STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE COTTAGES OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 10/19/21 and 10/20/21 Facility Number: 013753 Provider Number: 155846 AIM Number: 201362150 At this Emergency Preparedness survey, Green House Cottages of Carmel was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 72 certified beds. At the time of the survey, the census was 55. Quality Review completed on 10/26/21	E 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

Any deficiencystatement 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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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan 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 §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an	E 0004	**E004** **·What corrective action(s)**	11/16/2021

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	emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: 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, documentation that the (EOP) was reviewed by the facility within the most recent twelve-month period was not available for review. 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 had been updated within the last twelve months. 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.		**will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness plan that is reviewed and updated at least annually. **·How other residents having the 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 this alleged deficient practice. This facilities emergency preparedness policies and procedures have been updated to include the annual review of the emergency preparedness plan. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to review and update the emergency preparedness plan at least annually. **·How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.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 are noted during maintenance checks, they will be remedied immediately.	
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), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(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.			

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	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk			

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	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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: 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, documentation for a complete EOP reviewed by the facility within the most recent twelve-month period was not available for review. 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 had been updated within the last twelve months. 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.	E 0013	**E013** **·What corrective action(s) will be accomplished for those residents 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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. This facilities emergency preparedness plan has been updated to include the annual review of the facility policies and procedures. **·What measures will be put**	11/16/2021

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			into place or what systemic changes will be made to ensure that the deficient practice does not recur. This facility will continue to update and review emergency preparedness policy and procedures at least annually. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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 are noted during maintenance checks, they will be remedied immediately.	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).			

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	[(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities;			

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	transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the	E 0018	**E018** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	11/16/2021

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	LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b)(2). This deficient practice could affect all occupants. Findings include: 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, no documentation could be found ensuring the emergency preparedness policies and procedures include a system to track the location of on-duty staff during or after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. 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 had been updated within the last twelve months. 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.		The facility has developed and implemented an emergency preparedness plan that include a system to track the location of on-duty staff during and after an emergency. **·How other residents having the 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 this alleged deficient practice. This facilities emergency preparedness plan has been updated to include a system to track the location of on-duty staff during and after an emergency. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to update the emergency preparedness plan to include a system to track the location of on-duty staff during and after an emergency. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			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.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]			

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	(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address 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 procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: 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, the facility's EOP provided did not	E 0024	**E024** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness plan that include the use of volunteers in the event of an emergency. **How other residents having the 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 this	11/16/2021

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	address the use of volunteers in an emergency. 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 had addressed the use of volunteers 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.		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 into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to update the emergency preparedness plan to include the use of volunteers in the event of an emergency. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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 are noted during maintenance checks, they will be remedied immediately.	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING -- B. WING	10/20/2021

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GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants.	E 0026	**E026** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness plan to providing the provision of care at an	11/16/2021

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	Findings include: 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.		alternate care site in the event of an emergency. **·How other residents having the 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 this alleged deficient practice. This facilities emergency preparedness plan has been updated to include providing the provision of care at an alternate care site in the event of an emergency. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to update the emergency preparedness plan to include providing the provision of care at an alternate care site in the event of an emergency. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The emergency preparedness	

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			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.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency	E 0029	**E029** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness plan to include an emergency communication plan.	11/16/2021

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	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, the EOP communication plan had not been updated within the last twelve-month period. 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 any type of update within the last twelve-month period. 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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. This facilities emergency preparedness plan has been updated to include an emergency communication plan. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to update the emergency preparedness plan to include the emergency communication plan. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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 are	

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			noted during maintenance checks, they will be remedied immediately.	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants.	E 0035	**E035** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness plan that includes a	11/16/2021

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	Findings include: 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, the EOP communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. 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 a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. 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.		method for sharing information from the emergency plan with the elders, families, or representatives. **·How other residents having the 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 this alleged deficient practice. This facilities emergency preparedness plan has been updated to include the method for sharing information from the emergency plan with the elders, families, or representatives. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** This facility will continue to update the emergency preparedness plan to include the method for sharing information from the emergency plan with the elders, families, and representatives. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			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.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this			

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	section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing			

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	and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: 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, the EOP testing and training program had not been reviewed or updated within the last 12-month period. 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 an annual update. 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.	E 0036	**E036** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented an emergency preparedness training and testing program that is reviewed and updated annually. **·How other residents having the 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 this alleged deficient practice. This facilities emergency preparedness plan has been updated to include the training and testing program. **·What measures will be put into place or what systemic changes will be made to ensure**	11/16/2021

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			that the deficient practice does not recur. This facility will continue to update the emergency preparedness plan to include a training and testing program that is reviewed annually. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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 are noted during maintenance checks, they will be remedied immediately.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68,			

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	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE COTTAGES OF CARMEL	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is			

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	not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.			

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	(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan,			

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	the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next			

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	required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional	E 0039	**E039** **·What corrective action(s) will be accomplished for those residents found to have been affected by the 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 drills using emergency procedures. **·How other residents having the potential to be affected by the same deficient practice will**	11/16/2021

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	exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on 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, the EOP contained no documentation of at least two exercises that included a full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on interview at the time of record review, the Executive Director stated that this was only his sixth day in the facility, and		**be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this 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 drills using emergency procedures. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does 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 drills using emergency procedures. ·**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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 are noted during emergency plan	

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	he had not yet had an opportunity to review the EOP or even check to see if it contained any type of drills or exercises. 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.		tests, they will be remedied immediately.	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.			

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	482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park,			

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	Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 10/20/21 with the	E 0041	**E041** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility has developed and implemented a plan to inspect, test, and maintain the emergency power systems within each cottage.	11/16/2021

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	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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. The facility has developed and implemented a plan to inspect, test, and maintain the emergency power systems within each cottage. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The facility has developed and implemented a plan to inspect, test, and maintain the emergency power systems within each cottage. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.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	

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			QAPI monthly. If concerns are noted during emergency plan inspections, tests, or maintenance they will be remedied immediately.	
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 of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	

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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 01 is identified as Cottage #2. The cottage has a capacity of 12 and had a census of 10 at the time of this survey. Quality Review completed on 10/26/21			
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually.	K 0324	**K324** **·What corrective action(s) will be accomplished for those**	11/16/2021

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	NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection for Cottage #2, for the last six or 12-month period was not 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.		**residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the 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 this alleged deficient practice. A semi-annual inspection schedule has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance. **·How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The maintenance schedule 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.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device	K 0345	**K345** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the fire alarm system are performed	11/16/2021

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	type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility.		in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the 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 this alleged deficient practice. All 6 fire alarm systems have been placed on a schedule to have fire alarm system tested semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices.	

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	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(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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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	Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

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	1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices 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 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	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen. **·How other residents having the 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 this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the maintenance schedule to ensure compliance.	11/16/2021

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	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: 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		**·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director stated he did not believe sprinkler system gauges had been recalibrated within the most recent			

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	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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations	K 0511	**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The facility has obtained a letter of reliability from the company responsible for supplying natural gas to the generators in (cottages 1, 2, 3, 4, 5, 6). **·How other residents having the potential to be affected by the same deficient practice will be identified and what**	11/16/2021

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	where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on interview on 10/20/21 with the Executive Director at 10:48 a.m., the fuel source of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was determined that the fuel source of the five generators was not diesel but natural gas. During record review on 10/20/21 the documentation on 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)		**corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. A letter of reliability will be provided for the generators in (cottages 1, 2, 3, 4, 5, 6) **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director or designee will ensure each generator has documentation of a reliable source of fuel in accordance with NFPA 101. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	155846	A. BUILDING 01 B. WING	10/20/2021

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K 0712 SS=F Bldg. 01	NFPA 101 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 be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 10/20/21 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)	K 0712	**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 shift for all 6 cottages. **·How other residents having the 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 this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements.	11/16/2021

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	3.1-51(c)		**·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the			

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	monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be	K 0918	**K 918** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The generators for (cottages	11/16/2021

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	inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. 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 52-week period. 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. 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		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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All generators have been placed on a schedule to be inspected weekly and exercised monthly. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct weekly inspections and monthly load test and cool down for all 6 generators. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule will be maintained by maintenance personnel, monitored by the administrator, and reported to	

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	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 book provided had monthly generator testing documented, but the documentation 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)		QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/19/21 and 10/20/21	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set**	

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	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. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 02 is identified as Cottage #3. The cottage has a capacity of 12 and had a census of 11 at the time of this survey. This Cottage serves as the Memory Care building for this facility. Quality Review completed on 10/26/21		**forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	
K 0324 SS=F Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in			

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	accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include:	K 0324	**K324** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the potential to be affected by the same deficient practice will be identified and what**	11/16/2021

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	Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection for Cottage #3, for the last six or 12-month period was not 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.		**corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. A semi-annual inspection schedule has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors	K 0345	**K345** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the fire alarm system are performed in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**	11/16/2021

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	(11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. 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		All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All 6 fire alarm systems have been placed on a schedule to have fire alarm system tested semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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. 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			

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	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. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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			

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	155846	A. BUILDING 02 B. WING	10/20/2021

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	provided contrary to this deficient finding. 3.1-19(b)			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen.	11/16/2021

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	authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices 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 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		**·How other residents having the 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 this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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	

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	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: 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 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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25,		immediately.	

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director stated he did not believe sprinkler system gauges had been recalibrated 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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=F Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include:	K 0511	**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The facility has obtained a letter of reliability from the company responsible for supplying natural gas to the generators in (cottages 1, 2, 3, 4, 5, 6). **·How other residents having the 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 this alleged deficient practice. A letter of reliability will be provided for the generators in (cottages 1, 2, 3, 4, 5, 6) **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	11/16/2021

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	Based on interview on 10/20/21 with the Executive Director at 10:48 a.m., the fuel source of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was determined that the fuel source of the five generators was not diesel but natural gas. During record review on 10/20/21 the documentation on 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)		The maintenance director or designee will ensure each generator has documentation of a reliable source of fuel in accordance with NFPA 101. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0712 SS=F Bldg. 02	NFPA 101 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	K 0712	**K712**	11/16/2021

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	facility failed to conduct quarterly fire drills for 4 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: 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)		**·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 shift for all 6 cottages. **·How other residents having the 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 this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The maintenance schedule 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.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in			

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	accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. 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 52-week period. The book	K 0918	**K 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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All generators have been placed on a schedule to be inspected weekly	11/16/2021

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	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 ensure that the deficient practice does not recur.** The maintenance director will conduct weekly inspections and monthly load test and cool down for all 6 generators. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	book provided had monthly generator testing documented, but the documentation 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. * Note - Buildings #3 and #4 share a generator) 3.1-19(b)			
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey 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	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	

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	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. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 03 is identified as Cottage #1. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 10/26/21			
K 0324 SS=F Bldg. 03	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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	155846	A. BUILDING 03 B. WING	10/20/2021

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	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection for Cottage #1, for the last six or 12-month period was not 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)	K 0324	**K324** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the 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 this alleged deficient practice. A semi-annual inspection schedule has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does**	11/16/2021

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			not recur. The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0345 SS=F Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1	K 0345	**K345**	11/16/2021

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	of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority		**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the fire alarm system are performed in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the 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 this alleged deficient practice. All 6 fire alarm systems have been placed on a schedule to have fire alarm system tested semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test	

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	representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. 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		semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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. 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			

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	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. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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)			
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include:	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen. **·How other residents having the 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 this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put**	11/16/2021

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	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 ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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 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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture			

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	date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director stated he did not believe sprinkler system gauges had been recalibrated 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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0355 SS=F Bldg. 03	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 3 of 3 portable fire extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility	K 0355	**K355** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All portable fire extinguishers for (cottages 1, 2, 3, 4, 5 and 6) were inspected by the maintenance director in November per NFPA requirements. All portable fire extinguishers will be inspected	11/16/2021

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	(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 requirements. **How other residents having the 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 this alleged deficient practice. All portable fire extinguishers will be inspected monthly per NFPA requirements. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The monthly inspection dates for the fire extinguishers are in the maintenance schedule to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	was unsure if the portable fire extinguishers were being checked. 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)			
K 0363 SS=E Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 12 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately all residents, staff, and visitors. 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, the corridor door to resident room F failed to close and latch into the frame. Upon inspection of the door it was noticed that the bottom hinge had all three screws pulled out of the door and would not allow the door to fully close or latch. Based on interview at the time of observations, the facility Executive Director acknowledged the aforementioned door and stated that he would have his Maintenance man remedy the problem as soon as he returned to work. 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)	K 0363	**K363** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The door in cottage 2, room F, was repaired to ensure the door closed completely and latched into the door frame. **·How other residents having the 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 this alleged deficient practice. All doors will be inspected to ensure they close completely and latch into the frame. **·What measures will be put into place or what systemic**	11/16/2021

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			changes will be made to ensure that the deficient practice does not recur. The monthly inspection dates for the doors are in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0511 SS=F Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110,	K 0511	**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	11/16/2021

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	2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on interview on 10/20/21 with the Executive Director at 10:48 a.m., the fuel source of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was determined that the fuel source of the five generators was not diesel but natural gas. During record review on 10/20/21 the documentation on 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		The facility has obtained a letter of reliability from the company responsible for supplying natural gas to the generators in (cottages 1, 2, 3, 4, 5, 6). **·How other residents having the 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 this alleged deficient practice. A letter of reliability will be provided for the generators in (cottages 1, 2, 3, 4, 5, 6) **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director or designee will ensure each generator has documentation of a reliable source of fuel in accordance with NFPA 101. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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	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. * Note - Buildings 3 and 4 share a joint generator* 3.1-19(b)		**and** The maintenance schedule 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.	
K 0712 SS=F Bldg. 03	NFPA 101 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 be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 10/19/21 with the Executive Director at 10:56 a.m., there were no	K 0712	**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 shift for all 6 cottages.	11/16/2021

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	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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are	

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			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 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 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	K 0781	**K781** **·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 was immediately removed from the cottage. **·How other residents having the 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 this alleged deficient practice. All cottages will be inspected to ensure they do not contain any space heating devices.	11/16/2021

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	corrected prior to my exit conference and my exiting of the facility. 3.1-19(b)		**·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include inspections for heating devices at unexpected times and under varying conditions. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0918 SS=F Bldg. 03	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life			

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of	K 0918	**K 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	11/16/2021

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	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 residents, staff, and visitors. Findings include: Based on record review on 10/19/21 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 52-week period. 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. 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		weekly inspection schedule. **·How other residents having the 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 this alleged deficient practice. All generators have been placed on a schedule to be inspected weekly and exercised monthly. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct weekly inspections and monthly load test and cool down for all 6 generators. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule will be maintained by maintenance personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance	

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	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 book provided had monthly generator testing documented, but the documentation 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)		checks, they will be remedied immediately.	
K 0000 Bldg. 04	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/19/21 and 10/20/21 Facility Number: 013753 Provider Number: 155846	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of**	

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	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. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 04 is identified as Cottage #4. The cottage has a capacity of 12 and had a census of 10 at the time of this survey. Quality Review completed on 10/26/21		**correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	
K 0324 SS=F Bldg. 04	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:			

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	* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 10/19/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection	K 0324	**K324** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the 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	11/16/2021

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

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	for Cottage #4, for the last six or 12-month period was not available for review. Based on interview at the time of record review, the 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 additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		the potential to be affected by this alleged deficient practice. A semi-annual inspection schedule has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0345 SS=F Bldg. 04	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system	K 0345	**K345** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the fire alarm system are performed in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the 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 this alleged deficient practice. All 6	11/16/2021

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	control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. 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.		fire alarm systems have been placed on a schedule to have fire alarm system tested semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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. 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)			

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	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. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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)			

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K 0353 SS=F Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen. **·How other residents having the potential to be affected by the same deficient practice will**	11/16/2021

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	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 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		**be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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: 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 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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested			

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	every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director stated he did not believe sprinkler system gauges had been recalibrated 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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0712 SS=F Bldg. 04	NFPA 101 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			

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	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 be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: 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 sixth 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)	K 0712	**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 shift for all 6 cottages. **·How other residents having the 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 this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	11/16/2021

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			The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0000 Bldg. 05	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey 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	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance**	

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	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. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 05 is identified as Cottage #5. The cottage has a capacity of 12 and had a census of 10 at the time of this survey. Quality Review completed on 10/26/21		**with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	
K 0324 SS=F Bldg. 05	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or			

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	limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection for Cottage #5, for the last six or 12-month period was not available for review. Based on interview at the time of record review, the	K 0324	**K324** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the 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 this alleged deficient practice. A semi-annual inspection schedule	11/16/2021

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	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 additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
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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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall include a listing of all devices tested with device type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems	K 0345	**K345** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the fire alarm system are performed in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the 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 this alleged deficient practice. All 6 fire alarm systems have been placed on a schedule to have fire alarm system tested	11/16/2021

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	(14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. 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		semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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. 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			

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	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. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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)			
K 0353 SS=F Bldg. 05	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**	11/16/2021

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	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 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		All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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: 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 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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.			

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	This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director stated he did not believe sprinkler system gauges had been recalibrated 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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=F Bldg. 05	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on interview on 10/20/21 with the Executive Director at 10:48 a.m., the fuel source of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was determined that the fuel source of the five generators was not diesel but natural gas. During record review on 10/20/21 the documentation on	K 0511	**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The facility has obtained a letter of reliability from the company responsible for supplying natural gas to the generators in (cottages 1, 2, 3, 4, 5, 6). **·How other residents having the 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 this alleged deficient practice. A letter of reliability will be provided for the generators in (cottages 1, 2, 3, 4, 5, 6) **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director or designee will ensure each generator has documentation of a reliable source of fuel in accordance with NFPA 101.	11/16/2021

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	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(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0712 SS=F Bldg. 05	NFPA 101 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 be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include:	K 0712	**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 shift	11/16/2021

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	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)		for all 6 cottages. **·How other residents having the 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 this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule will be maintained by maintenance	

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			personnel, monitored by the administrator, and reported to QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	
K 0918 SS=F Bldg. 05	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels			

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	and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. Findings include: Based on record review on 10/19/21 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 52-week period. 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	K 0918	**K 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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All generators have been placed on a schedule to be inspected weekly and exercised monthly. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does**	11/16/2021

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	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 10/19/21 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 book provided had monthly generator testing documented, but the documentation 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		**not recur.** The maintenance director will conduct weekly inspections and monthly load test and cool down for all 6 generators. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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)			
K 0000 Bldg. 06	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey 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 of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. This facility is requesting paper compliance for all cited deficiencies.**	

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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 06 is identified as Cottage #6. The cottage has a capacity of 12 and had a census of 0 (Zero) at the time of this survey. This building is currently unoccupied. Quality Review completed on 10/26/21			
K 0324 SS=F Bldg. 06	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 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 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire	K 0324	**K324** **·What corrective action(s)**	11/16/2021

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	suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:21 a.m., documentation of a kitchen fire suppression system inspection for Cottage #6, for the last six or 12-month period was not available for review. Based on interview at the time of record review, the 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 additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**will be accomplished for those residents found to have been affected by the deficient practice.** All hood systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November and will be on a semi-annual inspection schedule per NFPA requirements. **·How other residents having the 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 this alleged deficient practice. A semi-annual inspection schedule has been established between this facility and Koorsen. Next inspection is scheduled for November 2021. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The semi-annual inspection date for the hood system was placed in the maintenance schedule to ensure compliance.	

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			·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The maintenance schedule 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.	
K 0345 SS=F Bldg. 06	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to ensure the documentation for the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at Section 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4. The record shall	K 0345	**K345** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Maintenance and testing of the	11/16/2021

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	include a listing of all devices tested with device type, address, location, and test results indicated: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility.		fire alarm system are performed in accordance with NFPA 110. The semi-annual fire alarm system testing logs for (cottages 1, 2, 3, 4, 5 and 6) have been updated and all 6 cottages are on schedule to be tested semi-annually. **How other residents having the 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 this alleged deficient practice. All 6 fire alarm systems have been placed on a schedule to have fire alarm system tested semi-annually. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct a fire alarm system test semi-annually. This test will be documented and will be visually testing the control unit trouble signals, remote annunciators, initiating devices, notification appliances and magnetic hold-open devices.	

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	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		**·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	Section 14.4.5.3.3. This deficient practice could affect all occupants. 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			

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	This deficient practice could affect all building occupants. Findings include: Based on record review on 10/20/21 with the Executive Director at 10:28 a.m., no documentation for a semiannual visual inspection of the fire alarm system 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)			
K 0353 SS=F Bldg. 06	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices 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 documentation for quarterly sprinkler system inspections was available for review for the past 12 months. Based on interview at the time of	K 0353	**K353** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All sprinkler systems on campus (cottages 1, 2, 3, 4, 5 and 6) are scheduled to be inspected by Koorsen in November per NFPA requirements. All sprinkler systems are on a quarterly inspection and testing schedule per contract with -------Koorsen. **·How other residents having the 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 this alleged deficient practice. All sprinkler systems are on a quarterly inspection and testing schedule per NFPA requirements. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The quarterly inspection dates for the sprinkler systems are in the	11/16/2021

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	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: 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		maintenance schedule to ensure compliance. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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	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 observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in 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 10/19/21, the facility had supervised wet sprinkler systems and had a total of three water pressure gauges. The manufacture date of all three gauges was 2015 and was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to or could be located on the sprinkler system gauges. Based on interview at the time of the observations, the facility Executive Director			

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	stated he did not believe sprinkler system gauges had been recalibrated 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 information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=F Bldg. 06	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal)	K 0511	**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The facility has obtained a letter of reliability from the company responsible for supplying natural gas to the generators in (cottages 1, 2, 3, 4, 5, 6). **·How other residents having the potential to be affected by**	11/16/2021

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	(3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents. Findings include: Based on interview on 10/20/21 with the Executive Director at 10:48 a.m., the fuel source of the facilities fire generators was thought to be diesel. During a tour of the 6 cottages, it was determined that the fuel source of the five generators was not diesel but natural gas. During record review on 10/20/21 the documentation on 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)		**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 this alleged deficient practice. A letter of reliability will be provided for the generators in (cottages 1, 2, 3, 4, 5, 6) **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director or designee will ensure each generator has documentation of a reliable source of fuel in accordance with NFPA 101. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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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K 0712 SS=F Bldg. 06	NFPA 101 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 be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: 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)	K 0712	**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 shift for all 6 cottages. **·How other residents having the 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 this alleged deficient practice. Quarterly fire drills at unexpected times, under varying conditions, and at least quarterly on each shift will be held at the facility per NFPA requirements.	11/16/2021

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	3.1-51(c)		**·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance schedule will be reviewed and revised to include scheduled fire drills at unexpected times, under varying conditions, and at least quarterly on each shift per NFPA requirements. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule 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.	
K 0918 SS=F Bldg. 06	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the			

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	monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be	K 0918	**K 918** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The generators for (cottages	11/16/2021

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	inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. Findings include: Based on record review on 10/19/21 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 52-week period. 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. 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		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 will be identified and what corrective action(s) will be taken.** All elders, staff, and visitors have the potential to be affected by this alleged deficient practice. All generators have been placed on a schedule to be inspected weekly and exercised monthly. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance director will conduct weekly inspections and monthly load test and cool down for all 6 generators. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The maintenance schedule will be maintained by maintenance personnel, monitored by the administrator, and reported to	

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	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 10/19/21 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 book provided had monthly generator testing documented, but the documentation 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)		QAPI monthly. If concerns are noted during maintenance checks, they will be remedied immediately.	