	, , , , -	3.73(e)(2), §485.625(e)(2)					
		rator inspection and testing.					
		H and LTC facility] must ergency power system					
	· ·	, and [maintenance]					
		nd in the Health Care					
	•	FPA 110, and Life Safety					
	Code.						
	482.15(e)(3), §48	3.73(e)(3), §485.625(e)(3)					
		ator fuel. [Hospitals, CAHs					
	_	that maintain an onsite					
	· ·	ver emergency generators					
	•	for how it will keep					
		systems operational					
	during the emerge	ency, unless it evacuates.					
	*[For hospitals at	§482.15(h), LTC at					
		CAHs §485.625(g):]					
	- ,-,	corporated by reference in					
	this section are ap	pproved for incorporation					
		ne Director of the Office of					
	_	ter in accordance with 5					
	` '	1 1 CFR part 51. You may					
		al from the sources listed					
		rspect a copy at the CMS					
		urce Center, 7500 Security ore, MD or at the National					
	,	ords Administration					
		mation on the availability of					
	,	ARA, call 202-741-6030, or					
	go to:	,					
	http://www.archive	es.gov/federal_register/cod					
		ulations/ibr_locations.html.					
	If any changes in	this edition of the Code are					
	incorporated by re	eference, CMS will publish					
		Federal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Par	k,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMPL	ETED
		155846	B. W	ING		10/20/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
			1				(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>		TAG	DEFICIENCY (DATE
	Quincy, MA 02169 1.617.770.3000.	9, www.mpa.org,					
		th Care Facilities Code,					
	. ,	ed August 11, 2011.					
		rim amendment (TIA) 12-2					
	l ` '	ed August 11, 2011.					
		FPA 99, issued August 9,					
	2012.	7 7 6 6 7 10 5 4 5 4 7 1 4 g 4 5 7 6 7 7 7 9 7 9 7 9 7 9 7 9 7 9 7 9 7 9					
		FPA 99, issued March 7,					
	2013.	,					
	(v) TIA 12-5 to NF	FPA 99, issued August 1,					
	2013.	_					
	(vi) TIA 12-6 to NI	FPA 99, issued March 3,					
	2014.						
	. ,	fe Safety Code, 2012					
	edition, issued Au	•					
	1 ' '	IFPA 101, issued August					
	11, 2011.						
	1 ' '	FPA 101, issued October					
	30, 2012.						
	1 ' '	FPA 101, issued October					
	22, 2013.						
	` '	FPA 101, issued October					
	22, 2013.	tandard for Emorganou					
	. ,	Standard for Emergency er Systems, 2010 edition,					
	1	chapter 7, issued August 6,					
	2009	criapter 1, issued August 0,					
		view and interview, the	E 0	041	E041		11/16/2021
		plement the emergency	LU	0+1	·What corrective action(s)		11/10/2021
	power system inspe				will be accomplished for tho	se	
		ements found in the Health			residents found to have been		
	_	e, NFPA 110, and Life Safety			affected by the deficient		
		e with 42 CFR 483.73(e)(2).			practice.		
	This deficient pract				The facility has developed and	i	
	occupants.				implemented a plan to inspect	,	
					test, and maintain the emerge	ncy	
	Findings include:				power systems within each		
					cottage.		
	Based on record rev	view on 10/20/21 with the					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING B. WING		COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GRE	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Executive Director at 12:26 p.m., there was no current documentation available for review in reference to weekly or monthly generator testing available for review for the last 52-week or 12-month periods. The book provided had weekly generator testing documented, but the testing stopped on 07/28/2020. Based on an interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding.		·How other residents having the potential to be affected by the same deficient practice of the identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. The facility has developed and implemented a plan to inspect test, and maintain the emerge power systems within each cottage.	y vill ave this
			·What measures will be purinto place or what systemic changes will be made to ensith the deficient practice do not recur. The facility has developed and implemented a plan to inspect test, and maintain the emerge power systems within each cottage.	ure es
			·How the corrective actions will be monitored to ensure to deficient practice will not redice., what quality assurance program will be put into place and. The emergency preparedness policy and procedure will be maintained by maintenance personnel, monitored by the administrator, and reported to	e;

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	OF CORRECTION OF CORRECTION 155846	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	DATE
			QAPI monthly. If concerns are noted during emergency plan inspections, tests, or maintenathey will be remedied immediate.	ance
K 0000				
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/19/21 and 10/20/21 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Life Safety Code survey, Green House Cottages 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 55 at the time of this survey.	K 0000	Preparation and/or execution this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions forth in this statement of deficiencies. The plan of corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance with the state and Medicare and Medicarequirements. This facility is requesting paper compliance for all cited deficiencies.	the set red ce on th

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846			UILDING	01	(X3) DATE (COMPL 10/20/	ETED	
	ROVIDER OR SUPPLIER		<u> </u>	616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
K 0324 SS=F Bldg. 01	were sprinklered and services with a cottage has a capaci 10 at the time of this Quality Review conditions Facilities Cooking Facilities Cooking Facilities Cooking equipmer accordance with Noventilation Control Commercial Cooking appliances such a toasters) are used limited cooking in a 18.3.2.5.2, 19.3.2. * cooking facilities smoke compartment patients comply with 30 or fewer patients comply with 30 or fewer patients conditions under 11 Cooking facilities with 30 or fewer patients comply with 30 or fewer patients as a cooking facilities patients as a cooking facilit	nt is protected in IFPA 96, Standard for and Fire Protection of ng Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or accordance with 5.2 open to the corridor in ents with 30 or fewer th the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. orotected according to 8 are not required to be dous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1	K 0	324	K324 ·What corrective action(s) will be accomplished for the	se	11/16/2021

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	<u>01 </u>	COMPL	ETED
		155846	B. W	ING		10/20/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF P	ROVIDER OR SUPPLIER						
ODEEN	IOLIOE COTTA OF	O OF OARME!			EEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
		tion, Standard for Ventilation	1		residents found to have been	n	
	, , , , , , , , , , , , , , , , , , ,	otection of Commercial			affected by the deficient	•	
		s, Section 11.2.1 states			practice.		
		fire-extinguishing systems			All hood systems on campus		
		oods containing a constant or			(cottages 1, 2, 3, 4, 5 and 6) a	ire	
		system that is listed to			scheduled to be inspected by		
	_	the grease removal devices.			Koorsen in November and will	e	
	•	ms, and the exhaust ducts			on a semi-annual inspection		
		operly trained, qualified, and			schedule per NFPA		
		ecceptable to the authority			requirements.		
		at lease every six months.					
	-	ice could affect all residents,					
	staff, and visitors w	ithin the facility.			·How other residents havir	ıg	
					the potential to be affected b	y	
	Findings include:				the same deficient practice v	vill	
					be identified and what		
	Based on record rev	view on 10/20/21 with the			corrective action(s) will be		
	Executive Director	at 10:21 a.m., documentation			taken.		
		pression system inspection			All elders, staff, and visitors ha	ave	
	-	the last six or 12-month			the potential to be affected by		
	-	lable for review. Based on			alleged deficient practice. A		
	-	e of record review, the			semi-annual inspection sched	ule	
		stated that this was only his			has been established between		
		acility, and his Maintenance			facility and Koorsen. Next	1 1110	
	,	ne with a sick child and not			inspection is scheduled for		
		two days of this survey.			November 2021.		
	_				November 2021.		
	_	ference with the Executive					
	Director on 10/20/2	1 /			NA/le of management will be many		
		on or evidence could be			·What measures will be pu	ı	
	provided contrary to	o this deficient finding.			into place or what systemic		
					changes will be made to ens		
					that the deficient practice do	es	
					not recur.		
					The semi-annual inspection d		
					for the hood system was place	ed in	
					the maintenance schedule to		
					ensure compliance.		
					·How the corrective action	(s)	
			- 1				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846	A. BUILDING 01 B. WING		COMPLETED 10/20/2021	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL		EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
K 0345 SS=F	NFPA 101 Fire Alarm System Maintenance	ı - Testing and		will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place and. The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	e;	
Bldg. 01	Fire Alarm System Maintenance A fire alarm syster in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1) Based on record facility failed to ensithe annual testing or of 1 fire alarm system National Fire Alarm Section 14.6.2.4 reginspections, testing, provided that including regarding tests and requested in Figure	m is tested and maintained an an approved program requirements of NFPA 70, code, and NFPA 72, an and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 review and interview, the cure the documentation for fall devices connected to 1 m was complete. NFPA 72, a Code, the 2010 Edition, at	K 0345	·What corrective action(s) will be accomplished for thos residents found to have been affected by the deficient practice. Maintenance and testing of the fire alarm system are performe) e	11/16/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLE			COMPLETED
		155846	B. W	ING	-	10/20/2021
					-	
NAME OF P	ROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE	
				1	REEN HOUSE WAY	
GREEN HOUSE COTTAGES OF CARMEL			CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CLUDERIS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	type, address, locati	ion, and test results indicated:			in accordance with NFPA 110	
	(1) Date	,			The semi-annual fire alarm sy	stem
	(2) Test frequency				testing logs for (cottages 1, 2,	
	(3) Name of proper	ty			4, 5 and 6) have been updated	
	(4) Address	•			and all 6 cottages are on sche	
	()	performing inspection,			to be tested semi-annually.	
		or combination thereof, and			ĺ	
		address, and telephone				
	number	, 1				
	(6) Name, address,	and representative of			How other residents having	
	approving agency (-			the potential to be affected b	y
		the detector(s) tested			the same deficient practice v	vill
	(8) Functional test of				be identified and what	
	(9) *Functional test	of required sequence of			corrective action(s) will be	
	operations	•			taken.	
	(10) Check of all sn	noke detectors				
		e for all fixed-temperature,			All elders, staff, and visitors h	ave
	line-type heat detec				the potential to be affected by	
	(12) Functional test	of mass notification system			alleged deficient practice. All	6
	control units				fire alarm systems have been	
	(13) Functional test	of signal transmission to			placed on a schedule to have	fire
	mass notification sy	ystems			alarm system tested	
	(14) Functional test	of ability of mass			semi-annually.	
	notification system	to silence fire alarm				
	notification applian	ces				
	(15) Tests of intellig	gibility of mass notification			·What measures will be put	į
	system speakers				into place or what systemic	
	(16) Other tests as r	required by the equipment			changes will be made to ens	ure
	manufacturer's publ	lished instructions			that the deficient practice do	es
	(17) Other tests as r	required by the authority			not recur.	
	having jurisdiction				The maintenance director will	
	(18) Signatures of t	ester and approved authority			conduct a fire alarm system te	st
	representative				semi-annually. This test will b	
		problems identified during			documented and will be visual	ly
		vner notified, problem			testing the control unit trouble	
	corrected/successfu	lly retested, device			signals, remote annunciators,	
	abandoned in place				initiating devices, notification	
	_	ice could affect all occupants			appliances and magnetic	
	in the facility.				hold-open devices.	

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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 01	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Findings include: Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., a fire alarm system inspection/testing report could not be located or provided for review with an itemized list of fire alarm system devices inspected/tested indicating the device type, address, location, and specific results of the testing. Based on interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants.		·How the corrective action(will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place and The maintenance schedule with maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he cur, e; Il be
l	arreet air occupants.			

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Event ID:

HTUQ21 Facility ID: 013753

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING B. WING	01	COMPLETED 10/20/2021
	NAME OF PROVIDER OR SUPPLIER GREEN HOUSE COTTAGES OF CARMEL		ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Findings include:			
	Based on record review on 10/20/21 with the Executive Director at 10:24 a.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding.			
	3.1-19(b) 3) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BU	JILDING	01	COMPI	ETED	
		155846	B. W			10/20	/2021
NAME OF F	PROVIDER OR SUPPLIER				.DDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY	E	
GREEN I	HOUSE COTTAGES	S OF CARMEL			L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE DEFICIENCY)	DBE	(X5) COMPLETION DATE
	Findings include:						
	Executive Director and documentation for a confidence of the fire alarm system and the Executive Director of the Executive	semiannual visual inspection tem was available for review. at the time of record review, tor stated that this was only					
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR	supply source RKS information on non-required or partial					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA			UILDING 01		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			01	COMPL	
		155846	B. WI	NG _		10/20/	(2021
NAME OF F	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY	•	
GREEN I	HOUSE COTTAGES	S OF CARMEL		CARM	EL, IN 46032		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1) Based on record	review and interview, the	K 0	353	K353		11/16/2021
		vide written documentation			·What corrective action(s)		
	or other evidence th				will be accomplished for tho		
	-	en inspected and tested for 4			residents found to have bee	n	
	_	1.6.12.1 requires any device,			affected by the deficient		
		n required for compliance			practice.		
		naintained in accordance with			All sprinkler systems on camp		
		quirements. Sprinkler			(cottages 1, 2, 3, 4, 5 and 6) a		
	systems shall be pro				scheduled to be inspected by		
		FPA 25, Standard for the			Koorsen in November per NF	PA	
		and Maintenance of			requirements. All sprinkler		
		rotection Systems. NFPA 25,			systems are on a quarterly		
	•	ds shall be made for all			inspection and testing schedu		
	-	nd maintenance of the system			per contract withKoorse	n.	
	-	all be made available to the isdiction upon request. 4.3.2					
		s shall indicate the procedure			·How other residents havir		
	performed (e.g., ins	_			the potential to be affected by	_	
		rganization that performed			the same deficient practice v	_	
	· ·	s, and the date. NFPA 25,			be identified and what	····	
		vaterflow alarm devices shall			corrective action(s) will be		
	-	rly to verify they are free of			taken.		
		FPA 25, 5.3.3.1 requires the			All elders, staff, and visitors h	ave	
		ow alarm devices including,			the potential to be affected by		
		vater motor gongs, shall be			alleged deficient practice. All		
		.3.2 requires vane-type and			sprinkler systems are on a		
		e waterflow alarm devices			quarterly inspection and testir	ng	
	shall be tested semi	annually. This deficient			schedule per NFPA		
	practice could affec	t all residents, staff, and			requirements.		
	visitors in the facilit	ty.					
	Findings include:				·What measures will be pu	t	
					into place or what systemic		
		view on 10/20/21 with the			changes will be made to ens		
	Executive Director				that the deficient practice do	es	
		quarterly sprinkler system			not recur.		
	*	ilable for review for the past			The quarterly inspection dates		
		n interview at the time of			the sprinkler systems are in the		
	, , , , , , , , , , , , , , , , , , ,	Executive Director stated that			maintenance schedule to ens	ure	
	this was only his se	venth day in the facility and			compliance.		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY GREEN HOUSE COTTAGES OF CARMEL CARMEL, IN 46032	2021
CALLET TO SEE SOT TAGES OF CARWILL	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CONTROL OF THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25, NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 shalte straight in the utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 10/20/21 with the Executive Director at 10.34 a.m., no documentation of monthly control valve and gauge inspections could be provided for review for the past 12 months. Based on interview at the time of record review, the Executive Director stated that this was only his seventh day in the	DATE

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846	A. BU	A. BUILDING 01 B. WING		COMPLETED 10/20/2021	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	home with a sick ch the two days of this conference with the 10/20/21 at 12:15 p. information or evide contrary to this defice 3.1-19(b)	ence could be provided cient finding.					
	facility failed to ens gauges were replace documented as teste comparison with a c Standard for the Ins Maintenance of Wat Systems, 2011 Editi gauges shall be replacevery 5 years by con gauge. Gauges not a the full scale shall b This deficient practi staff, and visitors in	d every 5 years by alibrated gauge. NFPA 25, pection, Testing, and ter-Based Fire Protection on, Section 5.3.2.1 states aced every 5 years or tested inparison with a calibrated ccurate to within 3 percent of the recalibrated or replaced. ce could affect all residents,					
	Director during a tor p.m. to 4:51 p.m. on supervised wet sprir of three water press date of all three gau on the face of each s recalibration date in could be located on Based on interview observations, the fac stated he did not bel	ns made with the Executive ar of the facility from 2:23 10/19/21, the facility had akler systems and had a total are gauges. The manufacture ges was 2015 and was listed sprinkler system gauge. No formation was affixed to or the sprinkler system gauges. at the time of the cility Executive Director ieve sprinkler system gauges d within the most recent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D.) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED	
		155846	B. W.	NG		10/20/	/2021	
				CEDELE	ADDRESS OF THE STREET STREET		-	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
0055111	101105 00774 054	0.05.04.04.54			REEN HOUSE WAY			
GREEN F	HOUSE COTTAGES	S OF CARMEL		CARME	EL, IN 46032			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		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	
	five-year period and	l acknowledged						
	documentation of sp	orinkler system gauge						
	replacement or reca	libration documentation was						
	not available for review for all three sprinkler							
		h were more than five years						
		conference with the						
	_	on 10/20/21 at 12:15 p.m.,						
		nation or evidence could be				ļ		
	provided contrary to	this deficient finding.						
		_						
	3.1-19(b)							
K 0511	NFPA 101							
SS=F	Utilities - Gas and	Electric						
Bldg. 01	Utilities - Gas and	Electric						
		gas or related gas piping						
	complies with NFF	PA 54, National Fuel Gas						
		ring and equipment						
	-	PA 70, National Electric						
	_	tallations can continue in						
	service provided n							
	18.5.1.1, 19.5.1.1,							
		riew and interview the facility	K 0	511	·What corrective action(s)		11/16/2021	
		the emergency generator had			will be accomplished for thos			
		fuel in accordance with the			residents found to have beer	1		
	_	PA 101 - 2012 edition,			affected by the deficient			
		1, 9.1.3.1 and NFPA 110,			practice	_		
		LSC Section 9.1.3.1 states			The facility has obtained a lett	er of		
		ors shall be installed, tested,			reliability from the company			
		ccordance with NFPA 110,			responsible for supplying natu			
	_	ency and Standby Power			gas to the generators in (cotta	ges		
	-	on. Section 5.1.1 states the			1, 2, 3, 4, 5, 6).			
		urces shall be permitted to						
		rgency power supply (EPS):						
		n products at atmospheric				ļ		
	pressure	a: ::						
		eum gas (liquid or vapor			·How other residents havin	_		
	withdrawal)				the potential to be affected b	-		
	(3) Natural or synth	_			the same deficient practice v	/ill		
	Exception: For Leve	el 1 installations in locations			be identified and what	ļ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		l í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
GREEN H (X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR where the probabilit fuel supplies is high alternate energy sou output of the EPSS specified shall be re automatic transfer fi source to the alterna A.5.1.1 states exam interruption could in earthquake, flood da utility unreliability, the potential to affect Findings include: Based on interview Executive Director of the facilities fire diesel. During a tou determined that the generators was not of record review on 10 the five books label- 6 P.M. logs, no nature could be located. Ba time of record revies stated that this was facility, and he was had even been reque Executive Director, one from his provid able to do so. Durin the Executive Director	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Ty of interruption of off-site To on-site storage of an orce sufficient to allow full to be delivered for the class quired, with the provision for orm the primary energy the energy source. The ples of probability of orchede the following: The amage, or a demonstrated This deficient practice had not all residents. This deficient practice had not all residents. The fuel source generators was thought to be or of the 6 cottages, it was fuel source of the five diesel but natural gas. During To only 120/21 the documentation on the das C 1 P.M. log through C oral gas letter of reliability of the Executive Director only his seventh day at the unsure if a letter of reliability tested by the previous but that he would request er as soon as he would be get the exit conference with tor on 10/20/21 at 12:15			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) corrective action(s) will be taken. All elders, staff, and visitors he the potential to be affected by alleged deficient practice. A letter of reliability will be proving for the generators in (cottages 2, 3, 4, 5, 6) What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice do not recur. The maintenance director or designee will ensure each generator has documentation reliable source of fuel in accordance with NFPA 101. How the corrective action will be monitored to ensure the deficient practice will not recipe, what quality assurance program will be put into place and The maintenance schedule will maintenance by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are	ave this ded s 1, t sure pes of a (s) the cur, ce; ill be	
		nformation or evidence could y to this deficient finding.			noted during maintenance checks, they will be remedied immediately.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		ľ	JILDING	onstruction 01	(X3) DATE COMPL 10/20/	ETED	
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	alarm signal and signer conditions. Fine expected and unevarying conditions shift. The staff is fa and is aware that a routine. Where dried 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1 Based on record revicality failed to conducted quarters. LSC be conducted quarter conditions. This definitions. This definitions include: Based on record revicated that the past twelve-more at the time of record documented fire drifthe past twelve-more at the time of record Director stated that drill documentation seventh day in the familia and not availated survey. During the executive Director on additional informations.	xpected times under , at least quarterly on each amiliar with procedures drills are part of established ills are conducted between AM, a coded ay be used instead of	K 0	712	K712 ·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Fire drills were conducted per NFPA requirements for 1st shifter all 6 cottages. ·How other residents having the potential to be affected by the same deficient practice was be identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. Quarterly fire drills at unexpectimes, under varying condition and at least quarterly on each shift will be held at the facility in NFPA requirements.	g y vill ave this ted s,	11/16/2021

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		DER/SUPPLIER/CLIA ATION NUMBER:	A. BUILDING B. WING	01	COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CAR	MEL	STREET A 616 GR CARME		
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BI REGULATORY OR LSC IDENTI 3.1-51(c)	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-51(c)			·What measures will be put into place or what systemic changes will be made to ens that the deficient practice do not recur. The maintenance schedule wi reviewed and revised to include scheduled fire drills at unexpetimes, under varying condition and at least quarterly on each shift per NFPA requirements. ·How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place and The maintenance schedule wi maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	ure es II be de cted s, s) he cur, e;
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essenti Electrical Systems - Essenti System Maintenance and To The generator or other alter source and associated equi of supplying service within 1 10-second criterion is not m	al Electric esting rnate power oment is capable 0 seconds. If the			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		NSTRUCTION 04	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION		B. WING	ING	<u>01</u>		
		155846	b. which			10/20/	2021
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL	C	ARME	L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		ocess shall be provided to					
	•	his capability for the life					
		branches. Maintenance					
	_	generator and transfer					
		rmed in accordance with					
	NFPA 110.						
		e inspected weekly,					
		pad 30 minutes 12 times a intervals, and exercised					
		nths for 4 continuous					
		test under load conditions					
		e simulated cold start and					
	•	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	IFPA 111. Main and feeder					
	circuit breakers ar	e inspected annually, and					
	a program for peri	odically exercising the					
		ablished according to					
	•	uirements. Written records					
		nd testing are maintained					
	-	ole. EES electrical panels					
		arked, readily identifiable,					
		normal power circuits.					
		ssibility of damage of the source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	•					
		review and interview, the	K 0918	,	K 918		11/16/2021
	1	ure a written record of	10010	´			11/10/2021
	-	for the generator was					
	maintained for 52 o	f 52 weeks. NFPA 99,					
	_	nsite generators shall be			·What corrective action(s)		
		dance with NFPA 110,			will be accomplished for thos		
	•	ency and Standby Power			residents found to have been	1	
	Systems. NFPA 110				affected by the deficient		
		Supply System (EPSS)			practice.		
	including all appurt	enant components, shall be			The generators for (cottages		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	<u>01</u>	COMPL	
		155846	B. W	ING		10/20/	/2021
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	L		616 GR	REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	Ι		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1.10		nd exercised monthly. NFPA			1,2,3,4,5,6) have all been add		5.112
	99, 6.4.4.2 requires				to the maintenance director's		
	inspection, performance, exercising period, and				weekly inspection schedule.		
	repairs for the gener				Weekly inepedient confidure.		
		ilable for inspection by the					
		risdiction. This deficient			·How other residents havi	na	
		t all residents, staff, and			the potential to be affected I	•	
	visitors.	, -,			the same deficient practice	-	
					be identified and what		
	Findings include:				corrective action(s) will be		
	C				taken.		
	Based on record rev	view on 10/20/21 with the			All elders, staff, and visitors h	ave	
Executive Director at 12:26 p.m., there was no				the potential to be affected by	this		
	current documentat	ion available for review in			alleged deficient practice. Al	I	
	reference to weekly	generator testing available			generators have been placed	on a	
	for review for the la	st 52-week period. The book			schedule to be inspected wee	kly	
	provided had weekl	y generator testing			and exercised monthly.		
	documented, but the	e testing stopped on					
	07/28/2020. Based	on an interview at the time of					
	record review, the I	Executive Director stated that			·What measures will be pu	t	
	_	venth day in the facility and			into place or what systemic		
		rector was at home with a			changes will be made to ens		
		vailable during the two days			that the deficient practice do	oes	
	•	ng the exit conference with			not recur.		
		tor on 10/20/21 at 12:15			The maintenance director will		
	*	information or evidence could			conduct weekly inspections a		
	be provided contrar	y to this deficient finding.			monthly load test and cool do	wn	
	2.1.10(1)				for all 6 generators.		
	3.1-19(b)						
	2) Rasad on manad	review and interview, the			·How the corrective action	(e)	
	· ·	intain a complete written			will be monitored to ensure		
	-	generator load testing for 12			deficient practice will not re		
		as. Chapter 6.4.4.1.1.4(a) of			i.e., what quality assurance	J	
		nires monthly testing of the			program will be put into place	ce:	
	•	ne emergency electrical			and	,	
	-	ordance with NFPA 110, the			The maintenance schedule w	ill be	
		ency and Standby Powers			maintained by maintenance		
	_	NFPA 110 8.4.2 requires			personnel, monitored by the		
		s in service to be exercised at			administrator, and reported to	,	
					· '		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u>01</u>	COMPLETED
		155846	B. WING		10/20/2021
	PROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
	minutes. Chapter 6.4 written record of ins exercising period, at to be regularly main inspection by the au This deficient practioccupants. Findings include: Based on record revexure Director accurrent documentation reference to weekly for review for the labook provided had adocumented, but the 07/28/2020. Based or record review, the Ethis was only his seeh his Maintenance Dirick child and not an of this survey. During the Executive Direct p.m., no additional in	for a minimum of 30 4.4.2 of NFPA 99 requires a spection, performance, and repairs for the generator attained and available for atthority having jurisdiction. Since could affect all series on 10/20/21 with the at 12:26 p.m., there was no non available for review in generator testing available st 12-month period. The monthly generator testing available on an interview at the time of executive Director stated that wenth day in the facility and rector was at home with a vailable during the two days and the exit conference with tor on 10/20/21 at 12:15 information or evidence could by to this deficient finding.		QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	
K 0000					
-					
Bldg. 02	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 1/21 and 10/20/21	K 0000	Preparation and/or execution this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of facts alleged or conclusions	the

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULT A. BUILD B. WING		NSTRUCTION 02	(X3) DATE : COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER		6	16 GRE	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	Facility Number: 0 Provider Number: 10 Provider Number: 2013 At this Life Safety Contages of Carmel with Requirements of Medicare/Medicaid, Life Safety from Fin National Fire Protect 101, Life Safety Contages of Carmel with Requirements of Medicare/Medicaid, Life Safety from Fin National Fire Protect 101, Life Safety Contages of Existing Health Cart 16.2. The facility consists 06). Each building if determined to be of and was fully sprink alarm system with secorridors, areas open hard-wired smoked frooms. The entire fatand had a census of All areas where resing were sprinklered and services were sp	13753 155846 362150 Code survey, Green House was found not in compliance for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) de (LSC), Chapter 19, re Occupancies and 410 IAC of six buildings (01 through as a one-story cottage Type V (111) construction releved. Each cottage has a fire moke detection in the resident recility has a capacity of 72 55 at the time of this survey. dents have customary access deall areas providing facility releved, with exception of a diministration building. iffied as Cottage #3. The ty of 12 and had a census of a survey. This Cottage serves a building for this facility.			forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in complian with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance wire Federal Medicare and Medicare quirements. This facility is requesting paper compliance for all cited deficiencies.	ce on th aid	DATE
K 0324 SS=F Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipmen	nt is protected in					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE (A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER		616 G	FADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY MEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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
	Ventilation Contro Commercial Cook* residential cookinappliances such a toasters) are used limited cooking in 18.3.2.5.2, 19.3.2.* cooking facilities smoke compartment patients comply who 18.3.2.5.3, 19.3.2.* cooking facilities with 30 or fewer phace conditions under a Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazaled be open to the corolation to the corolation and Fire procession system NFPA 96, 2011 Edit Control and Fire Procoking Operations Maintenance of the and listed exhaust he fire-activated water extinguish a fire in Hood exhaust plents shall be made by procertified person(s) a having jurisdiction and stream of the same procession system.	open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not reidor. 18.3.2.5.4, 19.3.2.5.1 19.9.2.3, TIA 12-2 Five and interview; the sure 1 of 1 kitchen fire was inspected semiannually. Ition, Standard for Ventilation of Commercial section of Commercial	K 0324	K324 ·What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice. All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) a scheduled to be inspected by Koorsen in November and will on a semi-annual inspection schedule per NFPA requirements. ·How other residents havin the potential to be affected at the same deficient practice of be identified and what	n are II be ng oy

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	î ´	JILDING	onstruction 02	(X3) DATE COMPL 10/20/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Executive Director of a kitchen fire sup for Cottage #3, for period was not availanterview at the tim Executive Director seventh day in the f Director was at hon available during the During the exit con Director on 10/20/2 additional informatic	view on 10/20/21 with the at 10:21 a.m., documentation oppression system inspection the last six or 12-month lable for review. Based on e of record review, the stated that this was only his facility, and his Maintenance ne with a sick child and not to two days of this survey. In at 12:15 p.m., no ion or evidence could be to this deficient finding.			corrective action(s) will be taken. All elders, staff, and visitors in the potential to be affected by alleged deficient practice. A semi-annual inspection sched has been established betwee facility and Koorsen. Next inspection is scheduled for November 2021. What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice do not recur. The semi-annual inspection of for the hood system was placed the maintenance schedule to ensure compliance. How the corrective action will be monitored to ensure deficient practice will not reive, what quality assurance program will be put into place and The maintenance schedule will maintenance schedule will maintenance by the administrator, and reported to QAPI monthly. If concerns an noted during maintenance checks, they will be remedied immediately.	this dule n this dule n this ut sure bes late ed in u(s) the cur, ce; iill be	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPL	ETED
		155846	B. W	NG		10/20/	/2021
				CTREET	ADDRESS OF A STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDEEN		S OF CARMEL			REEN HOUSE WAY		
GREEN	HOUSE COTTAGES	5 OF CARMEL		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 02	Maintenance						
	Fire Alarm System	n - Testing and					
	Maintenance						
	A fire alarm syster	n is tested and maintained					
	in accordance with	n an approved program					
	complying with the	e requirements of NFPA 70,					
	National Electric C	Code, and NFPA 72,					
	National Fire Alarr	n and Signaling Code.					
	Records of system	n acceptance, maintenance					
and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72							
		FPA 70, NFPA 72					
	1) Based on record	review and interview, the	K 0	345	K345	ļ	11/16/2021
	facility failed to ens	ure the documentation for					
	the annual testing of	f all devices connected to 1					
	of 1 fire alarm syste	em was complete. NFPA 72,					
	National Fire Alarm	Code, the 2010 Edition, at			·What corrective action(s)		
	Section 14.6.2.4 req	uires a record of all			will be accomplished for thos	se	
	inspections, testing,	and maintenance shall be			residents found to have beer	1	
	provided that includ	les the following information			affected by the deficient		
	regarding tests and	all the applicable information			practice.		
		14.6.2.4. The record shall			Maintenance and testing of the	e	
	include a listing of a	all devices tested with device			fire alarm system are performe	∍d	
	type, address, locati	on, and test results indicated:			in accordance with NFPA 110.		
	(1) Date				The semi-annual fire alarm sys	stem	
	(2) Test frequency				testing logs for (cottages 1, 2,	3,	
	(3) Name of propert	ty			4, 5 and 6) have been updated		
	(4) Address				and all 6 cottages are on sche	dule	
	(5) Name of person	performing inspection,			to be tested semi-annually.		
	maintenance, tests,	or combination thereof, and			-		
	affiliation, business	address, and telephone					
	number	•					
	(6) Name, address,	and representative of			How other residents having	ļ	
	approving agency (i	•			the potential to be affected b	У	
		he detector(s) tested			the same deficient practice w	-	
	(8) Functional test of				be identified and what	ļ	
	` /	of required sequence of			corrective action(s) will be	ļ	
	operations				taken.	ļ	
	(10) Check of all sn	noke detectors					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPLI	ETED
		155846	B. W	NG		10/20/	2021
				CED FEET	ADDRESS OF A STATE OF CODE		-
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	(11) Loop resistanc	e for all fixed-temperature,			All elders, staff, and visitors h	ave	
	line-type heat detec				the potential to be affected by		
	(12) Functional test of mass notification system				alleged deficient practice. All		
	control units				fire alarm systems have been		
	(13) Functional test of signal transmission to				placed on a schedule to have	fire	
	mass notification sy	-			alarm system tested		
	(14) Functional test				semi-annually.		
	notification system to silence fire alarm				ĺ		
	notification applian						
		gibility of mass notification			·What measures will be put	t I	
	system speakers				into place or what systemic		
		required by the equipment			changes will be made to ens	ure	
	manufacturer's publ				that the deficient practice do		
		required by the authority			not recur.		
	having jurisdiction	equired by the dumenty			The maintenance director will		
		ester and approved authority			conduct a fire alarm system te	st	
	representative	ester and approved damonty			semi-annually. This test will be		
	_	problems identified during			documented and will be visual		
		vner notified, problem			testing the control unit trouble	.,	
	corrected/successfu	-			signals, remote annunciators,		
	abandoned in place				initiating devices, notification		
		ice could affect all occupants			appliances and magnetic		
	in the facility.	ice coura arreer air occupants			hold-open devices.		
	in the facility.				neia spen aeviese.		
	Findings include:				·How the corrective action((s)	
	i mumgs meruue.				will be monitored to ensure t		
	Based on record rev	view on 10/20/21 with the			deficient practice will not rec		
		at 10:21 a.m., a fire alarm			i.e., what quality assurance	,	
		esting report could not be			program will be put into plac	e:	
		for review with an itemized			and	,	
	-	stem devices inspected/tested			The maintenance schedule wil	_{II be}	
	•	te type, address, location, and			maintained by maintenance		
		ne testing. Based on			personnel, monitored by the		
	_	e of record review, the			administrator, and reported to		
		stated that this was only his			QAPI monthly. If concerns are	و	
		acility and his Maintenance			noted during maintenance	-	
		ne with a sick child and not			checks, they will be remedied		
		two days of this survey.			immediately.		
		ference with the Executive			iodiatory.		
	During the Call Coll	icicinee with the Lacoutive					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	r í	JILDING	nstruction 02	(X3) DATE COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	616 GR	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
		1 at 12:15 p.m., no on or evidence could be this deficient finding.					
	3.1-19(b)						
	facility failed to ens was maintained in a LSC 9.6.1.3 require installed, tested, and with NFPA 70, National Section 14.4.5 states by other sections of performed in accord Table 14.4.5, or mo authority having jur 14.4.5.3.1 states sm be checked within 1 72, 14.4.5.3.2 states shall be checked evunless otherwise per	review and interview, the ure 1 of 1 fire alarm systems coordance with LSC 9.6.1.3. It is a fire alarm system to be a maintained in accordance onal Electrical Code and Fire Alarm Code. NFPA 72, is unless otherwise permitted this Code, testing shall be alance with the schedules in the often if required by the isdiction. NFPA 72, Section tooke detector sensitivity shall year after installation. NFPA smoke detector sensitivity ery alternate year thereafter remitted by compliance with This deficient practice could					
	Findings include:	······ 10/20/21					
	Executive Director and documentation for a test was available for at the time of record Director stated that in the facility and his at home with a sick the two days of this conference with the 10/20/21 at 12:15 p.	smoke detector sensitivity or review. Based on interview I review, the Executive this was only his seventh day s Maintenance Director was child and not available during survey. During the exit Executive Director on					

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	02	COMPI	
		155846	B. W	ING		10/20	/2021
		<u> </u>	_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			L, IN 46032		
(V4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID			(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
		NCY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCE		DATE
	contrary to this defi	icient finding.					
	2.1.10(1.)						
	3.1-19(b)						
	2) D 1 1	. 1:4 : 4					
	· ·	review and interview, the					
	-	nintain 1 of 1 fire alarm					
	-	nce with NFPA 72, National					
		s required by LSC Sections					
		NFPA 72, Section 14.3.1					
		therwise permitted by 14.3.2,					
	-	shall be performed in e schedules in Table 14.3.1, or					
	-	red by the authority having					
	-	14.3.1 states that the					
	following must be semi-annually:	visually inspected					
	a. Control unit trou	ble signals					
	b. Remote annuncia						
		s (e.g. duct detectors, manual					
	_	eat detectors, smoke					
	detectors, etc.)	eat detectors, smoke					
	d. Notification appl	iances					
	e. Magnetic hold-o						
	-	ice could affect all building					
	occupants.	nee could affect all building					
	occupants.						
	Findings include:						
	i mamga maraati						
	Based on record rev	view on 10/20/21 with the					
	Executive Director						
		a semiannual visual inspection					
		stem was available for review.					
	-	at the time of record review,					
		ctor stated that this was only					
	his seventh day in t						
	_	tor was at home with a sick					
		able during the two days of this					
		exit conference with the					
		on 10/20/21 at 12:15 p.m.,					
		nation or evidence could be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	INSTRUCTION 02	(X3) DATE SURVEY COMPLETED		
		155846	B. W		<u>02</u>	10/20/	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
		o this deficient finding.		9			3.1.2
K 0353 SS=F Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1) Based on record of	supply source RKS information on non-required or partial r system. and NFPA 25 review and interview, the	K 0	353	K353		11/16/2021
	or other evidence the components had beed of 4 quarters. LSC 4 equipment or system with this Code be mapplicable NFPA resystems shall be proaccordance with NFI Inspection, Testing, Water-Based Fire Paragraphs of the systems of the	en inspected and tested for 4 1.6.12.1 requires any device, in required for compliance aintained in accordance with quirements. Sprinkler			•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All sprinkler systems on camp (cottages 1, 2, 3, 4, 5 and 6) as scheduled to be inspected by Koorsen in November per NFF requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract withKoorsen	us re PA	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPLET	TED
		155846	B. W	ING		10/20/20	021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	, ,	risdiction upon request. 4.3.2					
	_	s shall indicate the procedure			·How other residents havin	- 1	
	performed (e.g., ins	-			the potential to be affected b	-	
		organization that performed			the same deficient practice w	/111	
		s, and the date. NFPA 25,			be identified and what		
		vaterflow alarm devices shall			corrective action(s) will be taken.		
		rly to verify they are free of IFPA 25, 5.3.3.1 requires the			All elders, staff, and visitors ha	,,, <u>,</u>	
		ow alarm devices including,			the potential to be affected by		
		vater motor gongs, shall be			alleged deficient practice. All		
		3.3.2 requires vane-type and			sprinkler systems are on a		
		e waterflow alarm devices			quarterly inspection and testin	a l	
		annually. This deficient			schedule per NFPA	9	
		et all residents, staff, and			requirements.		
	visitors in the facili				'		
		•					
	Findings include:				·What measures will be put	t l	
					into place or what systemic		
	Based on record rev	view on 10/20/21 with the			changes will be made to ens	ure	
	Executive Director	at 10:31 a.m., no			that the deficient practice do	es	
	documentation for	quarterly sprinkler system			not recur.		
	inspections was ava	ailable for review for the past			The quarterly inspection dates	for	
	12 months. Based of	on interview at the time of			the sprinkler systems are in th	e	
		Executive Director stated that			maintenance schedule to ensu	ıre	
	1	venth day in the facility and			compliance.		
		rector was at home with a					
		vailable during the two days					
		ng the exit conference with			·How the corrective action(
		etor on 10/20/21 at 12:15			will be monitored to ensure t		
		information or evidence could			deficient practice will not rec	ur,	
	be provided contrar	y to this deficient finding.			i.e., what quality assurance		
	2.1.10(1.)				program will be put into plac	е;	
	3.1-19(b)				and The maintenance ashedule wi	ll bo	
	2) Paged on man - 1	raviany and interview the			The maintenance schedule wi	ıı be	
		review and interview, the			maintained by maintenance		
	1	cument sprinkler system			personnel, monitored by the administrator, and reported to		
	inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and				QAPI monthly. If concerns are		
		ater-Based Fire Protection			noted during maintenance	_	
		ion, Section 5.2.4.1 states			checks, they will be remedied		
	bystems, 2011 Edit	ion, section 3.2.4.1 states			Checks, they will be remedied		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846 A. BUILDING 02 B. WING			COMPLETED 10/20/2021		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC INENTIFYING INFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	gauges on wet pipe inspected monthly to condition and that not is being maintained, and fire department inspected, tested, an with Chapter 13. Section 4.3.1.1.2 shall be util and maintenance of trim. Section 4.3.1 s for all inspections, to system and its compavailable to the auth request. This deficie residents, staff, and Findings include: Based on record reve Executive Director and documentation of me gauge inspections conform the past 12 mont time of record revies stated that this was of facility and his Mair home with a sick chapter than the two days of this conference with the 10/20/21 at 12:15 p. information or evide contrary to this defice 3.1-19(b) 3) Based on observational facility failed to ensure gauges were replaced.	iew on 10/20/21 with the at 10:34 a.m., no onthly control valve and ould be provided for review hs. Based on interview at the w, the Executive Director only his seventh day in the atenance Director was at ild and not available during survey. During the exit Executive Director on m., no additional ence could be provided cient finding.		TAG	immediately.		DATE
	documented as teste comparison with a c	alibrated gauge. NFPA 25,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	02	COMPL	
		155846	B. W	ING		10/20/	/2021
NAME OF B			•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIEF	C .		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA).TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE.	DATE
	Standard for the Ins	spection, Testing, and					
	Maintenance of Wa	ter-Based Fire Protection					
	Systems, 2011 Edit	ion, Section 5.3.2.1 states					
	gauges shall be repl	laced every 5 years or tested					
	every 5 years by co	mparison with a calibrated					
	gauge. Gauges not	accurate to within 3 percent of					
	the full scale shall b	be recalibrated or replaced.					
	This deficient pract	ice could affect all residents,					
	staff, and visitors in	the facility.					
	Findings include:						
		ons made with the Executive					
	_	our of the facility from 2:23					
		n 10/19/21, the facility had					
		nkler systems and had a total					
	_	sure gauges. The manufacture					
	_	iges was 2015 and was listed					
		sprinkler system gauge. No					
		nformation was affixed to or					
		the sprinkler system gauges.					
	Based on interview						
		cility Executive Director					
		lieve sprinkler system gauges ed within the most recent					
	five-year period and	prinkler system gauge					
		llibration documentation was view for all three sprinkler					
		ch were more than five years					
		conference with the					
	_	on 10/20/21 at 12:15 p.m.,					
		nation or evidence could be					
		o this deficient finding.					
		Č					
	3.1-19(b)						
K 0511	NFPA 101						
SS=F	Utilities - Gas and	Electric					
Bldg. 02	Utilities - Gas and	Electric					
-							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION A. BUILDING O2			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			02	COMPL	ETED
		155846	B. W	ING		10/20	/2021
NAME OF E	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
White of 1	ROVIDER OR SOLVEIE			616 GR	REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		gas or related gas piping PA 54, National Fuel Gas					
	•	riring and equipment					
		PA 70, National Electric					
	· ·	stallations can continue in					
	service provided r						
	18.5.1.1, 19.5.1.1	, 9.1.1, 9.1.2					
		view and interview the facility	K 0	511	·What corrective action(s)		11/16/2021
		t the emergency generator had			will be accomplished for those		
		fuel in accordance with the			residents found to have beer	ו	
		PA 101 - 2012 edition,			affected by the deficient		
		1, 9.1.3.1 and NFPA 110, LSC Section 9.1.3.1 states			practice The facility has obtained a lett	er of	
	· · · · · · · · · · · · · · · · · · ·	ors shall be installed, tested,			reliability from the company	Ci Oi	
		accordance with NFPA 110,			responsible for supplying natu	ral	
		gency and Standby Power			gas to the generators in (cotta		
	Systems, 2010 Edit	ion. Section 5.1.1 states the			1, 2, 3, 4, 5, 6).		
		ources shall be permitted to					
		ergency power supply (EPS):					
		m products at atmospheric					
	pressure	I			Usus other residents beginning	-	
	withdrawal)	leum gas (liquid or vapor			·How other residents havin the potential to be affected b	•	
	(3) Natural or synth	netic gas			the same deficient practice v	•	
		el 1 installations in locations			be identified and what	••••	
	-	ty of interruption of off-site			corrective action(s) will be		
	-	n, on-site storage of an			taken.		
	alternate energy sou	arce sufficient to allow full			All elders, staff, and visitors ha		
	-	to be delivered for the class			the potential to be affected by	this	
	-	equired, with the provision for			alleged deficient practice. A		
	automatic transfer f	from the primary energy			letter of reliability will be provid		
		ate energy source. uples of probability of			for the generators in (cottages 2, 3, 4, 5, 6)	1,	
		nclude the following:			2, 0, 1 , 0, 0)		
	_	amage, or a demonstrated					
	-	This deficient practice had			·What measures will be put	t	
	the potential to affe	ect all residents.			into place or what systemic		
					changes will be made to ens		
	Findings include:				that the deficient practice do	es	
					not recur.		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 10/20/2021
	ROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	Executive Director a of the facilities fire diesel. During a tour determined that the generators was not or record review on 10 the five books labele 6 P.M. logs, no nature could be located. Batime of record revier stated that this was a facility, and he was had even been requered executive Director, one from his providable to do so. During the Executive Direct p.m., no additional in	on 10/20/21 with the at 10:48 a.m., the fuel source generators was thought to be r of the 6 cottages, it was fuel source of the five diesel but natural gas. During 1/20/21 the documentation on ed as C 1 P.M. log through C aral gas letter of reliability used on an interview at the w, the Executive Director only his seventh day at the unsure if a letter of reliability ested by the previous but that he would request er as soon as he would be g the exit conference with tor on 10/20/21 at 12:15 information or evidence could y to this deficient finding.		The maintenance director or designee will ensure each generator has documentation reliable source of fuel in accordance with NFPA 101. How the corrective action(will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place and The maintenance schedule witmaintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	s) he cur, e; Il be
K 0712 SS=F Bldg. 02	alarm signal and s fire conditions. Fire expected and uner varying conditions shift. The staff is fa and is aware that or routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1	xpected times under , at least quarterly on each amiliar with procedures drills are part of established ills are conducted between AM, a coded ay be used instead of	K 0712	K712	11/16/2021

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPLETED	
		155846	B. W	ING		10/20/2	2021
				CTD FET A	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	ADOLUDEDIO DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	1E	DATE
	facility failed to cor	nduct quarterly fire drills for			·What corrective action(s)		
	-	C 19.7.1.6 requires drills to			will be accomplished for thos	se	
	_	erly on each shift under varied			residents found to have been		
	_	ficient practice affects all			affected by the deficient	'	
	staff and residents.	freight practice affects an			practice.		
	starr and residents.				Fire drills were conducted per		
	Findings include:				NFPA requirements for 1st shi	ff	
	rindings include:				The state of the s	"	
	Dagad on	view on 10/19/21 with the			for all 6 cottages.		
		at 10:56 a.m., there were no			Have ather residents beside	_	
		ills available for review for			·How other residents havin	-	
	-	nth period. Based on interview			the potential to be affected by	-	
		d review, the Executive			the same deficient practice w	/III	
		he could not locate any fire			be identified and what		
		and that this was only his			corrective action(s) will be		
		acility. Furthermore, his			taken.		
		tor was at home with a sick			All elders, staff, and visitors ha		
		ble during the two days of this			the potential to be affected by	this	
		exit conference with the			alleged deficient practice.		
		on 10/20/21 at 12:15 p.m.,			Quarterly fire drills at unexpec		
		nation or evidence could be			times, under varying condition	s,	
	provided contrary to	o this deficient finding.			and at least quarterly on each		
					shift will be held at the facility p	per	
	3.1-19(b)				NFPA requirements.		
	3.1-51(c)						
					·What measures will be put	,	
					into place or what systemic		
					changes will be made to ensu	ure	
					that the deficient practice do	es	
					not recur.		
					The maintenance schedule wil	l be	
					reviewed and revised to includ	e l	
					scheduled fire drills at unexpe	cted	
					times, under varying condition		
					and at least quarterly on each		
					shift per NFPA requirements.		
					por tra i / troquiromonto.		
					·How the corrective action(۱ ا	
			1		Thow the corrective action(ار ح	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPLE	ETED
		155846	B. W	ING		10/20/2	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EL, IN 46032		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the essitiches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mon hours. Scheduled include a complete automatic or manu- loads, and are con-	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer frimed in accordance with e inspected weekly, had 30 minutes 12 times a lintervals, and exercised hiths for 4 continuous test under load conditions test under load conditions test simulated cold start and lial transfer of all EES inducted by competent		TAG	will be monitored to ensure to deficient practice will not receive, what quality assurance program will be put into place and. The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he ur, e; II be	DATE
	Generator sets are exercised under lo year in 20-40 day once every 36 more hours. Scheduled include a complete automatic or manuloads, and are conpersonnel. Maintel	and 30 minutes 12 times a intervals, and exercised on this for 4 continuous test under load conditions a simulated cold start and ual transfer of all EES					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	f '	ILDING	nstruction 02	(X3) DATE S COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	circuit breakers and a program for pericomponents is est manufacturer requof maintenance and readily available and circuits are mand separate from Minimizing the postemergency power consideration for reference to weekly inspections maintained for 52 of 6.4.4.1.3 requires of maintained in according to the following all appurers including all appurers inspected weekly are 99, 6.4.4.2 requires inspection, performs repairs for the gener maintained and available authority having jur practice could affect visitors. Findings include: Based on record reverse Executive Director accurrent documentation reference to weekly inspected weekly and the program of the gener maintained and available authority having jur practice could affect visitors.	(NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, the ure a written record of for the generator was f 52 weeks. NFPA 99, asite generators shall be dance with NFPA 110, ency and Standby Power 0, 8.4.1 requires an Supply System (EPSS) enant components, shall be and exercised monthly. NFPA a written record of ance, exercising period, and	K 09	918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The generators for (cottages 1,2,3,4,5,6) have all been added to the maintenance director's weekly inspection schedule. How other residents having the potential to be affected by the same deficient practice where identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. All generators have been placed eschedule to be inspected weekly inspected weekly alleged to be alleged to be inspected weekly all all alleged to be alleged to	ed g y vill ave this	11/16/2021

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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 02	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	provided had weekly generator testing documented, but the testing stopped on 07/28/2020. Based on an interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 10/20/21 with the Executive Director at 12:26 p.m., there was no current documentation available for review in reference to weekly generator testing available for review for the last 12-month period. The		and exercised monthly. 'What measures will be put into place or what systemic changes will be made to ens that the deficient practice do not recur. The maintenance director will conduct weekly inspections ar monthly load test and cool do for all 6 generators. 'How the corrective actions will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place and. The maintenance schedule with maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	ure es nd wn (s) he eur, e;	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	02	COMPL	ETED
		155846	B. W	B. WING 10/20/2021			2021
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0000	documented, but the 07/28/2020. Based of record review, the E this was only his set his Maintenance Dir sick child and not at of this survey. During the Executive Direct p.m., no additional is be provided contrary.	e documentation stopped on on an interview at the time of executive Director stated that eventh day in the facility and rector was at home with a vailable during the two days ing the exit conference with tor on 10/20/21 at 12:15 information or evidence could by to this deficient finding.					
Bldg. 03	Licensure Survey w Department of Heal CFR 483.90(a). Survey Date: 10/19 Facility Number: 0 Provider Number: 2013 At this Life Safety C Cottages of Carmel with Requirements of Medicare/Medicaid, Life Safety from Fin National Fire Protect 101, Life Safety Co Existing Health Car 16.2.	13753 155846 362150 Code survey, Green House was found not in compliance	K 0	000	Preparation and/or execution this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of tacts alleged or conclusions forth in this statement of deficiencies. The plan of correction and specific corrective actions are preparand/or executed in compliant with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicar requirements. This facility is requesting paper compliance for all cited deficiencies.	the set ed ce on th	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING	03	COMPL	
		155846	B. W.			10/20/	2021
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		building is a one-story					
	_	to be of Type V (111)					
		s 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 55 at the time of this survey.							
	survey.						
	All areas where resi	dents have customary access					
	were sprinklered and all areas providing facility						
	-	klered, with exception of a					
separate detached administration building.		-					
	Building 03 is ident	ified as Cottage #1. The					
	cottage has a capaci	ty of 12 and had a census of					
	12 at the time of this	s survey.					
	Quality Review con	npleted on 10/26/21					
K 0324	NFPA 101						1
SS=F	Cooking Facilities						
Bldg. 03	Cooking Facilities						
	Cooking equipmer	nt is protected in					
	accordance with N	IFPA 96, Standard for					
		I and Fire Protection of					
		ing Operations, unless:					
		ng equipment (i.e., small					
		s microwaves, hot plates,					
		for food warming or					
	limited cooking in						
	18.3.2.5.2, 19.3.2.	open to the corridor in					
	_	ents with 30 or fewer					
		ith the conditions under					
	18.3.2.5.3, 19.3.2.						
		in smoke compartments					
	_	atients comply with					
	· ·	8.3.2.5.4, 19.3.2.5.4.					
		protected according to					
]	J					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	03	COMPL	ETED
		155846	B. W	WING 10/20/2021			
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
ODEEN	LOUISE SOTTAGE	0.05.04.51451			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	NFPA 96 per 9.2.3 are not required to be						
		rdous areas, but shall not					
	be open to the co	•					
	18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1						
	through 19.3.2.5.5						
	_	view and interview; the	KO	324	K324		11/16/2021
		sure 1 of 1 kitchen fire	I K U	<i>32</i> ¬	·What corrective action(s)		11/10/2021
	1	was inspected semiannually.			will be accomplished for those	se	
		ition, Standard for Ventilation			residents found to have been		
	· /	otection of Commercial			affected by the deficient	•	
		s, Section 11.2.1 states			practice.		
Maintenance of the fire-extinguishing systems				All hood systems on campus			
	and listed exhaust hoods containing a constant or				(cottages 1, 2, 3, 4, 5 and 6) a	re	
	fire-activated water system that is listed to				scheduled to be inspected by		
	extinguish a fire in the grease removal devices.				Koorsen in November and will	he	
	_	ams, and the exhaust ducts			on a semi-annual inspection	ьс	
	_	operly trained, qualified, and			schedule per NFPA		
		acceptable to the authority			requirements.		
		at lease every six months.			requirements.		
		ice could affect all residents,					
	staff, and visitors w				·How other residents havin	a	
	starr, and visitors w	Tillin the facility.			the potential to be affected b	•	
	Findings include:				the same deficient practice v	-	
	rindings include.				be identified and what	VIII	
	Rased on record rea	view on 10/20/21 with the			corrective action(s) will be		
		at 10:21 a.m., documentation			taken.		
		opression system inspection			All elders, staff, and visitors ha	ave	
		the last six or 12-month			the potential to be affected by		
	I -	lable for review. Based on			alleged deficient practice. A	uno	
	_	e of record review, the			semi-annual inspection sched	مارر	
		stated that this was only his			has been established between		
		Facility, and his Maintenance			facility and Koorsen. Next	1 11113	
	I -	ne with a sick child and not			inspection is scheduled for		
		e two days of this survey.			November 2021.		
		ference with the Executive			1.070111001 2021.		
	Director on 10/20/2						
		ion or evidence could be			·What measures will be put	+	
		o this deficient finding.			into place or what systemic	•	
	provided contrary t	o and deficient finding.			changes will be made to ens	urα	
	2 1 10(b)				_		
3.1-19(b)				that the deficient practice do	es		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING B. WING	03	COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER		616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
				not recur. The semi-annual inspection date for the hood system was placed the maintenance schedule to ensure compliance.		
				·How the corrective action(will be monitored to ensure t deficient practice will not rec i.e., what quality assurance program will be put into place and The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he ur, e; II be	
K 0345 SS=F Bldg. 03	in accordance with complying with the National Electric C National Fire Alarn Records of systen and testing are rea 9.6.1.3, 9.6.1.5, N	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72				
	facility failed to ens	review and interview, the sure the documentation for fall devices connected to 1	K 0345	K345		11/16/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	03	COMPL	ETED
		155846	B. W	ING		10/20/	2021
		.000.10		_		. 0, 20,	
NAME OF P	ROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE		
				616 GR	REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of 1 fire alarm syste	em was complete. NFPA 72,					
	National Fire Alarn	n Code, the 2010 Edition, at			·What corrective action(s)		
	Section 14.6.2.4 requires a record of all				will be accomplished for thos	se	
	inspections, testing,	, and maintenance shall be			residents found to have beer	1	
	provided that include	des the following information			affected by the deficient		
	_	all the applicable information			practice.		
		14.6.2.4. The record shall			Maintenance and testing of the	Э	
include a listing of all devices tested with device				fire alarm system are performe			
type, address, location, and test results indicated:				in accordance with NFPA 110.			
(1) Date				The semi-annual fire alarm sys			
(2) Test frequency				testing logs for (cottages 1, 2,			
(3) Name of property				4, 5 and 6) have been updated			
(4) Address				and all 6 cottages are on sche			
	(5) Name of person performing inspection,				to be tested semi-annually.		
		or combination thereof, and			to be tosted semi armadily.		
		address, and telephone					
	number	address, and terephone					
		and representative of			How other residents having		
	approving agency (i				the potential to be affected b	v	
		the detector(s) tested			the same deficient practice w	-	
	(8) Functional test of				be identified and what	••••	
	` /	of required sequence of			corrective action(s) will be		
	operations	or required sequence or			taken.		
	(10) Check of all sn	noke detectors			tunon:		
	` '	e for all fixed-temperature,			All elders, staff, and visitors h	ave	
	line-type heat detec				the potential to be affected by		
		of mass notification system			alleged deficient practice. All		
	control units	of mass nonneadon system			fire alarm systems have been	J	
		of signal transmission to			placed on a schedule to have	fire	
	mass notification sy				alarm system tested	0	
	(14) Functional test				semi-annually.		
		to silence fire alarm			Schill-allitually.		
	notification system						
					·What measures will be put		
		gibility of mass notification			-	L	
	system speakers				into place or what systemic		
		required by the equipment			changes will be made to ens		
	manufacturer's publ				that the deficient practice do	es	
		required by the authority			not recur.		
	having jurisdiction				The maintenance director will		
(18) Signatures of tester and approved authority				conduct a fire alarm system te	st		

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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 <u>03</u>	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIEF		616 GI	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPR DEFICIENCY)	DATE
	test (e.g., system ov corrected/successfu abandoned in place	-		semi-annually. This test will documented and will be visual testing the control unit trouble signals, remote annunciators initiating devices, notification appliances and magnetic hold-open devices.	ally e
	Executive Director system inspection/t located or provided list of fire alarm system indicating the device specific results of the interview at the time Executive Director seventh day in the f Director was at hon available during the During the exit con Director on 10/20/2 additional informat	view on 10/20/21 with the at 10:21 a.m., a fire alarm esting report could not be for review with an itemized stem devices inspected/tested the type, address, location, and the testing. Based on the of record review, the stated that this was only his facility and his Maintenance the with a sick child and not the two days of this survey. If at 12:15 p.m., no ion or evidence could be to this deficient finding.		·How the corrective action will be monitored to ensure deficient practice will not refice, what quality assurance program will be put into plan and. The maintenance schedule was maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns a noted during maintenance checks, they will be remedied immediately.	the ecur, ce; vill be
	facility failed to ens was maintained in a LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nat NFPA 72, National Section 14.4.5 state by other sections of performed in according	review and interview, the sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3. It is a fire alarm system to be domaintained in accordance ional Electrical Code and Fire Alarm Code. NFPA 72, is unless otherwise permitted of this Code, testing shall be dedance with the schedules in one often if required by the			

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	OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	03	COMPL	
		155846	B. WI	NG		10/20/	/2021
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		616 GRI	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	L, IN 46032		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		risdiction. NFPA 72, Section		1710			DATE
	14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA						
		s smoke detector sensitivity					
		ery alternate year thereafter					
		rmitted by compliance with					
	-	This deficient practice could					
	affect all occupants	-					
	arrect air occupants	•					
Findings include:							
i mangs nicitate.							
Based on record review on 10/20/21 with the							
Executive Director at 10:24 a.m., no							
documentation for a smoke detector sensitivity							
	test was available for	or review. Based on interview					
	at the time of record	d review, the Executive					
		this was only his seventh day					
		is Maintenance Director was					
	-	child and not available during					
		survey. During the exit					
	conference with the	Executive Director on					
	10/20/21 at 12:15 p	.m., no additional					
	-	ence could be provided					
	contrary to this defi	-					
	·						
	3.1-19(b)						
	/	review and interview, the					
	•	intain 1 of 1 fire alarm					
	*	nce with NFPA 72, National					
		required by LSC Sections					
		NFPA 72, Section 14.3.1					
		herwise permitted by 14.3.2,					
	_	hall be performed in					
		e schedules in Table 14.3.1, or					
	-	red by the authority having					
	-	14.3.1 states that the					
	following must be v	visually inspected					
	semi-annually:						
	a. Control unit troul	ble signals					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		 JILDING	<u>03</u>	COMPL 10/20/	ETED	
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL		L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
	fire alarm boxes, he detectors, etc.) d. Notification appli e. Magnetic hold-op This deficient practi occupants. Findings include:	(e.g. duct detectors, manual at detectors, smoke ances en devices ce could affect all building				
	Executive Director a documentation for a of the fire alarm sys Based on interview the Executive Direct his seventh day in the Maintenance Direct child and not availal survey. During the executive Director on additional inform provided contrary to	semiannual visual inspection tem was available for review. at the time of record review, tor stated that this was only				
K 0353 SS=F Bldg. 03	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing r and standpipe systems red, and maintained in IFPA 25, Standard for the rg, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a readily available. system last checked				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	03	COMPL	ETED
		155846	B. W	ING	NG 10/20/2021		
		<u> </u>		CTREET	ADDRESS CITY STATE ZID CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	b) Who provided	system test					
	.,	,					
	c) Water system	supply source					
	o, maio. Gyotom.	омрр., сом. ос					
	Provide in REMARKS information on coverage for any non-required or partial						
	automatic sprinkle						
	-						
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the		I K O	353	K353		11/16/2021
		ovide written documentation	1 1 1	555	·What corrective action(s)		11/10/2021
	or other evidence the sprinkler system				will be accomplished for those	20	
components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance				residents found to have been			
				affected by the deficient			
				practice.			
	with this Code be maintained in accordance with				1 ⁻		
					All sprinkler systems on camp		
		equirements. Sprinkler			(cottages 1, 2, 3, 4, 5 and 6) a	ie	
		operly maintained in			scheduled to be inspected by	٦,٨	
		FPA 25, Standard for the			Koorsen in November per NFF	A	
	-	, and Maintenance of			requirements. All sprinkler		
		Protection Systems. NFPA 25,			systems are on a quarterly	1	
	-	ds shall be made for all			inspection and testing schedul		
	_	nd maintenance of the system			per contract withKoorse	١.	
	_	all be made available to the					
		risdiction upon request. 4.3.2					
	_	s shall indicate the procedure			·How other residents havin	_	
	performed (e.g., ins	-			the potential to be affected b	-	
		organization that performed			the same deficient practice v	/ill	
		s, and the date. NFPA 25,			be identified and what		
	•	waterflow alarm devices shall			corrective action(s) will be		
	• •	rly to verify they are free of			taken.		
		FPA 25, 5.3.3.1 requires the			All elders, staff, and visitors ha		
		ow alarm devices including,			the potential to be affected by		
		vater motor gongs, shall be			alleged deficient practice. All		
		3.3.2 requires vane-type and			sprinkler systems are on a		
	•	e waterflow alarm devices			quarterly inspection and testin	g	
		annually. This deficient			schedule per NFPA		
	_	et all residents, staff, and			requirements.		
	visitors in the facili	ty.					
	Findings include:				·What measures will be put	:	

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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 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Based on record review on 10/20/21 with the Executive Director at 10:31 a.m., no documentation for quarterly sprinkler system inspections was available for review for the past 12 months. Based on interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include:		into place or what systemic changes will be made to ens that the deficient practice do not recur. The quarterly inspection dates the sprinkler systems are in the maintenance schedule to ensure compliance. How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place and. The maintenance schedule with maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	es for e ure (s) che cur, ee;

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846			COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER		6	16 GRE	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Executive Director a documentation of m gauge inspections or for the past 12 mont time of record revier stated that this was a facility and his Main home with a sick che the two days of this conference with the 10/20/21 at 12:15 p. information or evide contrary to this defice on the two days of this conference with the 10/20/21 at 12:15 p. information or evide contrary to this defice on the following that the full scale shall be replaced by the following that the full scale shall be the	onthly control valve and bould be provided for review ths. Based on interview at the w, the Executive Director only his seventh day in the intenance Director was at ild and not available during survey. During the exit Executive Director on m., no additional ence could be provided cient finding. Intion and interview, the ure 3 of 3 sprinkler system and every 5 years or devery 5 years or devery 5 years by alibrated gauge. NFPA 25, pection, Testing, and ter-Based Fire Protection on, Section 5.3.2.1 states acced every 5 years or tested inparison with a calibrated accurate to within 3 percent of the recalibrated or replaced. In could affect all residents,					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	03	COMPLETED
		155846	B. WING		10/20/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				REEN HOUSE WAY	
GREEN H	HOUSE COTTAGES	S OF CARMEL	CARME	EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	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
		ges was 2015 and was listed			
		sprinkler system gauge. No			
		formation was affixed to or			
		the sprinkler system gauges.			
	Based on interview				
		cility Executive Director			
		lieve sprinkler system gauges ed within the most recent			
five-year period and acknowledged documentation of sprinkler system gauge					
replacement or recalibration documentation was not available for review for all three sprinkler system gauges which were more than five years					
old. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m.,					
	no additional inform	nation or evidence could be			
	provided contrary to	this deficient finding.			
	3.1-19(b)				
K 0355	NFPA 101				
SS=F	Portable Fire Extir	nguishers			
Bldg. 03	Portable Fire Extir	nguishers			
		guishers are selected,			
		d, and maintained in			
		IFPA 10, Standard for			
	Portable Fire Extin	-			
	18.3.5.12, 19.3.5.1				
		on and interview, the facility	K 0355	K355	11/16/2021
	failed to inspect 3 of	A 10, Standard for Portable		What corrective action(s) will be accomplished for those]
	_	Section 7.2.1.2 states fire		residents found to have beer	,
	_	be inspected either manually		affected by the deficient	·
	•	lectronic device / system at a		practice.	
	_	intervals. Section 7.2.2		All portable fire extinguishers f	or
	states periodic inspe			(cottages 1, 2, 3, 4, 5 and 6) w	l l
		xtinguishers shall include a		inspected by the maintenance	
	check of at least the			director in November per NFP	Α
	(1) Location in design			requirements. All portable fire	l l
	(2) No obstruction t	o access or visibility		extinguishers will be inspected	
			1	•	ı

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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	DISTRUCTION 03	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	DATE
	(3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect up to all residents, staff, and visitors within the facility. Findings include: Based on observations made with the Executive Director during a tour of the facility from 2:23 p.m. to 4:51 p.m. on 10/20/21, the monthly inspection tags on all portable fire extinguishers located in the cottage lacked documentation of a monthly inspections for the months of December 2020 through August of 2021. This was acknowledged by the Executive Director at the time of each observation who stated that this was only his seventh day at the facility, and he		monthly per NFPA requirement How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. All portable fire extinguishers will inspected monthly per NFPA requirements. What measures will be put implace or what systemic changes will be made to ensith the deficient practice do not recur. The monthly inspection dates the fire extinguishers are in the maintenance schedule to ensite the fire extinguishers are in the maintenance schedule to ensite deficient practice will not recise, what quality assurance program will be put into place and The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	nts. the e pe e ave this be tto ure es for e ure the cur, e; Il be

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPI A. BUILDIN B. WING		3	(X3) DATE : COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER		616	GREEN	ESS, CITY, STATE, ZIP CODE N HOUSE WAY N 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	being checked. Duri the Executive Direc p.m., no additional i	ortable fire extinguishers were fing the exit conference with tor on 10/20/21 at 12:15 information or evidence could by to this deficient finding.					
K 0363 SS=E Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required enclopenings, exits, or the passage of sminch solid-bonded material capable of 20 minutes. Doors compartments are passage of smoke to rooms containing combustible material capable of the compartments are passage of smoke to rooms containing combustible material capable of the compartments are passage of smoke to rooms containing combustible material capable material capable of the compartments are passage of smoke to rooms containing combustible material capable of the compartments are partially to auxiliary significant complying with the door closed with a compartment c	chazardous areas resist toke and are made of 1 3/4 core wood or other of resisting fire for at least in fully sprinklered smoke only required to resist the corridor doors and doors grammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORREC	ΓΙΟΝ	IDENTIFICATION NUMBER:	A. BUILDING <u>03</u> COMPLETED			ETED	
		155846	B. W	VING 10/20/2021			2021
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER O	R SUPPLIEI	₹					
CDEEN HOUSE C	OTT 4 OF	S OF CARME!			REEN HOUSE WAY		
GREEN HOUSE C	OTTAGE	5 OF CARMEL		CARIVIE	EL, IN 46032		
(X4) ID S	JMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EAC	H DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG REGUI	ATORY OF	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
unless th	ne smoke	compartment is					
sprinkler	ed. Fixed	fire window assemblies					
are allowed per 8.3. In sprinklered							
	-	ere are no restrictions in					
· ·		ance of glass or frames in					
	assemblie	_					
19.3.6.3	42 CFR	Parts 403, 418, 460, 482,					
483, and		, ,, - ,					
		(S details of doors such as					
		ngs, automatics closing					
	devices, etc. Based on observation and interview, the facility failed to ensure 1 of 12 sets of resident room						
			K 0	363	K363		11/16/2021
			I K U	303	·What corrective action(s)		11/10/2021
		or would close completely			will be accomplished for thos	80	
		oor frame. This deficient			residents found to have beer		
		et approximately all residents,			affected by the deficient	•	
staff, and		approximately an residents,			practice.		
Staff, and	visitois.				The door in cottage 2, room F,		
Findings	inaludae				was repaired to ensure the do		
Tilluligs	merade.				closed completely and latched		
Događ on	obcomieti	ons made with the Executive			the door frame.	IIIO	
					l lie door frame.		
	_	our of the facility from 2:23 n 10/19/21, the corridor door					
_	_	failed to close and latch into			·How other residents havin	_	
		spection of the door it was			the potential to be affected b	•	
	•	tom hinge had all three			<u> </u>	-	
					the same deficient practice w	/111	
_		f the door and would not			be identified and what		
		ally close or latch. Based on			corrective action(s) will be		
		ne of observations, the facility			taken.		
		acknowledged the			All elders, staff, and visitors ha		
		or and stated that he would			the potential to be affected by		
		ice man remedy the problem			alleged deficient practice. All		
		ned to work. During the exit			doors will be inspected to ensu		
		Executive Director on			they close completely and late	n	
		o.m., no additional			into the frame.		
		lence could be provided					
contrary	to this def	icient finding.					
					·What measures will be put		
3.1-19(b)					into place or what systemic		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	03	COMPLETED 10/20/2021
	PROVIDER OR SUPPLIEF		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	DATE
				changes will be made to ens that the deficient practice do not recur. The monthly inspection dates the doors are in the maintenar schedule to ensure compliance	es for nce
				·How the corrective action(will be monitored to ensure to deficient practice will not red i.e., what quality assurance program will be put into place and The maintenance schedule wi maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he cur, e; Il be
K 0511 SS=F Bldg. 03	complies with NFF Code, electrical w complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life.			
	failed to ensure that a reliable source of requirements of NF	the emergency generator had fuel in accordance with the PA 101 - 2012 edition, 1, 9.1.3.1 and NFPA 110,	K 0511	·What corrective action(s) will be accomplished for the residents found to have beer affected by the deficient practice	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	03	COMPL	ETED
		155846	B. W	B. WING 10/20/2021			′2021
		.000.10		_	-	. 07 = 07	
NAME OF I	PROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				616 GR	REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
	``			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	
TAG		LSC IDENTIFYING INFORMATION)	-	IAG			DATE
	· · · · · · · · · · · · · · · · · · ·	LSC Section 9.1.3.1 states			The facility has obtained a lett	er of	
	emergency generators shall be installed, tested,				reliability from the company		
		accordance with NFPA 110,			responsible for supplying natu		
	I -	gency and Standby Power			gas to the generators in (cotta	ges	
	l .	ion. Section 5.1.1 states the			1, 2, 3, 4, 5, 6).		
		ources shall be permitted to					
	be used for the eme	ergency power supply (EPS):					
	(1) Liquid petroleur	m products at atmospheric					
	pressure						
	(2) Liquefied petrol	leum gas (liquid or vapor			·How other residents havin	g	
	withdrawal)				the potential to be affected b	у	
	(3) Natural or synthetic gas				the same deficient practice v	/ill	
	Exception: For Lev	el 1 installations in locations			be identified and what		
	where the probability of interruption of off-site				corrective action(s) will be		
	_	n, on-site storage of an			taken.		
		arce sufficient to allow full			All elders, staff, and visitors ha	ave	
		to be delivered for the class			the potential to be affected by		
	_	equired, with the provision for			alleged deficient practice. A		
	_	from the primary energy			letter of reliability will be provide	led	
	source to the alterna				for the generators in (cottages		
		ples of probability of			2, 3, 4, 5, 6)	٠,	
		nclude the following:			2, 3, 1, 3, 3)		
	_	amage, or a demonstrated					
		This deficient practice had			·What measures will be put		
	the potential to affe	•			into place or what systemic	•	
	the potential to affe	et all residents.			changes will be made to ens	uro	
	Findings include:				that the deficient practice do		
	rindings include.				<u>-</u>	62	
	D1:	10/20/21			not recur. The maintenance director or		
		on 10/20/21 with the					
		at 10:48 a.m., the fuel source			designee will ensure each	- c -	
		generators was thought to be			generator has documentation	oı a	
		or of the 6 cottages, it was			reliable source of fuel in		
		fuel source of the five			accordance with NFPA 101.		
		diesel but natural gas. During					
		0/20/21 the documentation on				_	
		led as C 1 P.M. log through C			·How the corrective action(-	
		ural gas letter of reliability			will be monitored to ensure t	-	
		ased on an interview at the			deficient practice will not rec	ur,	
		ew, the Executive Director			i.e., what quality assurance		
	stated that this was	only his seventh day at the			program will be put into plac	e;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	03	COMPL	ETED
		155846	B. WINC	·		10/20/	2021
	PROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)	-	DATE
V 0712	had even been reque Executive Director, one from his provide able to do so. During the Executive Direct p.m., no additional in	unsure if a letter of reliability ested by the previous but that he would request er as soon as he would be g the exit conference with tor on 10/20/21 at 12:15 information or evidence could y to this deficient finding.			and The maintenance schedule wil maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.		
K 0712 SS=F Bldg. 03	Fire Drills Fire drills include to alarm signal and so fire conditions. Fire expected and unerwarying conditions shift. The staff is far and is aware that croutine. Where dr 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1 Based on record reverse facility failed to conducted quarter conditions. This definitions. This definitions include: Based on record reverse based on record reverse facility failed to conducted quarter conditions. This definitions include:	xpected times under , at least quarterly on each amiliar with procedures drills are part of established ills are conducted between AM, a coded ay be used instead of	K 071	2	K712 ·What corrective action(s) will be accomplished for thos residents found to have been affected by the deficient practice. Fire drills were conducted per NFPA requirements for 1st shi for all 6 cottages.	1	11/16/2021

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	of correction identification number: 155846	A. BUILDING B. WING	03	COMPLETED 10/20/2021
GREEN (X4) ID	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL SUMMARY STATEMENT OF DEFICIENCIES	616 GR CARME	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) documented fire drills available for review for	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	documented fire drills available for review for the past twelve-month period. Based on interview at the time of record review, the Executive Director stated that he could not locate any fire drill documentation and that this was only his seventh day in the facility. Furthermore, his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		How other residents having the potential to be affected by the same deficient practice with be identified and what corrective action(s) will be taken. All elders, staff, and visitors have the potential to be affected by alleged deficient practice. Quarterly fire drills at unexpectimes, under varying condition and at least quarterly on each shift will be held at the facility NFPA requirements. What measures will be purinto place or what systemic changes will be made to ensith at the deficient practice do not recur. The maintenance schedule wireviewed and revised to include scheduled fire drills at unexpetimes, under varying condition and at least quarterly on each shift per NFPA requirements. How the corrective actions will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place and The maintenance schedule wire maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are	y y y ill ave this ted s, per t ure es ll be de cted s, s) he cur, e; ll be

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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 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			noted during maintenance checks, they will be remedied immediately.	
K 0781 SS=F Bldg. 03	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview the facility	K 0781	K781	11/16/2021
	failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect all residents, staff, and visitors in Cottage #1. Findings include: Based on observations made with the Executive Director during a tour of the facility from 2:23 p.m. to 4:51 p.m. on 10/19/21, a portable space		·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The space heater in cottage 1 immediately removed from the cottage.	se 1 was
	heater was located in the main nurse's station in Cottage #1. Manufacturer's documentation affixed to the portable space heater did not state the maximum temperature achieved by the unit. Based on interview at the time of observation, the facility Executive Director stated portable space heaters are not allowed to be used in the facility but acknowledged a portable space heater was used at the aforementioned location. At that time, the Executive Director immediately removed the portable space heater from the nurse's station and had an employee throw it in the dumpster. Therefore, this deficiency was		How other residents having the potential to be affected by the same deficient practice whose identified and what corrective action(s) will be taken. All elders, staff, and visitors has the potential to be affected by alleged deficient practice. All cottages will be inspected to ensure they do not contain any space heating devices.	vill ave this

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 03	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGE		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	corrected prior to mexiting of the facility 3.1-19(b)	y exit conference and my y.		·What measures will be purinto place or what systemic changes will be made to ensith the deficient practice do not recur. The maintenance schedule we reviewed and revised to including pections for heating device unexpected times and under varying conditions.	sure pes ill be de
				·How the corrective action will be monitored to ensure deficient practice will not relie., what quality assurance program will be put into place and. The maintenance schedule we maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	the cur, ce; ill be
K 0918 SS=F Bldg. 03	Electrical Systems System Maintenal The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro-	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 03	(X3) DATE SURVEY COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER		616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	safety and critical and testing of the switches are performed. NFPA 110. Generator sets are exercised under logger in 20-40 day once every 36 monours. Scheduled include a complete automatic or manuloads, and are corpersonnel. Mainte energy power soun accordance with Nocircuit breakers are a program for pericomponents is est manufacturer requipal of maintenance are and readily available and circuits are maintenance are and separate from Minimizing the posterior maintenance of 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 NFPA 110, 700.1	branches. Maintenance generator and transfer rmed in accordance with en inspected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised intervals, and exercised intervals and event and testing of stored roes (Type 3 EES) are in event and even and event and even and event and even and ev	K 0918	What corrective action(s) will be accomplished for thoresidents found to have been affected by the deficient practice. The generators for (cottages 1,2,3,4,5,6) have all been add to the maintenance director's	11/16/2021

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	ì í	ILDING	DNSTRUCTION 03	(X3) DATE S COMPLE 10/20/2	ETED
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	(X5) COMPLETION
TAG	inspection, perform	LSC IDENTIFYING INFORMATION) ance, exercising period, and		TAG	weekly inspection schedule.		DATE
	authority having jur practice could affect visitors. Findings include: Based on record rev Executive Director current documentation reference to weekly for review for the later	lable for inspection by the isdiction. This deficient tall residents, staff, and iew on 10/19/21 with the at 12:26 p.m., there was no on available for review in generator testing available st 52-week period. The book			How other residents havi the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors in the potential to be affected by alleged deficient practice. A generators have been placed schedule to be inspected were	by will nave y this II	
	record review, the E this was only his se his Maintenance Di sick child and not a of this survey. During the Executive Direct p.m., no additional				and exercised monthly. •What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice do not recur. The maintenance director will conduct weekly inspections a monthly load test and cool do for all 6 generators.	sure oes I and	
	facility failed to ma record of monthly g of the last 12 month 2012 NFPA 99 requ generator serving th system to be in acco Standard for Emerg Systems, Chapter 8. diesel generator sets least once monthly,	review and interview, the intain a complete written enerator load testing for 12 s. Chapter 6.4.4.1.1.4(a) of tires monthly testing of the e emergency electrical ordance with NFPA 110, the ency and Standby Powers NFPA 110 8.4.2 requires in service to be exercised at for a minimum of 30 4.4.2 of NFPA 99 requires a			·How the corrective action will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla and The maintenance schedule waintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns a noted during maintenance	the ccur, ce; vill be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE Co		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	03	COMPLETED
		155846	B. WING		10/20/2021
	ROVIDER OR SUPPLIER		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(V4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES OV MUST BE PRECEDED BY ELL I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
TAG			IAG		DATE
		spection, performance, and repairs for the generator		checks, they will be remedied immediately.	
		ntained and available for		ininediately.	
		thority having jurisdiction.			
	This deficient practi				
	occupants.				
	-				
	Findings include:				
	Based on record rev	riew on 10/20/21 with the			
	Executive Director	at 12:26 p.m., there was no			
	current documentation available for review in				
	reference to weekly generator testing available				
	for review for the last 12-month period. The				
	_	monthly generator testing			
		e documentation stopped on			
		on an interview at the time of			
		Executive Director stated that			
	_	venth day in the facility and			
		rector was at home with a			
		vailable during the two days			
		ng the exit conference with tor on 10/20/21 at 12:15			
		information or evidence could			
	* '	y to this deficient finding.			
	be provided contrary	y to this deficient finding.			
	3.1-19(b)				
K 0000					
Bldg. 04					
	A Life Safety Code	Recertification and State	K 0000	Preparation and/or execution	ı of
	•	as conducted by the Indiana		this plan of correction in	
	•	th in accordance with 42		general, or this corrective	
	CFR 483.90(a).			action in particular, does not	;
	Survey Date: 10/19	0/21 and 10/20/21		constitute an admission or agreement by this facility of facts alleged or conclusions	
	Facility Number: 0	13753		forth in this statement of	
	Provider Number:			deficiencies. The plan of	
			1	1	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	04	COMPL	
		155846	B. W	ING		10/20/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L .			EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
(X4) ID	STIMMADA S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
mo	AIM Number: 201			mo	correction and specific		DATE
	Alivi Nulliber. 201.	302130			corrective actions are prepar	od.	
	At this Life Safety (Code survey, Green House			and/or executed in complian		
	Cottages of Carmel was found not in compliance				with state and federal laws.	CC	
	with Requirements	-			This plan of correction		
	_	, 42 CFR Subpart 483.90(a),			constitutes a written allegati	on	
		re and the 2012 edition of the			of substantial compliance w		
	_	ction Association (NFPA)			Federal Medicare and Medica		
		ode (LSC), Chapter 19,			requirements. This facility is		
		re Occupancies and 410 IAC			requesting paper compliance		
	16.2.	1			for all cited deficiencies.		
	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 sprinl	klered. Each cottage has a fire					
	alarm system with s	smoke detection in the					
	corridors, areas ope	n to the corridors and					
	hard-wired smoke d	letectors in the resident					
		acility has a capacity of 72					
	and had a census of	255 at the time of this survey.					
		idents have customary access					
		d all areas providing facility					
		klered, with exception of a					
	separate detached a	dministration building.					
	D '11' 04' '1	ee 1 oo waa waa ma					
	U	tified as Cottage #4. The					
	-	ity of 12 and had a census of					
	10 at the time of thi	s survey.					
	Quality Review con	mpleted on 10/26/21					
K 0324	NFPA 101						
SS=F	Cooking Facilities						
Bldg. 04	Cooking Facilities						
	Cooking equipmen	The state of the s					
		NFPA 96, Standard for					
		l and Fire Protection of					
	Commercial Cook	ing Operations, unless:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	04	COMPL	ETED
		155846	B. WIN	NG		10/20/	/2021
			'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			REEN HOUSE WAY		
GREENI	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
OILLIV				O/ II (IVIL			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng equipment (i.e., small					
		s microwaves, hot plates,					
	toasters) are used	I for food warming or					
	limited cooking in	accordance with					
	18.3.2.5.2, 19.3.2	.5.2					
	_	open to the corridor in					
		ents with 30 or fewer					
	l ' ' ' '	ith the conditions under					
	18.3.2.5.3, 19.3.2	.5.3, or					
		in smoke compartments					
	with 30 or fewer p	atients comply with					
	conditions under 1	18.3.2.5.4, 19.3.2.5.4.					
	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be						
	enclosed as haza	rdous areas, but shall not					
	be open to the cor						
	18.3.2.5.1 through	n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5	5, 9.2.3, TIA 12-2					
	Based on record rev	view and interview; the	K 03	24	K324		11/16/2021
	facility failed to ens	sure 1 of 1 kitchen fire			·What corrective action(s)		
		was inspected semiannually.			will be accomplished for tho	se	
	NFPA 96, 2011 Edi	ition, Standard for Ventilation			residents found to have been	1	
		otection of Commercial			affected by the deficient		
	Cooking Operations	s, Section 11.2.1 states			practice.		
		fire-extinguishing systems			All hood systems on campus		
		loods containing a constant or			(cottages 1, 2, 3, 4, 5 and 6) a	re	
		system that is listed to			scheduled to be inspected by		
	U	the grease removal devices.			Koorsen in November and will	be	
	_	ims, and the exhaust ducts			on a semi-annual inspection		
		operly trained, qualified, and			schedule per NFPA		
		acceptable to the authority			requirements.		
		at lease every six months.					
	_	ice could affect all residents,					
	staff, and visitors w	othin the facility.			·How other residents havin	_	
	F: 1:				the potential to be affected b	•	
	Findings include:				the same deficient practice v	VIII	
		10/10/01			be identified and what		
		view on 10/19/21 with the			corrective action(s) will be		
		at 10:21 a.m., documentation			taken.		
	of a kitchen fire sup	ppression system inspection			All elders, staff, and visitors ha	ave	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	04	COMPI	LETED
		155846	B. W	ING		10/20	/2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	₹					
005511		0.05.04.54.51			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		the last six or 12-month			the potential to be affected by		
	I -	lable for review. Based on			alleged deficient practice. A	uno	
	1 ~	e of record review, the			semi-annual inspection sched	ulo	
					has been established between		
		stated that this was only his				i triis	
	I	llity, and his Maintenance			facility and Koorsen. Next		
	Director was at home with a sick child and not				inspection is scheduled for		
	available during the two days of this survey.				November 2021.		
	~	ference with the Executive					
	Director on 10/20/2	-					
		ion or evidence could be			·What measures will be put	t	
	provided contrary to	o this deficient finding.			into place or what systemic		
					changes will be made to ens		
	3.1-19(b)				that the deficient practice do	es	
					not recur.		
					The semi-annual inspection da	ate	
					for the hood system was place	ed in	
					the maintenance schedule to		
					ensure compliance.		
					·		
					·How the corrective action(s)	
					will be monitored to ensure t		
					deficient practice will not red		
					i.e., what quality assurance	, ,	
					program will be put into place	٥.	
					and	С,	
					The maintenance schedule wi	ll bo	
						ii be	
					maintained by maintenance		
					personnel, monitored by the		
					administrator, and reported to		
					QAPI monthly. If concerns are	Э	
					noted during maintenance		
					checks, they will be remedied		
					immediately.		
K 0345	NFPA 101						
SS=F	Fire Alarm Systen	n - Testing and					
Bldg. 04	Maintenance	-					
J							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	04	COMPLETED	
		155846	B. W	ING		10/20	/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1			
ODEEN	LOUICE COTTACE	C OF CARMEL			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	3 OF CARINEL		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	Fire Alarm Syster	n - Testing and					
	Maintenance						
	A fire alarm syste	m is tested and maintained					
	in accordance with an approved program						
	complying with the	e requirements of NFPA 70,					
	National Electric (Code, and NFPA 72,					
	National Fire Alar	m and Signaling Code.					
	Records of syster	n acceptance, maintenance					
	and testing are re	adily available.					
	9.6.1.3, 9.6.1.5, N	IFPA 70, NFPA 72					
	1) Based on record	review and interview, the	K 0	345	K345		11/16/2021
	facility failed to en	sure the documentation for					
	the annual testing of	of all devices connected to 1					
	of 1 fire alarm syste	em was complete. NFPA 72,					
	National Fire Alarn	n Code, the 2010 Edition, at			·What corrective action(s)		
	Section 14.6.2.4 red	quires a record of all			will be accomplished for tho	se	
	inspections, testing	, and maintenance shall be			residents found to have been	1	
	provided that inclu-	des the following information			affected by the deficient		
		all the applicable information			practice.		
		14.6.2.4. The record shall			Maintenance and testing of the		
	_	all devices tested with device			fire alarm system are performe		
		ion, and test results indicated:			in accordance with NFPA 110		
	(1) Date				The semi-annual fire alarm sy		
	(2) Test frequency				testing logs for (cottages 1, 2,		
	(3) Name of proper	ty			4, 5 and 6) have been updated		
	(4) Address				and all 6 cottages are on sche	dule	
		performing inspection,			to be tested semi-annually.		
		or combination thereof, and					
		s address, and telephone					
	number						
		and representative of			How other residents having		
	approving agency (the potential to be affected b	-	
		the detector(s) tested			the same deficient practice v	VIII	
	(8) Functional test				be identified and what		
		t of required sequence of			corrective action(s) will be		
	operations	1 1			taken.		
	(10) Check of all sr						
	(11) Loop resistance for all fixed-temperature,				All elders, staff, and visitors h		
	line-type heat detec				the potential to be affected by		
(12) Functional test of mass notification system				alleged deficient practice. All	6		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	04	COMPLE	ETED
		155846	B. WI	NG		10/20/2	2021
				CTDEET 4	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2					
ODEEN	IOLIOE COTTA OF	0.05.0451			EEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CHIPPING N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	control units				fire alarm systems have been		
		of signal transmission to			placed on a schedule to have	fire	
	mass notification systems				alarm system tested		
	(14) Functional test				semi-annually.		
		to silence fire alarm			Seriii-ariiraany.		
	notification applian						
		gibility of mass notification			·What measures will be put	.	
	system speakers	gronniy of mass nonneanon			into place or what systemic	•	
		required by the equipment			changes will be made to ens		
	manufacturer's publ				that the deficient practice do	I	
	-	required by the authority			not recur.	62	
		required by the authority			The maintenance director will		
	having jurisdiction	4				ot	
		ester and approved authority			conduct a fire alarm system te		
	representative	11 '1 '' 11 '			semi-annually. This test will b		
		problems identified during			documented and will be visual	ıy	
		vner notified, problem			testing the control unit trouble		
	corrected/successfu	-			signals, remote annunciators,		
	abandoned in place				initiating devices, notification		
	-	ice could affect all occupants			appliances and magnetic		
	in the facility.				hold-open devices.		
	Findings include:				·How the corrective action	· ′	
					will be monitored to ensure t		
		view on 10/20/21 with the			deficient practice will not rec	ur,	
		at 10:21 a.m., a fire alarm			i.e., what quality assurance		
		esting report could not be			program will be put into plac	e;	
	1	for review with an itemized			and		
		stem devices inspected/tested			The maintenance schedule wi	ll be	
	-	e type, address, location, and			maintained by maintenance		
	specific results of the	-			personnel, monitored by the		
	interview at the tim	e of record review, the			administrator, and reported to		
	Executive Director	stated that this was only his			QAPI monthly. If concerns are	e	
	,	acility and his Maintenance			noted during maintenance		
	Director was at hon	ne with a sick child and not			checks, they will be remedied		
	available during the	two days of this survey.			immediately.		
	During the exit con	ference with the Executive					
	Director on 10/20/2						
	additional informati	ion or evidence could be					
	provided contrary to	o this deficient finding.					
	1 ^	8					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	A. BUILDING <u>04</u>			COMPLETED	
		155846	B. W	ING		10/20	/2021	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
ODEEN		-0.05.04.04.51			EEN HOUSE WAY			
GREEN	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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 APPROPRI	ΔTF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	3.1-19(b)							
	2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems							
	1	accordance with LSC 9.6.1.3.						
		es a fire alarm system to be						
	_	nd maintained in accordance						
		tional Electrical Code and						
		l Fire Alarm Code. NFPA 72,						
	Section 14.4.5 state	es unless otherwise permitted						
	by other sections o	f this Code, testing shall be						
	performed in accor	dance with the schedules in						
	Table 14.4.5, or mo	ore often if required by the						
		risdiction. NFPA 72, Section						
		noke detector sensitivity shall						
		1 year after installation. NFPA						
		es smoke detector sensitivity						
		very alternate year thereafter						
	_	ermitted by compliance with						
		This deficient practice could						
	affect all occupants	S.						
	Findings include:							
	Based on record re	view on 10/20/21 with the						
	Executive Director	at 10:24 a.m., no						
		a smoke detector sensitivity						
		for review. Based on interview						
	at the time of recor	rd review, the Executive						
		t this was only his seventh day						
	in the facility and h	nis Maintenance Director was						
	at home with a sick	child and not available during						
	the two days of this survey. During the exit							
		e Executive Director on						
	10/20/21 at 12:15 p.m., no additional information or evidence could be provided							
	contrary to this def	ficient finding.						
	21.10(1)							
	3.1-19(b)							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING 04 B. WING			COMPLETED 10/20/2021		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EEN HOUSE WAY EL, IN 46032		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)		IAG	DEFICIENCE		DATE
TAG	3) Based on record a facility failed to ma systems in accordant Fire Alarm Code as 19.3.4.5.1 and 9.6. It states that unless of the visual inspections of accordance with the more often if requiring jurisdiction. Table 1 following must be a semi-annually: a. Control unit trouble. Remote annunciate. Initiating devices fire alarm boxes, he detectors, etc.) d. Notification applies. Magnetic hold-op. This deficient praction occupants. Findings include: Based on record reverse Executive Directors adocumentation for a series.	ole signals tors (e.g. duct detectors, manual at detectors, smoke tiances tiances tiances tiances tiance could affect all building		TAG	DEFICIENCY		DATE
	Based on interview	at the time of record review,					
	the Executive Directhis seventh day in the	tor stated that this was only ne facility and his					
	Maintenance Direct child and not availa survey. During the Executive Director no additional inform	or was at home with a sick ble during the two days of this exit conference with the on 10/20/21 at 12:15 p.m., nation or evidence could be o this deficient finding.					
į	3.1-19(b)						

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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 <u>04</u>	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIEF		616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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
K 0353 SS=F Bldg. 04	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1) Based on record facility failed to pro or other evidence the components had be of 4 quarters. LSC 4 equipment or system with this Code be in applicable NFPA re systems shall be pro accordance with NI Inspection, Testing, Water-Based Fire P 4.3.1 requires record inspections, tests, a components and sha authority having jun requires that record performed (e.g., inspection).	supply source RKS information on non-required or partial er system. , and NFPA 25 review and interview, the ovide written documentation has sprinkler system en inspected and tested for 4 4.6.12.1 requires any device, in required for compliance maintained in accordance with equirements. Sprinkler operly maintained in FPA 25, Standard for the pand Maintenance of the total maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure	K 0353	K353 ·What corrective action(s) will be accomplished for tho residents found to have been affected by the deficient practice. All sprinkler systems on camp (cottages 1, 2, 3, 4, 5 and 6) as scheduled to be inspected by Koorsen in November per NFI requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract withKoorse ·How other residents having the potential to be affected by the same deficient practice with the same deficient practice.	nus are PA le n.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING B. WING	04	COMPLETED 10/20/2021			
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	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 shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:31 a.m., no		be identified and what corrective action(s) will be taken. All elders, staff, and visitors had the potential to be affected by alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice do	this g t			
	documentation for quarterly sprinkler system inspections was available for review for the past 12 months. Based on interview at the time of record review, the Executive Director stated that this was only his seventh day in the facility and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding.		not recur. The quarterly inspection dates the sprinkler systems are in the maintenance schedule to ensicompliance. How the corrective actions will be monitored to ensure the deficient practice will not recite, what quality assurance	s for ne ure (s)			
	3.1-19(b) 2) Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves		program will be put into place and The maintenance schedule with maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	II be			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	l í	JILDING	nstruction 04	(X3) DATE COMPL 10/20	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	and fire department inspected, tested, ar with Chapter 13. Set 13.1.1.2 shall be utiliand maintenance of trim. Section 4.3.1 sfor all inspections, to system and its compavailable to the autiliary request. This deficience is defined in the first passed on record reversidents, staff, and and Findings include: Based on record reversidents in the past 12 montains of the past 12 montains of record revies the first passed in the two days of this conference with the 10/20/21 at 12:15 printenation or evidents conference with the 10/20/21 at 12:15 printenation or evidents as the first passed on observation of the past 12 montains of the secondary to this defination of the secondary to this defination of the secondary is a standard for the Instandard fo	connections shall be ad maintained in accordance action 13.1.1.2 states Table lized for inspection, testing valves, valve components and states records shall be made ests, and maintenance of the conents and shall be made ests, and maintenance of the conents and shall be made ests, and maintenance of the conents and shall be made ests, and maintenance of the conents and shall be made ests, and maintenance of the conents and shall be made ests, and maintenance all visition upon ent practice could affect all visitors. The work of 10/20/21 with the est 10:34 a.m., no conthly control valve and could be provided for review this. Based on interview at the ext. Based on interview at the ext. Executive Director conly his seventh day in the entenance Director was at a fill and not available during survey. During the exit Executive Director on ext., no additional ence could be provided cient finding. The states of the control of th							

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		ľ		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	04	COMPL	
		155846	B. W	ING		10/20/	2021
NAME OF D	DOMDED OD CLIDDLIED		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL		CARME	L, IN 46032		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE).TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	every 5 years by con	mparison with a calibrated					
	gauge. Gauges not a	accurate to within 3 percent of					
	the full scale shall b	e recalibrated or replaced.					
	This deficient pract	ice could affect all residents,					
	staff, and visitors in	the facility.					
	Findings include:						
	Based on observation	ons made with the Executive					
		our of the facility from 2:23					
	_	1 10/19/21, the facility had					
		nkler systems and had a total					
		ure gauges. The manufacture					
	•	ges was 2015 and was listed					
	_	sprinkler system gauge. No					
		formation was affixed to or					
	could be located on	the sprinkler system gauges.					
	Based on interview						
	observations, the fa	cility Executive Director					
		lieve sprinkler system gauges					
		ed within the most recent					
	five-year period and	ł acknowledged					
	documentation of sp	orinkler system gauge					
	replacement or reca	libration documentation was					
	not available for rev	view for all three sprinkler					
	system gauges which	th were more than five years					
	old. During the exit	conference with the					
	Executive Director	on 10/20/21 at 12:15 p.m.,					
		nation or evidence could be					
	provided contrary to	o this deficient finding.					
	3.1-19(b)						
K 0712	NFPA 101						l
SS=F	Fire Drills						
Bldg. 04	Fire Drills						
ag. 0 i		the transmission of a fire					
		simulation of emergency					
	fire conditions. Fire	0 ,					
		xpected times under					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	04	COMPL	ETED
		155846	B. W	NG		10/20/	2021
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
GILLIN	TIOUSE COTTAGE	3 OF CARWILL	CARIVIE				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s, at least quarterly on each					
	shift. The staff is familiar with procedures						
		drills are part of established					
		rills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.						
	19.7.1.4 through 1						
		view and interview, the	K 0	712	K712		11/16/2021
		nduct quarterly fire drills for			·What corrective action(s)		
		C 19.7.1.6 requires drills to			will be accomplished for thos		
	_	erly on each shift under varied			residents found to have beer	1	
	staff and residents.	ficient practice affects all			affected by the deficient		
	starr and residents.				practice. Fire drills were conducted per		
	Findings include:				NFPA requirements for 1st shi	ft	
	rindings include:				for all 6 cottages.	IL	
	Rosed on record rev	view on 10/19/21 with the			l lor all o collages.		
		at 10:56 a.m., there were no					
		ills available for review for			·How other residents havin	a	
		nth period. Based on interview			the potential to be affected b	_	
	_	d review, the Executive			the same deficient practice w	-	
		he could not locate any fire			be identified and what		
		and that this was only his			corrective action(s) will be		
		ility. Furthermore, his			taken.		
	•	tor was at home with a sick			All elders, staff, and visitors ha	ave	
		able during the two days of this			the potential to be affected by		
		exit conference with the			alleged deficient practice.		
		on 10/20/21 at 12:15 p.m.,			Quarterly fire drills at unexpec	ted	
	no additional inforr	nation or evidence could be			times, under varying condition	s,	
	provided contrary t	o this deficient finding.			and at least quarterly on each		
					shift will be held at the facility	per	
	3.1-19(b)				NFPA requirements.		
	3.1-51(c)						
					·What measures will be put	:	
					into place or what systemic		
					changes will be made to ens		
					that the deficient practice do	es	
					not recur.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	04	COMPL	ETED
		155846	B. WI	NG		10/20/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		616 GREEN HOUSE WAY				
ODEENIA	IOURE COTTACE	C OF CADME!					
GREEN	HOUSE COTTAGES	S OF CARMEL		CARMEL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
					The maintenance schedule wil	l be	
					reviewed and revised to includ	е	
					scheduled fire drills at unexped	cted	
					times, under varying conditions	5,	
					and at least quarterly on each		
					shift per NFPA requirements.		
					·How the corrective action(s)	
					will be monitored to ensure t	he	
					deficient practice will not rec	ur,	
					i.e., what quality assurance		
				program will be put into pla		e;	
				and			
			The maintenance schedule		l be		
			maintained by maintenance				
					personnel, monitored by the		
					administrator, and reported to		
					QAPI monthly. If concerns are)	
					noted during maintenance		
					checks, they will be remedied		
					immediately.		
					,		
K 0000							
Bldg. 05							
Ŭ	A Life Safety Code	Recertification and State	K 0	000	Preparation and/or execution	of	
	•	ras conducted by the Indiana	110	000	this plan of correction in		
	_	th in accordance with 42			general, or this corrective		
	CFR 483.90(a).				action in particular, does not		
					constitute an admission or		
	Survey Date: 10/19	0/21 and 10/20/21			agreement by this facility of t	he	
					facts alleged or conclusions		
	Facility Number: 0	13753			forth in this statement of		
	Provider Number:				deficiencies. The plan of		
	AIM Number: 2013				correction and specific		
	711111 1 (dilloct. 201.	002100			corrective actions are prepar	ed	
	At this Life Sofety	Code survey, Green House			and/or executed in compliant		
	At this Life Safety	Loue survey, Green House			and/or executed in compliant	, c	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	05	(X3) DATE : COMPL		
		155846	B. W	ING		10/20/	2021
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032	•	
				<u> </u>	LL, IIV 40002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	λΤΕ	(X5) COMPLETION DATE
	Cottages 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.				with state and federal laws. This plan of correction constitutes a written allegati of substantial compliance w Federal Medicare and Medic requirements. This facility is requesting paper compliance for all cited deficiencies.	ith aid	
	06). Each building i determined to be of and was fully sprink alarm system with s corridors, areas open hard-wired smoke d rooms. The entire fa	of six buildings (01 through s a one-story cottage Type V (111) construction thered. Each cottage has a fire moke detection in the in to the corridors and etectors in the resident intility has a capacity of 72 55 at the time of this survey.					
	were sprinklered and services were sprink separate detached and Building 05 is ident	dents have customary access d all areas providing facility clered, with exception of a dministration building. ified as Cottage #5. The ty of 12 and had a census of s survey.					
	Quality Review con	npleted on 10/26/21					
K 0324 SS=F Bldg. 05	Ventilation Control Commercial Cookin * residential cookin appliances such a	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or					3

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î î		A. BUILDING	construction 05	(X3) DATE SURVEY COMPLETED 10/20/2021	
	OF PROVIDER OR SUPPLIER		616 G	T ADDRESS, CITY, STATE, ZIP CODE GREEN HOUSE WAY MEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	smoke compartment patients comply with 30 or fewer proconditions under a Cooking facilities with 30 or fewer proconditions under a Cooking facilities NFPA 96 per 9.2. I enclosed as hazar be open to the cooking 19.3.2.5.5 Based on record refacility failed to ensuppression system NFPA 96, 2011 Ed Control and Fire Procoking Operation Maintenance of the and listed exhaust in fire-activated water extinguish a fire in Hood exhaust plent shall be made by procertified person(s) a having jurisdiction This deficient pract staff, and visitors with the staff of the suppression include: Based on record reference in the suppression include:	open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not reidor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 view and interview; the sure 1 of 1 kitchen fire was inspected semiannually. Ition, Standard for Ventilation of Commercial section of Commercial section of Commercial section 11.2.1 states fire-extinguishing systems and scontaining a constant or system that is listed to the grease removal devices. Itins, and the exhaust ducts operly trained, qualified, and acceptable to the authority at lease every six months. Itice could affect all residents,	K 0324	K324 ·What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice. All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) scheduled to be inspected by Koorsen in November and whom a semi-annual inspection schedule per NFPA requirements. ·How other residents have the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors if the potential to be affected by alleged deficient practice. A semi-annual inspection schedule.	are / ill be ng by will nave y this

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		05	COMPLETED 10/20/2021
	ROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	
	Executive Director stated that this was only his sixth day in the facility, and his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no		has been established between facility and Koorsen. Next inspection is scheduled for November 2021.	n this
	additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		·What measures will be pu into place or what systemic changes will be made to enst that the deficient practice do not recur. The semi-annual inspection d for the hood system was place the maintenance schedule to ensure compliance.	ure es ate
			How the corrective action will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place and The maintenance schedule with maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns an noted during maintenance checks, they will be remedied immediately.	the cur, ce;
K 0345 SS=F Bldg. 05	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155846		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/20/2021	
GREEN I	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	complying with the National Electric C National Fire Alam Records of system and testing are respectively. As a system and testing are respectively failed to ensure the annual testing of a silvent facility failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of a silvent failed to ensure the annual testing of the annual testing of the annual testing of a silvent failed to ensure the annual testi	review and interview, the sure the documentation for fall devices connected to 1 cm was complete. NFPA 72, in Code, the 2010 Edition, at quires a record of all and maintenance shall be less the following information all the applicable information 14.6.2.4. The record shall all devices tested with device on, and test results indicated:	K 0	345	What corrective action(s) will be accomplished for tho residents found to have been affected by the deficient practice. Maintenance and testing of the fire alarm system are perform in accordance with NFPA 110. The semi-annual fire alarm systesting logs for (cottages 1, 2, 4, 5 and 6) have been update and all 6 cottages are on scheet to be tested semi-annually.	e ed stem 3,	11/16/2021
	(6) Name, address, approving agency (7) Designation of t (8) Functional test (9) *Functional test	he detector(s) tested			How other residents having the potential to be affected to the same deficient practice to be identified and what corrective action(s) will be	-	
	line-type heat detec (12) Functional test control units	e for all fixed-temperature, tors of mass notification system of signal transmission to			All elders, staff, and visitors he the potential to be affected by alleged deficient practice. All fire alarm systems have been placed on a schedule to have alarm system tested	this 6	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	05	COMPLI	ETED
		155846	B. W	ING		10/20/	2021
				CTREET	ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	(14) Functional test	of ability of mass			semi-annually.		
	notification system	to silence fire alarm			·		
	notification applian						
		gibility of mass notification			·What measures will be put	:	
	system speakers				into place or what systemic		
	(16) Other tests as required by the equipment				changes will be made to ens	ure	
	manufacturer's published instructions				that the deficient practice do	es	
	(17) Other tests as required by the authority				not recur.		
	having jurisdiction				The maintenance director will		
	(18) Signatures of tester and approved authority				conduct a fire alarm system te	st	
	representative				semi-annually. This test will b	e	
	(19) Disposition of problems identified during				documented and will be visual	ly	
	test (e.g., system owner notified, problem				testing the control unit trouble		
	corrected/successfully retested, device				signals, remote annunciators,		
	abandoned in place)				initiating devices, notification		
	This deficient pract	ice could affect all occupants			appliances and magnetic		
	in the facility.				hold-open devices.		
	Findings include:						
					·How the corrective action(
		view on 10/20/21 with the			will be monitored to ensure t		
		at 10:21 a.m., a fire alarm			deficient practice will not rec	ur,	
		esting report could not be			i.e., what quality assurance		
	•	for review with an itemized			program will be put into plac	e;	
		stem devices inspected/tested			and		
		e type, address, location, and			The maintenance schedule wi	ll be	
	-	ne testing. Based on			maintained by maintenance		
		e of record review, the			personnel, monitored by the		
		stated that this was only his			administrator, and reported to		
		acility and his Maintenance			QAPI monthly. If concerns are	9	
		ne with a sick child and not			noted during maintenance		
	_	e two days of this survey.			checks, they will be remedied		
		ference with the Executive			immediately.		
	Director on 10/20/2						
		ion or evidence could be					
	provided contrary to	o this deficient finding.					
	2.1.10(1)						
	3.1-19(b)						
	0.5						
	2) Based on record	review and interview, the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	05	COMPL	
		155846	B. WI	NG		10/20/	/2021
			-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		616 GRI	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility failed to ens	sure 1 of 1 fire alarm systems					
	was maintained in a	accordance with LSC 9.6.1.3.					
	LSC 9.6.1.3 require	es a fire alarm system to be					
	installed, tested, and	d maintained in accordance					
	with NFPA 70, Nat	ional Electrical Code and					
	NFPA 72, National	Fire Alarm Code. NFPA 72,					
	Section 14.4.5 state	s unless otherwise permitted					
	•	f this Code, testing shall be					
	performed in accord	dance with the schedules in					
		ore often if required by the					
	authority having jur	risdiction. NFPA 72, Section					
		oke detector sensitivity shall					
		l year after installation. NFPA					
		s smoke detector sensitivity					
		ery alternate year thereafter					
	_	ermitted by compliance with					
		This deficient practice could					
	affect all occupants						
	Findings include:						
	Based on record rev	view on 10/20/21 with the					
	Executive Director	at 10:24 a.m., no					
	documentation for a	a smoke detector sensitivity					
	test was available for	or review. Based on interview					
	at the time of record	d review, the Executive					
	Director stated that	this was only his seventh day					
	,	is Maintenance Director was					
		child and not available during					
	1	survey. During the exit					
		Executive Director on					
	10/20/21 at 12:15 p						
		ence could be provided					
	contrary to this defi	icient finding.					
	3.1-19(b)						
	3) Based on record	review and interview, the					
	1 '	intain 1 of 1 fire alarm					
	1	nce with NFPA 72, National					
							1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846			JILDING	05	COMPLETED 10/20/2021		
	ROVIDER OR SUPPLIER			616 GR	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
				<u> </u>			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	BIATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	19.3.4.5.1 and 9.6.1 states that unless of visual inspections s accordance with the more often if requirigurisdiction. Table of following must be a semi-annually: a. Control unit troubly. Remote annualized. Initiating devices fire alarm boxes, he detectors, etc.) d. Notification applied. Magnetic hold-open states of the st	ole signals stors (e.g. duct detectors, manual at detectors, smoke					
V 0252	Executive Director documentation for a of the fire alarm syst Based on interview the Executive Direct his seventh day in the Maintenance Direct child and not availated survey. During the Executive Director no additional information provided contrary to 3.1-19(b)	a semiannual visual inspection stem was available for review. at the time of record review, stor stated that this was only					
K 0353 SS=F Bldg. 05	•	- Maintenance and Testing - Maintenance and Testing					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846		(X2) MULTIPLE (A. BUILDING B. WING	O5	(X3) DATE SURVEY COMPLETED 10/20/2021	
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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
	are inspected, test accordance with Nater-based Fire Records of syster inspection and test secure location are a) Date sprinkler. b) Who provided c) Water system. Provide in REMAI coverage for any automatic sprinkler. 9.7.5, 9.7.7, 9.7.8 1) Based on record facility failed to proof or other evidence the components had be of 4 quarters. LSC equipment or system with this Code be napplicable NFPA resystems shall be preaccordance with NI Inspection, Testing Water-Based Fire F4.3.1 requires recording that record performed (e.g., instantonic), the content of the work, the result 5.2.5 requires that we shall to the work, the result 5.2.5 requires that we shall to the work the result 5.2.5 requires that we shall to the work the result 5.2.5 requires that we work the result 5.2.5 requires that we work the work the result 5.2.5 requires that we work the work the work the work the work the work the result 5.2.5 requires that we work the work the work the result 5.2.5 requires that we work the work the result 5.2.5 requires that we work the work the work the work the work the work the result 5.2.5 requires that we work the result 5.2.5 requires that we work the result 5.2.5 requires that we work the	supply source RKS information on non-required or partial er system. , and NFPA 25 review and interview, the ovide written documentation has sprinkler system en inspected and tested for 4 4.6.12.1 requires any device, an required for compliance maintained in accordance with equirements. Sprinkler operly maintained in FPA 25, Standard for the pand Maintenance of the system and maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure	K 0353	K353 ·What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice. All sprinkler systems on camp (cottages 1, 2, 3, 4, 5 and 6) a scheduled to be inspected by Koorsen in November per NF requirements. All sprinkler systems are on a quarterly inspection and testing scheduler contract withKoorse or contract with	n Dus are PA ule en.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	mechanical waterfle but not limited to, v tested quarterly. 5.3 pressure switch-typ shall be tested semi practice could affect visitors in the facili	FPA 25, 5.3.3.1 requires the ow alarm devices including, vater motor gongs, shall be 3.2. requires vane-type and e waterflow alarm devices annually. This deficient all residents, staff, and ty.			All elders, staff, and visitors had the potential to be affected by alleged deficient practice. All sprinkler systems are on a quarterly inspection and testin schedule per NFPA requirements.	this	
	Executive Director documentation for or inspections was avantation 12 months. Based or record review, the Ithis was only his sends is Maintenance Disick child and not a of this survey. Durithe Executive Direct p.m., no additional	view on 10/20/21 with the at 10:31 a.m., no quarterly sprinkler system tilable for review for the past on interview at the time of executive Director stated that wenth day in the facility and rector was at home with a vailable during the two days ng the exit conference with extor on 10/20/21 at 12:15 information or evidence could y to this deficient finding.			·What measures will be put into place or what systemic changes will be made to ensithat the deficient practice do not recur. The quarterly inspection dates the sprinkler systems are in the maintenance schedule to ensicompliance. ·How the corrective action will be monitored to ensure the deficient practice will not reconside, what quality assurance program will be put into place and the maintenance schedule will be maintenance schedule will not reconsidered.	ure es for e ure s) he ur,	
	facility failed to dod inspections in accordance of the 25, Standard for the Maintenance of Wa Systems, 2011 Edit gauges on wet pipe inspected monthly to condition and that re is being maintained and fire department inspected, tested, ar	review and interview, the cument sprinkler system redance with NFPA 25. NFPA Inspection, Testing, and ter-Based Fire Protection ion, Section 5.2.4.1 states sprinkler systems shall be to ensure that they are in good normal water supply pressure. Section 5.1.2 states valves connections shall be and maintained in accordance ection 13.1.1.2 states Table			maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	e	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155846	A. BUILDING 05 B. WING			COMPLETED 10/20/2021	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	ΓE	(X5) COMPLETION DATE
	13.1.1.2 shall be util and maintenance of trim. Section 4.3.1 s for all inspections, t system and its comp available to the auth	lized for inspection, testing valves, valve components and tates records shall be made ests, and maintenance of the bonents and shall be made ority having jurisdiction upon ent practice could affect all					
	Executive Director a documentation of m gauge inspections or for the past 12 mont time of record revies stated that this was a facility and his Main home with a sick ch the two days of this conference with the 10/20/21 at 12:15 p.	onthly control valve and buld be provided for review ths. Based on interview at the w, the Executive Director only his seventh day in the intenance Director was at ild and not available during survey. During the exit Executive Director on m., no additional ence could be provided					
	1 '	ation and interview, the ure 3 of 3 sprinkler system and every 5 years or					
	documented as teste comparison with a c Standard for the Ins Maintenance of Wat Systems, 2011 Editi gauges shall be repleevery 5 years by congauge. Gauges not a						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE COI UILDING	NSTRUCTION 05	(X3) DATE COMPL		
		155846	B. W	ING		10/20	/2021
	PROVIDER OR SUPPLIER		<u> </u>	616 GR	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	E	(X5) COMPLETION DATE
	This deficient practi staff, and visitors in	ice could affect all residents, the facility.					
	Findings include:						
	Director during a to p.m. to 4:51 p.m. or supervised wet sprin of three water press date of all three gau on the face of each recalibration date in could be located on Based on interview observations, the fact stated he did not be had been recalibrate five-year period and documentation of spreplacement or recanot available for revisystem gauges which old. During the exit Executive Director no additional inform	cility Executive Director lieve sprinkler system gauges od within the most recent					
K 0511 SS=F Bldg. 05	complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas					
	complies with NFF						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>05</u> COMPLE		
		155846	B. WING 10/20/2021			10/20/2021
					-	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					REEN HOUSE WAY	
GREEN H	HOUSE COTTAGES	S OF CARMEL		CARME	EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPR		TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Based on record rev	riew and interview the facility	K 0	511	·What corrective action(s)	11/16/2021
	failed to ensure that	the emergency generator had			will be accomplished for thos	
	a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition,				residents found to have beer	1
					affected by the deficient	
	Section 19.5.1.1, 9.	1, 9.1.3.1 and NFPA 110,			practice	
	2010 Edition, 5.1. LSC Section 9.1.3.1 states				The facility has obtained a lett	er of
	emergency generators shall be installed, tested,				reliability from the company	
	and maintained in accordance with NFPA 110,				responsible for supplying natu	ral
	Standard for Emergency and Standby Power				gas to the generators in (cotta	ges
	Systems, 2010 Editi	ion. Section 5.1.1 states the			1, 2, 3, 4, 5, 6).	
	following energy so	ources shall be permitted to			,	
	be used for the eme	rgency power supply (EPS):				
		n products at atmospheric				
	pressure					
	(2) Liquefied petrol	eum gas (liquid or vapor			·How other residents havin	q
	withdrawal)			the potential to be affected by		·
	(3) Natural or synth	etic gas			·	
		el 1 installations in locations		the same deficient practice will be identified and what		
	-	ty of interruption of off-site			corrective action(s) will be	
	_	i, on-site storage of an			taken.	
		arce sufficient to allow full			All elders, staff, and visitors ha	ave
		to be delivered for the class			the potential to be affected by	
	_	equired, with the provision for			alleged deficient practice. A	
	•	rom the primary energy			letter of reliability will be provid	ded
	source to the alterna				for the generators in (cottages	
		ples of probability of			2, 3, 4, 5, 6)	
		nclude the following:				
	•	amage, or a demonstrated				
	• •	This deficient practice had			·What measures will be put	.
	the potential to affe	-			into place or what systemic	
	1				changes will be made to ens	ure
	Findings include:				that the deficient practice do	
	<i>S</i>				not recur.	
	Based on interview	on 10/20/21 with the			The maintenance director or	
		at 10:48 a.m., the fuel source			designee will ensure each	
	of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was				generator has documentation	of a
					reliable source of fuel in	
	_	fuel source of the five			accordance with NFPA 101.	
		diesel but natural gas. During				
		0/20/21 the documentation on				
	1200101011011 011 10	inc accommentation on	ı			l l

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING 05 B. WING		COMPLETED 10/20/2021	
	ROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)		
K 0712	the five books labeled as C 1 P.M. log through C 6 P.M. logs, no natural gas letter of reliability could be located. Based on an interview at the time of record review, the Executive Director stated that this was only his seventh day at the facility, and he was unsure if a letter of reliability had even been requested by the previous Executive Director, but that he would request one from his provider as soon as he would be able to do so. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		·How the corrective action(will be monitored to ensure t deficient practice will not rec i.e., what quality assurance program will be put into plac and The maintenance schedule wil maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he ur, e; I be	
SS=F Bldg. 05	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 4 of 4 quarters. LSC 19.7.1.6 requires drills to	K 0712	K712 •What corrective action(s) will be accomplished for thos	11/16/2021	
	be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include:		residents found to have beer affected by the deficient practice. Fire drills were conducted per NFPA requirements for 1st shi		

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	of correction identification number: 155846	A. BUILDING B. WING	05	COMPLETED 10/20/2021
	PROVIDER OR SUPPLIER HOUSE COTTAGES OF CARMEL	616 GF	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review on 10/19/21 with the Executive Director at 10:56 a.m., there were no documented fire drills available for review for the past twelve-month period. Based on interview at the time of record review, the Executive Director stated that he could not locate any fire drill documentation and that this was only his seventh day in the facility. Furthermore, his Maintenance Director was at home with a sick child and not available during the two days of this survey. During the exit conference with the Executive Director on 10/20/21 at 12:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		reviewed and revised to inclustrate of the different practice. What measures will be printo place or what systemic changes will be made to en that the deficient practice do not recur. The maintenance schedule viewed and at least quarterly on each scheduled fire drills at unexpetimes, under varying condition and at least quarterly on each shift will be held at the facility NFPA requirements.	by will nave y this cted ns, h y per ut sure oes vill be ide ected ns, h
			·How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plant and The maintenance schedule waintained by maintenance	the ecur, ce;

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	OF OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155846		UILDING	NSTRUCTION 05	COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	616 GR	EEN HOUSE WAY	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E IATE	(X5) COMPLETION DATE
					personnel, monitored by the administrator, and reported to QAPI monthly. If concerns a noted during maintenance checks, they will be remedie immediately.	re	
K 0918 SS=F Bldg. 05	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under low year in 20-40 day once every 36 mo hours. Scheduled include a complete automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with No circuit breakers are a program for peri- components is est manufacturer requirements.	a - Essential Electric Syste b - Essential Electric coce and Testing other alternate power ated equipment is capable coce within 10 seconds. If the cocess shall be provided to comis capability for the life branches. Maintenance generator and transfer commed in accordance with cocess shall be provided to comis capability for the life branches. Maintenance generator and transfer commed in accordance with comments a sintervals, and exercised control of the simulated cold start and could transfer of all EES conducted by competent comments and testing of stored comments and testing of stored comments and testing the comments and testing the comments. Written records and testing are maintained cole. EES electrical panels					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155846		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ATE	(X5) COMPLETION DATE
	and separate from Minimizing the pose emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 1) Based on record facility failed to ensweekly inspections maintained for 52 o 6.4.4.1.3 requires or maintained in accord Standard for Emerg Systems. NFPA 110 Emergency Power Standard for Emerge	(NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, the sure a written record of for the generator was f 52 weeks. NFPA 99, nsite generators shall be dance with NFPA 110, gency and Standby Power 0, 8.4.1 requires an Supply System (EPSS) enant components, shall be not exercised monthly. NFPA a written record of ance, exercising period, and rator to be regularly ilable for inspection by the risdiction. This deficient at all residents, staff, and	K 0	918	What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice. The generators for (cottages 1,2,3,4,5,6) have all been add to the maintenance director's weekly inspection schedule. How other residents having the potential to be affected by the potential to be affected by the identified and what corrective action(s) will be taken. All elders, staff, and visitors have potential to be affected by alleged deficient practice. All generators have been placed schedule to be inspected were and exercised monthly. What measures will be purinto place or what systemic changes will be made to ensuthat the deficient practice do	ng by will ave this on a ekly	11/16/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULT: A. BUILD B. WING		NSTRUCTION 05	(X3) DATE S COMPL 10/20/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the Executive Direct p.m., no additional	ng the exit conference with tor on 10/20/21 at 12:15 information or evidence could by to this deficient finding.			not recur. The maintenance director will conduct weekly inspections ar monthly load test and cool dow for all 6 generators.		
	facility failed to ma record of monthly g of the last 12 month 2012 NFPA 99 requirements generator serving the system to be in accompanient of the systems, Chapter 8. It is diesel generator sets least once monthly, minutes. Chapter 6. written record of insexercising period, a to be regularly main inspection by the autority occupants. Findings include:				·How the corrective action(will be monitored to ensure to deficient practice will not rective, what quality assurance program will be put into place and The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he ur, e; I be	
	Executive Director current documentation reference to weekly for review for the labook provided had a documented, but the 07/28/2020. Based or record review, the Ethis was only his see his Maintenance Di	iew on 10/19/21 with the at 12:26 p.m., there was no on available for review in generator testing available st 12-month period. The monthly generator testing e documentation stopped on on an interview at the time of executive Director stated that wenth day in the facility and rector was at home with a vailable during the two days					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846			UILDING	05	COMPLETED 10/20/2021		
GREEN I	PROVIDER OR SUPPLIER	S OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	on BE PRIATE	(X5) COMPLETION DATE
K 0000	the Executive Direc p.m., no additional i	ng the exit conference with tor on 10/20/21 at 12:15 information or evidence could by to this deficient finding.					
Bldg. 06	Licensure Survey w Department of Heal CFR 483.90(a). Survey Date: 10/19 Facility Number: 0 Provider Number: 2013 At this Life Safety C Cottages of Carmel with Requirements of Medicare/Medicaid Life Safety from Fin National Fire Protect 101, Life Safety Co Existing Health Car 16.2. The facility consists 06). Each building in determined to be of and was fully sprink alarm system with s corridors, areas ope wired smoke detected.	13753 155846 362150 Code survey, Green House was found not in compliance for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) de (LSC), Chapter 19, re Occupancies and 410 IAC of six buildings (01 through a one story cottage Type V (111) construction thereof the corridors and hard for in the resident rooms. as a capacity of 72 and had a	K 0	000	Preparation and/or execut this plan of correction in general, or this corrective action in particular, does constitute an admission of agreement by this facility facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are presently and/or executed in complimitation of the correction complimitation of the correction constitutes a written allegt of substantial compliance. Federal Medicare and Medicare an	not r of the ns set pared ance s. ation with dicaid	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846 A. BUILL B. WING		IILDING <u>06</u>			COMPLETED 10/20/2021		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 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)	Ē	(X5) COMPLETION DATE
K 0324 SS=F Bldg. 06	were sprinklered and services were sprink separate detached act Building 06 is identicottage has a capacit (Zero) at the time of currently unoccupied Quality Review commercial unoccupied Quality Review commercial Cooking Facilities Cooking Facilities Cooking equipmer accordance with N Ventilation Control Commercial Cooking appliances such act toasters) are used limited cooking in a 18.3.2.5.2, 19.3.2. * cooking facilities smoke compartme patients comply with 30 or fewer patients under 1 Cooking facilities with 30 or fewer patients under 1 Cooking facilities proper in the corula size. It through 19.3.2.5.5 Based on record reviews a capacity with size open to the corula size. Size of the corula size. Size of the corula	at is protected in FPA 96, Standard for and Fire Protection of ng Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or accordance with 5.2 open to the corridor in onts with 30 or fewer th the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. orotected according to a are not required to be dous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1	K 0:	324	K324 ·What corrective action(s)		11/16/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155846	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 06	(X3) DATE SURVEY COMPLETED 10/20/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	ON (X5) DE COMPLETION PRIATE DATE		
	NFPA 96, 2011 Edit Control and Fire Pro Cooking Operations Maintenance of the and listed exhaust his fire-activated water extinguish a fire in Hood exhaust plenus shall be made by procertified person(s) a having jurisdiction at This deficient practistaff, and visitors with Findings include: Based on record revexue Executive Director of a kitchen fire supfor Cottage #6, for the period was not available during the facilibration of the process of the period was at hom available during the During the exit continuing the exit continuing the exit continuing the continuing the exit continuing the record of additional informations.	iew on 10/20/21 with the at 10:21 a.m., documentation pression system inspection he last six or 12-month lable for review. Based on the of record review, the stated that this was only his lity, and his Maintenance are with a sick child and not two days of this survey.		will be accomplished for residents found to have a affected by the deficient practice. All hood systems on camp (cottages 1, 2, 3, 4, 5 and scheduled to be inspected Koorsen in November and on a semi-annual inspection schedule per NFPA requirements. -How other residents has the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitor the potential to be affected alleged deficient practice. semi-annual inspection so has been established between facility and Koorsen. Next inspection is scheduled for November 2021. -What measures will be into place or what system changes will be made to that the deficient practice not recur. The semi-annual inspection for the hood system was put the maintenance schedule ensure compliance.	us 6) are by will be on aving ad by ce will e s have by this A nedule veen this put nic ensure does n date laced in		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING B. WING	06	COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIEF		STREET A 616 GR CARME		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	
				How the corrective action(will be monitored to ensure to deficient practice will not rectore., what quality assurance program will be put into place and The maintenance schedule will maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	he cur, e; Il be
K 0345 SS=F Bldg. 06	in accordance with complying with the National Electric (National Fire Alari Records of system and testing are re	m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance			
	1) Based on record facility failed to ensure the annual testing of 1 fire alarm system. National Fire Alarm Section 14.6.2.4 reconstructions, testing, provided that including regarding tests and	review and interview, the sure the documentation for of all devices connected to 1 tem was complete. NFPA 72, in Code, the 2010 Edition, at equires a record of all interview and maintenance shall be dest the following information all the applicable information in 14.6.2.4. The record shall	K 0345	·What corrective action(s) will be accomplished for thos residents found to have been affected by the deficient practice. Maintenance and testing of the	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 06		COMPL	ETED	
		155846	B. W	NG		10/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARMEL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'E	DATE
	include a listing of	all devices tested with device			fire alarm system are performe	ed	
	type, address, locati	ion, and test results indicated:			in accordance with NFPA 110.		
	(1) Date				The semi-annual fire alarm sys	stem	
	(2) Test frequency				testing logs for (cottages 1, 2,		
	(3) Name of proper	ty			4, 5 and 6) have been updated		
	(4) Address	•			and all 6 cottages are on sche		
	(5) Name of person performing inspection,				to be tested semi-annually.		
		or combination thereof, and					
		affiliation, business address, and telephone					
	number						
	(6) Name, address, and representative of				How other residents having		
	approving agency (ies)				the potential to be affected by	v l	
	(7) Designation of the detector(s) tested				the same deficient practice w		
	(8) Functional test of detectors				be identified and what		
	` /	of required sequence of			corrective action(s) will be		
	operations	or required sequence of			taken.		
	(10) Check of all sn	noke detectors					
		e for all fixed-temperature,			All elders, staff, and visitors h	ave	
	line-type heat detec				the potential to be affected by		
		of mass notification system			alleged deficient practice. All		
	control units				fire alarm systems have been		
		of signal transmission to			placed on a schedule to have	fire	
	mass notification sy	_			alarm system tested		
	(14) Functional test				semi-annually.		
		to silence fire alarm					
	notification applian						
		gibility of mass notification			·What measures will be put		
	system speakers	,			into place or what systemic		
		required by the equipment			changes will be made to ensu	ure	
	manufacturer's publ				that the deficient practice do		
		required by the authority			not recur.		
	having jurisdiction	equired by the dumently			The maintenance director will		
		ester and approved authority			conduct a fire alarm system te	_{st}	
	representative				semi-annually. This test will be		
	(19) Disposition of problems identified during				documented and will be visual		
	test (e.g., system owner notified, problem				testing the control unit trouble	'	
	corrected/successfully retested, device				signals, remote annunciators,		
	abandoned in place)				initiating devices, notification		
		ice could affect all occupants			appliances and magnetic		
	in the facility.	ice could affect an occupants			hold-open devices.		
	in the facility.		1		noid-open devices.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CC UILDING	ONSTRUCTION	COMPI		
AND PLAN	OF CORRECTION			'ING	<u>06</u>		
		155846	D. W			10/20	/2021
NAME OF P	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
					REEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:				·How the corrective action	. ,	
					will be monitored to ensure		
		view on 10/20/21 with the			deficient practice will not re		
		at 10:21 a.m., a fire alarm			i.e., what quality assurance		
	system inspection/testing report could not be				program will be put into pla	ce;	
	located or provided for review with an itemized				and The maintenance ashedule w	ما الله	
	list of fire alarm system devices inspected/tested				The maintenance schedule v	viii be	
	indicating the device type, address, location, and specific results of the testing. Based on				maintained by maintenance personnel, monitored by the		
	interview at the time of record review, the				administrator, and reported to	.	
	Executive Director stated that this was only his				QAPI monthly. If concerns a		
	seventh day in the facility and his Maintenance				noted during maintenance	10	
	Director was at home with a sick child and not				checks, they will be remedied	d	
		e two days of this survey.			immediately.		
	_	ference with the Executive					
	Director on 10/20/2						
	additional informat	ion or evidence could be					
	provided contrary to	o this deficient finding.					
	3.1-19(b)						
	2) Based on record	review and interview, the					
	/	sure 1 of 1 fire alarm systems					
		accordance with LSC 9.6.1.3.					
		es a fire alarm system to be					
	-	d maintained in accordance					
	with NFPA 70, Nat	ional Electrical Code and					
	NFPA 72, National	Fire Alarm Code. NFPA 72,					
		s unless otherwise permitted					
	-	this Code, testing shall be					
	-	dance with the schedules in					
		ore often if required by the					
		risdiction. NFPA 72, Section					
		oke detector sensitivity shall					
		l year after installation. NFPA					
		s smoke detector sensitivity					
		ery alternate year thereafter					
	uniess otherwise pe	rmitted by compliance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	06	COMPL	
		155846	B. WI	NG		10/20/	/2021
NAME OF F	DOLUDED OD GLIDDLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Section 14.4.5.3.3.	This deficient practice could					
	affect all occupants	-					
	_						
	Findings include:						
	Based on record rev	view on 10/20/21 with the					
	Executive Director	at 10:24 a.m., no					
		a smoke detector sensitivity					
		or review. Based on interview					
		d review, the Executive					
		this was only his seventh day					
	-	is Maintenance Director was					
	at home with a sick child and not available during the two days of this survey. During the exit						
	•	Executive Director on					
	10/20/21 at 12:15 p						
	-	ence could be provided					
	contrary to this defi	-					
	contrary to this den	erent initing.					
	3.1-19(b)						
	3) Based on record	review and interview, the					
	· /	intain 1 of 1 fire alarm					
		nce with NFPA 72, National					
		required by LSC Sections					
		NFPA 72, Section 14.3.1					
		herwise permitted by 14.3.2,					
		hall be performed in					
	accordance with the	e schedules in Table 14.3.1, or					
	_	red by the authority having					
	-	14.3.1 states that the					
	following must be v	visually inspected					
	semi-annually:						
	a. Control unit troul						
	b. Remote annuncia						
	_	(e.g. duct detectors, manual					
	fire alarm boxes, he	eat detectors, smoke					
	detectors, etc.)						
	d. Notification appl						
	e. Magnetic hold-op	pen devices					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 06	COM	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER		616	ET ADDRESS, CITY, STATE, ZIF GREEN HOUSE WAY RMEL, IN 46032	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	This deficient pract occupants. Findings include:	ice could affect all building				
	Based on record rev Executive Director documentation for a of the fire alarm sys Based on interview the Executive Direct his seventh day in the Maintenance Direct child and not availa survey. During the of Executive Director no additional inform	a semiannual visual inspection stem was available for review. at the time of record review, tor stated that this was only				
K 0353 SS=F Bldg. 06	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR	<u> </u>				

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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	ONSTRUCTION 06	COMPL	
12.512.11		155846	B. WI		00	10/20/	
		1.000 10			ADDRESS CITY STATE ZID CODE	10/20/	
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	automatic sprinkle	•					
	9.7.5, 9.7.7, 9.7.8						
	· ·	review and interview, the	K 0	353	K353		11/16/2021
		ovide written documentation			·What corrective action(s)		
	or other evidence th	-			will be accomplished for tho residents found to have been		
	-	en inspected and tested for 4				n	
		4.6.12.1 requires any device, m required for compliance			affected by the deficient practice.		
		naintained in accordance with			All sprinkler systems on camp	NIC.	
		equirements. Sprinkler			(cottages 1, 2, 3, 4, 5 and 6) a		
		-			scheduled to be inspected by	110	
	systems shall be properly maintained in accordance with NFPA 25, Standard for the				Koorsen in November per NF	PA	
	Inspection, Testing, and Maintenance of				requirements. All sprinkler		
	Water-Based Fire Protection Systems. NFPA 25,				systems are on a quarterly		
	4.3.1 requires records shall be made for all				inspection and testing schedu	le	
	inspections, tests, a	nd maintenance of the system			per contract withKoorse	n.	
	components and sh	all be made available to the					
	authority having ju	risdiction upon request. 4.3.2					
	requires that record	s shall indicate the procedure			·How other residents havir	ng	
	performed (e.g., ins	-			the potential to be affected by	_	
		organization that performed			the same deficient practice v	will	
		s, and the date. NFPA 25,			be identified and what		
	_	waterflow alarm devices shall			corrective action(s) will be		
		rly to verify they are free of			taken.		
		IFPA 25, 5.3.3.1 requires the			All elders, staff, and visitors ha		
		ow alarm devices including,			the potential to be affected by		
		vater motor gongs, shall be 3.3.2 requires vane-type and			alleged deficient practice. All sprinkler systems are on a	l	
	1 ,	e waterflow alarm devices			quarterly inspection and testir	na	
		annually. This deficient			schedule per NFPA	19	
		et all residents, staff, and			requirements.		
	visitors in the facili				requirements.		
		-5					
	Findings include:				·What measures will be pu	t	
					into place or what systemic		
	Based on record rev	view on 10/20/21 with the			changes will be made to ens	ure	
	Executive Director	at 10:31 a.m., no			that the deficient practice do	es	
	documentation for	quarterly sprinkler system			not recur.		
	inspections was ava	ailable for review for the past			The quarterly inspection dates	s for	
	12 months. Based of	on interview at the time of			the sprinkler systems are in th	ne	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	06	COMPL	
		155846	B. W	ING		10/20/	2021
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		616 GR	EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		Executive Director stated that			maintenance schedule to ens		
	, , , , , , , , , , , , , , , , , , ,	venth day in the facility and			compliance.		
		rector was at home with a					
		vailable during the two days					
		ng the exit conference with			·How the corrective action	(s)	
		etor on 10/20/21 at 12:15			will be monitored to ensure	` '	
		information or evidence could			deficient practice will not red		
	*	y to this deficient finding.			i.e., what quality assurance	,	
	•	-			program will be put into place	e;	
	3.1-19(b)				and		
					The maintenance schedule w	ill be	
	2) Based on record	review and interview, the			maintained by maintenance		
	facility failed to do	cument sprinkler system			personnel, monitored by the		
	inspections in accor	dance with NFPA 25. NFPA			administrator, and reported to		
	25, Standard for the	Inspection, Testing, and			QAPI monthly. If concerns ar	е	
	Maintenance of Wa	ter-Based Fire Protection			noted during maintenance		
	Systems, 2011 Edit	ion, Section 5.2.4.1 states			checks, they will be remedied		
	gauges on wet pipe	sprinkler systems shall be			immediately.		
	inspected monthly t	o ensure that they are in good					
		ormal water supply pressure					
	_	. Section 5.1.2 states valves					
	_	connections shall be					
	-	nd maintained in accordance					
	-	ection 13.1.1.2 states Table					
		lized for inspection, testing					
		valves, valve components and					
		states records shall be made					
	1 /	tests, and maintenance of the					
		ponents and shall be made					
		nority having jurisdiction upon					
	request. This deficient residents, staff, and	ent practice could affect all					
	residents, starr, and	VISITOIS.					
	Findings include:						
	1 manigo merade.						
	Based on record rev	view on 10/20/21 with the					
	Executive Director						
		nonthly control valve and					
		ould be provided for review					
		ths. Based on interview at the					
	_						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		A. BUILDING <u>06</u> B. WING			COMPLETED 10/20/2021		
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE EEN HOUSE WAY		
GREEN I	HOUSE COTTAGES	S OF CARMEL			EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	time of record revies stated that this was of facility and his Main home with a sick che the two days of this conference with the 10/20/21 at 12:15 p. information or evide contrary to this deficient of the second or evide contrary to this deficient failed to ensure a suggest were replaced documented as tested comparison with a compari	w, the Executive Director only his seventh day in the intenance Director was at ild and not available during survey. During the exit Executive Director on im., no additional ence could be provided cient finding. Intion and interview, the intensive of every 5 years or divery 5 years by alibrated gauge. NFPA 25, prection, Testing, and iter-Based Fire Protection on, Section 5.3.2.1 states aced every 5 years or tested inparison with a calibrated inccurate to within 3 percent of the recalibrated or replaced. Iter could affect all residents, the facility. Intensive of the facility from 2:23 in 10/19/21, the facility had alkler systems and had a total three gauges. The manufacture ges was 2015 and was listed sprinkler system gauge. No formation was affixed to or the sprinkler system gauges. at the time of the					
	recalibration date in could be located on Based on interview	formation was affixed to or the sprinkler system gauges.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 06	(X3) DATE SURVEY COMPLETED 10/20/2021		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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	
K 0511 SS=F Bldg. 06	had been recalibrate five-year period and documentation of spreplacement or recal not available for revisive gauges which old. During the exit Executive Director on additional inform provided contrary to 3.1-19(b) NFPA 101 Utilities - Gas and Equipment using group with NFF Code, electrical with Complies with NFF Code. Existing instructive provided in 18.5.1.1, 19.5.1.1, Based on record revisive provided in 18.5.1.1, 19.5.1.1, Based on record revisited to ensure that a reliable source of requirements of NFI Section 19.5.1.1, 9.1.2010 Edition, 5.1. I emergency generate and maintained in action of the section of the emergency generate and maintained in action of	orinkler system gauge libration documentation was iew for all three sprinkler th were more than five years conference with the on 10/20/21 at 12:15 p.m., nation or evidence could be of this deficient finding. Electric Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.	K 0511	·What corrective action(s) will be accomplished for thos residents found to have been affected by the deficient practice The facility has obtained a letter reliability from the company responsible for supplying natu gas to the generators in (cotta 1, 2, 3, 4, 5, 6). ·How other residents having the potential to be affected by the deficient practice.	er of ral ges	

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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	06	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER		616 G	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY IEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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 APPROPR DEFICIENCY)	DATE
	where the probability fuel supplies is high alternate energy sour output of the EPSS specified shall be reautomatic transfer from the source to the alternation A.5.1.1 states examinate interruption could be fried interview. Based on interview i	el 1 installations in locations ty of interruption of off-site to, on-site storage of an arce sufficient to allow full to be delivered for the class quired, with the provision for rom the primary energy atte energy source. ples of probability of nelude the following: amage, or a demonstrated This deficient practice had		the same deficient practice be identified and what corrective action(s) will be taken. All elders, staff, and visitors in the potential to be affected be alleged deficient practice. As letter of reliability will be proving for the generators in (cottage 2, 3, 4, 5, 6) •What measures will be print place or what systemic changes will be made to enthat the deficient practice of not recur. The maintenance director or designee will ensure each generator has documentation reliable source of fuel in accordance with NFPA 101. •How the corrective action will be monitored to ensure deficient practice will not reite, what quality assurance program will be put into place and the maintenance schedule will maintenance schedule will be monitored by the administrator, and reported to QAPI monthly. If concerns a noted during maintenance checks, they will be remedied immediately.	nave y this wided es 1, ut sure loes n of a n(s) ethe ecur, ace; will be

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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 <u>06</u>	(X3) DATE SURVEY COMPLETED 10/20/2021	
	PROVIDER OR SUPPLIER		616 GI	ADDRESS, CITY, STATE, ZIP CODE REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
K 0712 SS=F Bldg. 06	alarm signal and signer conditions. Fir expected and une varying conditions shift. The staff is fand is aware that routine. Where dr 9:00 PM and 6:00 announcement material audible alarms. 19.7.1.4 through 1 Based on record revifacility failed to cord 4 of 4 quarters. LSC be conducted quarter conditions. This definitions. This definitions include: Based on record review Executive Director documented fire drift the past twelve-more at the time of record Director stated that drill documentation seventh day in the find Maintenance Direct child and not availate survey. During the executive Director no additional informations.	xpected times under , at least quarterly on each amiliar with procedures drills are part of established ills are conducted between AM, a coded ay be used instead of	K 0712	K712 ·What corrective action(s) will be accomplished for the residents found to have bee affected by the deficient practice. Fire drills were conducted per NFPA requirements for 1st sh for all 6 cottages. ·How other residents having the potential to be affected by the same deficient practice of the potential to be affected by alleged deficient practice. Quarterly fire drills at unexpectimes, under varying condition and at least quarterly on each shift will be held at the facility NFPA requirements.	ng by will ave this cted ns,

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155846			JILDING	06	COMPL 10/20/	ETED	
	PROVIDER OR SUPPLIER	OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC 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	
	3.1-51(c)				·What measures will be purinto place or what systemic changes will be made to ensith the deficient practice do not recur. The maintenance schedule wireviewed and revised to include scheduled fire drills at unexpetimes, under varying condition and at least quarterly on each shift per NFPA requirements. ·How the corrective actions will be monitored to ensure a deficient practice will not recise, what quality assurance program will be put into place and The maintenance schedule wire maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	ure es II be de cted s, (s) he cur, e;		
K 0918 SS=F Bldg. 06	Electrical Systems System Maintenan The generator or c source and associa of supplying service							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL		nstruction 06	(X3) DATE COMPL		
THIND I EARLY	or condition.	155846	B. WING		00	10/20/	
		1000.10	<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP CODE	10/20/	2021
NAME OF I	PROVIDER OR SUPPLIEF	R			EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL			EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ocess shall be provided to					
	· ·	his capability for the life branches. Maintenance					
	-	generator and transfer					
	_	ormed in accordance with					
	NFPA 110.	office in accordance with					
	_	e inspected weekly,					
		oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	onths for 4 continuous					
	hours. Scheduled	test under load conditions					
	include a complete	e simulated cold start and					
	automatic or manual transfer of all EES						
	loads, and are conducted by competent						
		nance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and					
		iodically exercising the					
		tablished according to uirements. Written records					
	-	nd testing are maintained					
		ble. EES electrical panels					
	· ·	arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
	emergency power	source is a design					
	consideration for r	new installations.					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	•					
	· /	review and interview, the	K 091	18	K 918		11/16/2021
	_	sure a written record of					
		for the generator was					
		of 52 weeks. NFPA 99,			.What commontive action (-)		
	_	nsite generators shall be rdance with NFPA 110,			 What corrective action(s) will be accomplished for those 	20	
		gency and Standby Power			residents found to have beer		
	Systems. NFPA 110				affected by the deficient	•	
	-	Supply System (EPSS)			practice.		
		enant components, shall be			The generators for (cottages		
		* ′			, ,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	06	COMPL	LETED
		155846	B. Wl	ING _		10/20	/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
ODEEN	HOUSE COTTACE	C OF CARME!			REEN HOUSE WAY		
GREEN	HOUSE COTTAGE	5 OF CARMEL		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\	DATE
	inspected weekly as	nd exercised monthly. NFPA			1,2,3,4,5,6) have all been add	led	
	99, 6.4.4.2 requires				to the maintenance director's		
	-	ance, exercising period, and			weekly inspection schedule.		
		rator to be regularly					
		ilable for inspection by the					
		risdiction. This deficient			·How other residents havir	na	
		et all residents, staff, and			the potential to be affected b	_	
	visitors.				the same deficient practice	-	
					be identified and what		
	Findings include:				corrective action(s) will be		
Findings include.					taken.		
Based on record review on 10/19/21 with the					All elders, staff, and visitors h	ave	
Executive Director at 12:26 p.m., there was no					the potential to be affected by		
	current documentation available for review in				alleged deficient practice. Al		
	reference to weekly generator testing available				generators have been placed		
		ast 52-week period. The book			schedule to be inspected wee		
	provided had week	-			and exercised monthly.	,	
	_	e testing stopped on					
		on an interview at the time of					
		Executive Director stated that			·What measures will be pu	t	
		eventh day in the facility and			into place or what systemic	•	
		rector was at home with a			changes will be made to ens	ure	
		vailable during the two days			that the deficient practice do		
		ng the exit conference with			not recur.		
		etor on 10/20/21 at 12:15			The maintenance director will		
		information or evidence could			conduct weekly inspections a	nd	
		y to this deficient finding.			monthly load test and cool do		
	oc provided contrar	y to this deficient finding.			for all 6 generators.	VVII	
	3.1-19(b)				lor all o generators.		
	3.1-17(0)						
	2) Based on record	review and interview, the			·How the corrective action	(s)	
	· ·	iintain a complete written			will be monitored to ensure		
		generator load testing for 12			deficient practice will not rec		
		ns. Chapter 6.4.4.1.1.4(a) of			i.e., what quality assurance	· · · · · ·	
		uires monthly testing of the			program will be put into place	·e.	
	-	ne emergency electrical			and	λ,	
	-	ordance with NFPA 110, the			The maintenance schedule w	ill he	
	-	gency and Standby Powers			maintained by maintenance	III DE	
	_	. NFPA 110 8.4.2 requires			personnel, monitored by the		
					·		
	diesei generator set	s in service to be exercised at			administrator, and reported to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	06	COMPLETED	
		155846	B. W	NG		10/20/	2021
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	S.			EEN HOUSE WAY		
GREEN I	HOUSE COTTAGE	S OF CARMEL	CARMEL, IN 46032				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		for a minimum of 30			QAPI monthly. If concerns ar	е	
		4.4.2 of NFPA 99 requires a			noted during maintenance		
		spection, performance,			checks, they will be remedied		
	• •	nd repairs for the generator			immediately.		
		ntained and available for					
		thority having jurisdiction.					
	This deficient pract	ice could affect all					
	occupants.						
	Findings include:						
	Based on record rev	view on 10/19/21 with the					
	Executive Director	at 12:26 p.m., there was no					
		ion available for review in					
	reference to weekly	generator testing available					
	-	ast 12-month period. The					
	book provided had	monthly generator testing					
	_	e documentation stopped on					
		on an interview at the time of					
	record review, the I	Executive Director stated that					
	this was only his se	venth day in the facility and					
	his Maintenance Di	rector was at home with a					
	sick child and not a	vailable during the two days					
	•	ng the exit conference with					
		tor on 10/20/21 at 12:15					
	p.m., no additional	information or evidence could					
	be provided contrar	y to this deficient finding.					
	3.1-19(b)						

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