	r of health and hu R medicare & medio					FORM APPROVED OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BL	JILDING	DNSTRUCTION	(X3) DATI COMF	E SURVEY PLETED
		155846	B. WI	NG		01/1	1/2023
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY		
RESTOR	ACY OF CARMEL			CARM	EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E RIATE	COMPLETION
TAG E 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
= 0000 Bldg	An Emergency Preparedness Survey was E 0000 This Plan of Correction of						
			E 00	000	This Plan of Correction cons		
	conducted by the I accordance with 42	ndiana Department of Health in 2 CFR 483.73.			this facility's written allegatio compliance for the deficienc cited. However, submission	ies	
	Survey Dates: 01/	10/23 and 01/11/23			Plan of Correction is not an admission that a deficiency of		
	Facility Number:	013753			or the that one was cited		
	Provider Number:				correctly. This Plan of Corre	ction	
	AIM Number: 20	1362150			is submitted to meet require established by the state and	ments	
	At this Emergency	Preparedness survey,			federal law.		
		el was found in compliance with					
	Medicare and Med	edness Requirements for licaid Participating Providers					
	and Suppliers, 42 (_FK 483.75					
	The facility has 72 the survey, the cen	certified beds. At the time of sus was 63.					
	Quality Review co	mpleted on 01/17/23					
K 0000							
Bldg. 01							
	-	e Recertification and State	K 0	000	This Plan of Correction cons		
		was conducted by the Indiana			this facility's written allegation		
	Department of Hea 483.90(a).	alth in accordance with 42 CFR			compliance for the deficienc cited. However, submission Plan of Correction is not an		
	Survey Dates: 01/10/23 and 01/11/23				admission that a deficiency of the that one was cited	exists	
	Facility Number:	013753			correctly. This Plan of Corre	ction	
	Provider Number:				is submitted to meet require		
	AIM Number: 20				established by the state and federal law.		
	At this Life Safety	Code survey, Restoracy of					
		not in compliance with					
	<u> </u>) VIDER/SUPPLIER REPRESENTATIVE'S S			TITLE		(X6) DATE

Dryan	Elliusay	01/21/2023
Brvan	Lindsav	01/27/2023
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRE	SENTATIVE'S SIGNATURE 111L	E (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

013753

PRINTED:

02/03/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 63 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 01 is identified as Cottage #2. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. Quality Review completed on 01/17/23 K 0324 **NFPA 101** SS=F **Cooking Facilities** Bldg. 01 **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 LL8021 Event ID: Facility ID: 013753 Page 2 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

02/03/2023

PRINTED:

02/03/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE * 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 K 0324 01/13/2023 Based on record review, observation, and Disclaimer: interview; the facility failed to ensure 1 of 1 This Plan of Correction constitutes kitchen fire suppression system was inspected this facility's written allegation of semiannually. NFPA 96, 2011 Edition, Standard for compliance for the deficiencies Ventilation Control and Fire Protection of cited. However, submission of this Commercial Cooking Operations, Section 11.2.1 Plan of Correction is not an states Maintenance of the fire-extinguishing admission that a deficiency exists systems and listed exhaust hoods containing a or the that one was cited constant or fire-activated water system that is correctly. This Plan of Correction listed to extinguish a fire in the grease removal is submitted to meet requirements devices. Hood exhaust plenums, and the exhaust established by the state and ducts shall be made by properly trained, qualified, federal law. and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This Alleged deficiency: Failed to deficient practice could affect all occupants in the ensure kitchen fire suppression cottage. system was inspected semiannually for the kitchen in Findings include: house 6. Based on review with the Maintenance Director Corrective Action for resident(s) on 01/10/23 at 10:01 a.m., documentation of a fire found to have deficient: The suppression system inspection for the Cottage #2 previous Maintenance man had let kitchen was not available for review. Based on the contract with the vendor lapse. interview at the time of record review, the The new maintenance director has Maintenance Director stated that he was hired in since entered into a new contract September 0f 2022 and the previous Maintenance with Nelbud, a fire suppression man had let the contract with the vendor lapse. He vendor, and we are now on a Event ID: LL8021 Facility ID: 013753 Page 3 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	СОМ	'e survey pleted 1/2023
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COT REEN HOUSE WAY FL . IN 46032)	
RESTO	(EACH DEFICIE REGULATORY O has since signed a and they are now o rotation for the kit testing in all six of During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION new contract with the vendor, on a semi-annual inspection chens fire suppression system	ID PREFIX TAG	EL, IN 46032 PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) semi-annual inspection re the kitchen's fire suppress system with the first serv scheduled for 2/28/2023. Identify other residents the same potential deficient: All 6 homes in community have the sam setup and will be under t semi-annual service cont in place. Measures put into place systemic changes: The Maintenance Director se services for kitchen fire suppression inspection for homes in our community February 28th, 2023. All have the same kitchen se will be under the same semi-annual service cont Plan to monitor perform maintain compliance: Maintenan Director or designee will the semi-annual mainten completed, as scheduled	ADDBE ROPRIATE otation for ssion ice having n our he kitchen he same tract put e or t up or all 6 for homes etup and tract. hance to ce ensure ance is	(X5) COMPLETIC DATE
				semi-annually. If any mis inspections occur, it will b reviewed and addressed meetings. Date of Compliance: 1	be in QAPI	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTI A. BUILDI B. WING	ple construction ing <u>01</u>	СОМ	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE		61	TREET ADDRESS, CITY, STATE, ZIF 16 GREEN HOUSE WAY ARMEL, IN 46032	, COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	II PRE TA	FIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETION DATE	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testin Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.4 Based on record re failed to provide w evidence the sprin been inspected and 4.6.12.1 requires a required for compl maintained in accor for the Inspection, Water-Based Fire 4.3.1 requires recor inspections, tests, components and sl authority having ju requires that recor performed (e.g., in the organization th	RKS information on non-required or partial er system.	K 0353	Disclaimer: This Plan of Correction this facility's written a compliance for the de cited. However, subre Plan of Correction is admission that a defin or the that one was co correctly. This Plan of is submitted to meet established by the st federal law. Alleged deficiency: no quarterly sprinkles inspection reports av review in the second quarter of 2022. The maintenance director	allegation of eficiencies nission of this not an ciency exists sited of Correction requirements ate and There were r system vailable for and third e previous	01/13/202	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/11/2023	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
RESTO	RACY OF CARMEL	-		MEL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	Ň	(X5)
PREFIX TAG	ί.	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	^{BE} RIATE	COMPLETION DATE
		evices shall be inspected		record of these tests.		Diffe
	quarterly to verify	they are free of physical				
	damage. NFPA 25	, 5.3.3.1 requires the mechanical		Corrective Action for resid	ent(s)	
	waterflow alarm d	evices including, but not limited		found to have deficient: ⊤	he	
	to, water motor go	ngs, shall be tested quarterly.		new Maintenance Director h	nad	
	5.3.3.2 requires va	ne-type and pressure		completed quarterly sprinkle	er	
	switch-type waterf	flow alarm devices shall be		system inspection for the 4t	h	
	tested semiannuall	y. This deficient practice could		quarter of 2022 on 11/2/202	22 by	
	affect all residents facility.	, staff, and visitors in the		Koorsen Fire & Security cor	npany.	
	Findings include:			Identify other residents ha the same potential deficier	-	
				The other 5 homes in the		
	Based on review w	vith the Maintenance Director		community did not have the	2nd	
	on 01/10/23 at 10:	22 a.m., there was no quarterly		and 3rd quarterly sprinkler		
	sprinkler system ir	spection report available for		inspection reports, but were		
	review in the second	nd quarter (April, May, and		completed by the new		
	June) of 2022. Fur	thermore, there was no quarterly		maintenance director for the	e 4th	
		spection documentation for the August, and September) of		quarter of 2022 on 11/2/202	2.	
	2022 as well. Base	ed on an interview at the time of		Measures put into place or		
	record review, the	Maintenance Director		systemic changes: The		
	acknowledged the	re was no written		Maintenance Director or des	signee	
	documentation ava	ailable to show the sprinkler		will conduct quarterly sprink	ler	
	system had been in	nspected during the second and		system inspections and kee		
	third quarters of 20	022.		them in the preventative		
				maintenance logbook.		
	During the exit con	nference with the Maintenance		_		
	Director, the visiti	ng Maintenance Director, and				
	the facility Admin	istrator via telephone on		Plan to monitor performan	ce to	
	01/11/23 at 1:30 p	.m., no additional information or		maintain compliance: The		
	evidence could be	provided contrary to this		Maintenance Director or dea	signee	
	deficient finding.			will audit sprinkler system		
				inspections quarterly for the	next 4	
	3.1-19(b)			quarters and until 100% of		
				compliance is maintained. If	any	
				compliance trends are ident	ified,	
				they will be reviewed in QAI	PI	
				meetings.		
			1			

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	r í	JILDING	ONSTRUCTION 01	COMI	te survey Mpleted 11/2023	
	PROVIDER OR SUPPLIE		-	616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
K 0712 SS=F Bldg. 01	alarm signal and conditions. Fire d and unexpected f conditions, at lea The staff is famili aware that drills a routine. Where c 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record re failed to conduct q quarters. LSC 19.7 conducted quarter conditions. This do residents, staff, and Findings include: Based on review w on 01/10/23 at 9:44 following fire drill a) fire drills condu (April, May, or Jun third shifts. b) fire drills condu	hay be used instead of 19.7.1.7 view and interview, the facility uarterly fire drills for 2 of 3 1.6 requires drills to be y on each shift under varied efficient practice affects all d visitors. with the Maintenance Director 6 a.m., documentation of the s could be provided: cted in the second quarter ne) of 2022 on the second or cted in the third quarter (July,	К 0	712	Date of Compliance: 1/13/2 Disclaimer: This Plan of Correction const this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency effort or the that one was cited correctly. This Plan of Correct is submitted to meet requirer established by the state and federal law. Alleged deficiency: There w no monthly fire drill reports available for review in the set	itutes n of es of this xists ction nents ere cond	01/13/202	
sec Bas	second shifts. Based on interview	ber) of 2022 on the first or at the time of record review, pirector acknowledged that			and third quarter of 2022. The previous maintenance directed not keep record of these drills	or did		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/11/2023	
NAME OF I	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD		
RESTOF	RACY OF CARMEL	-		MEL, IN 46032		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		itional available fire drill		Corrective Action for reside		
		iew as of the time of this		found to have deficient: Th		
	survey.			new Maintenance Director s		
	During the oxit of	nference with the Maintenance		in September and has comp		
	e	ng Maintenance Director, and		monthly fire drills in home 6 September, October, Novem		
		istrator via telephone on		and December of 2022.		
	-	.m., no additional information or				
	_	provided contrary to this		Identify other residents have	/ina	
	deficient finding.			the same potential deficien	-	
				The other 5 homes in the		
	3.1-19(b)			community did not have fire	drill	
	3.1-51(c)			records available for the 2nd	and	
				3rd quarter, but were comple		
				by the new maintenance dire		
				for September, October, Nov and December of 2022.	/ember	
				Measures put into place or systemic changes: The Maintenance Director or des will conduct monthly fire drill keep them in the preventive maintenance logbook.	-	
				Plan to monitor performance maintain compliance: The Maintenance Director or des will audit that fire alarm drills conducted monthly for the ne months and until 100% of compliance is maintained. If compliance trends are identit they will be reviewed in QAF meetings.	ignee are ext 6 any fied,	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155846	NUMBER A. BUILDIN B. WING		01	COMPLETED 01/11/2023	
NAME OF 1	PROVIDER OR SUPPLIE	GR			ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY		
RESTOF	RACY OF CARMEL	-			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG	REGULATORY C	DR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY) Date of Compliance: 1/13	3/23	DATE
< 0000							
Bldg. 02							
Didg. 02	A Life Safety Cod	e Recertification and State	K 0	000	This Plan of Correction cor	stitutes	
		was conducted by the Indiana	1.0		this facility's written allegat		
	Department of Heat 483.90(a).	alth in accordance with 42 CFR			compliance for the deficien cited. However, submission	cies	
	Survey Dates: 01/	/10/23 and 01/11/23			Plan of Correction is not ar admission that a deficiency		
	Facility Number:	013753			or the that one was cited	oction	
	Provider Number:				correctly. This Plan of Corr is submitted to meet require		
	AIM Number: 20				established by the state an federal law.		
	At this Life Safety	Code survey, Restoracy of					
	-	not in compliance with					
	Requirements for	Participation in					
	Medicare/Medicai	d, 42 CFR Subpart 483.90(a),					
		Fire and the 2012 edition of the					
		ection Association (NFPA) 101,					
		LSC), Chapter 19, Existing pancies and 410 IAC 16.2.					
		ts of six buildings (01 through is a one-story cottage					
		of Type V (111) construction and					
		red. Each cottage has a fire alarm					
		e detection in the corridors,					
		corridors and hard-wired smoke					
		sident rooms. The entire facility					
		2 and had a census of 63 at the					
	time of this survey	7.					
	All areas where re	sidents have customary access					
	-	nd all areas providing facility					
	-	nklered, with exception of a					
	separate detached	administration building.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155846 B. WING 01/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Building 02 is identified as Cottage #3. The cottage has a capacity of 12 and had a census of 12 at the time of this survey. This Cottage serves as the Memory Care building for this facility. Quality Review completed on 01/17/23 K 0324 **NFPA 101** SS=F **Cooking Facilities** Bldg. 02 **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, observation, and K 0324 **Disclaimer:** 01/13/2023 interview; the facility failed to ensure 1 of 1 This Plan of Correction constitutes kitchen fire suppression system was inspected this facility's written allegation of semiannually. NFPA 96, 2011 Edition, Standard for compliance for the deficiencies Ventilation Control and Fire Protection of cited. However, submission of this Commercial Cooking Operations, Section 11.2.1 Plan of Correction is not an states Maintenance of the fire-extinguishing admission that a deficiency exists systems and listed exhaust hoods containing a or the that one was cited LL8021 Page 10 of 46 Event ID: Facility ID: 013753 If continuation sheet FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:

02/03/2023

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	COM	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE		616 G	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY			
RESTOR	RACY OF CARMEL		CARM	IEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETIC DATE	
TAG	constant or fire-act listed to extinguish devices. Hood exh ducts shall be mad and certified perso having jurisdiction deficient practice of cottage. Findings include: Based on review w on 01/10/23 at 10: suppression system kitchen was not av interview at the tim Maintenance Direct September 0f 2022 man had let the co has since signed a and they are now of rotation for the kit testing in all six of During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p	ivated water system that is a fire in the grease removal aust plenums, and the exhaust e by properly trained, qualified, n(s) acceptable to the authority at lease every six months. This could affect all occupants in the rith the Maintenance Director 02 a.m., documentation of a fire n inspection for the Cottage #3 ailable for review. Based on ne of record review, the extor stated that he was hired in and the previous Maintenance ntract with the vendor lapse. He new contract with the vendor, on a semi-annual inspection chens fire suppression system	TAG	 correctly. This Plan of Corris submitted to meet requires the state and federal law. Alleged deficiency: Failed ensure kitchen fire suppressystem was inspected semiannually for the kitcher house 6. Corrective Action for rest found to have deficient: previous Maintenance matthe contract with the vender The new maintenance diressince entered into a new cowith Nelbud, a fire suppressives when annual inspection root the kitchen's fire suppressives system with the first service scheduled for 2/28/2023. Identify other residents in the same potential deficient: All 6 homes in a community have the same setup and will be under the semi-annual service contration in place. Measures put into place a systemic changes: The Maintenance Director set a services for kitchen fire 	rements ad d to ssion en in ident(s) The n had let or lapse. ector has contract ssion n a tation for ion ce having our e kitchen e same act put	DATE	
				Maintenance Director set	all 6 or nomes		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155846	A. BUILDING B. WING	02	COMPLETED 01/11/2023		
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP	COD		
RESTOR	ACY OF CARMEL			GREEN HOUSE WAY MEL, IN 46032			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION Y CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG			DATE	
				will be under the same semi-annual service c			
				Plan to monitor performaintain compliance: Mainter Director or designee withe semi-annual main completed, as schedu semi-annually. If any inspections occur, it wireviewed and address meetings.	nance vill ensure tenance is iled missed <i>i</i> ll be		
(0353 SS=F Bldg. 02	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of system inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA	RKS information on non-required or partial		Date of Compliance:	1/13/2023		

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155846	B. WING		01/11/2023	
IAME OF	PROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP COD		
	RACY OF CARMEL			REEN HOUSE WAY		
				EL, IN 46032		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Based on record re	view and interview, the facility	K 0353	Disclaimer:	01/13/202.	
	failed to provide w	ritten documentation or other		This Plan of Correction constit	utes	
	evidence the sprink	tler system components had		this facility's written allegation	of	
	been inspected and	tested for 2 of 4 quarters. LSC		compliance for the deficiencies	6	
	4.6.12.1 requires an	ny device, equipment or system		cited. However, submission of	this	
	required for compl	iance with this Code be		Plan of Correction is not an		
	maintained in acco	rdance with applicable NFPA		admission that a deficiency ex	ists	
	requirements. Spri	nkler systems shall be properly		or the that one was cited		
	maintained in acco	rdance with NFPA 25, Standard		correctly. This Plan of Correcti	on	
	for the Inspection,	Testing, and Maintenance of		is submitted to meet requireme		
	-	Protection Systems. NFPA 25,		established by the state and		
		rds shall be made for all		federal law.		
	-	and maintenance of the system				
	-	all be made available to the		Alleged deficiency: There we	re	
	-	risdiction upon request. 4.3.2		no quarterly sprinkler system		
		Is shall indicate the procedure		inspection reports available for		
	-	spection, test, or maintenance),		review in the second and third		
		at performed the work, the				
	-	e. NFPA 25, 5.2.5 requires that		quarter of 2022. The previous		
		-		maintenance director did not k	eep	
		evices shall be inspected		record of these tests.		
		they are free of physical				
		5.3.3.1 requires the mechanical		Corrective Action for residen	t(s)	
		evices including, but not limited		found to have deficient: The		
	-	ngs, shall be tested quarterly.		new Maintenance Director had		
	-	ne-type and pressure		completed quarterly sprinkler		
		low alarm devices shall be		system inspection for the 4th		
		y. This deficient practice could		quarter of 2022 on 11/2/2022	-	
		staff, and visitors in the		Koorsen Fire & Security compa	any.	
	facility.					
				Identify other residents having	Ig	
	Findings include:			the same potential deficient:		
				The other 5 homes in the		
	Based on review w	ith the Maintenance Director		community did not have the 2r	nd	
	on 01/10/23 at 10:2	23 a.m., there was no quarterly		and 3rd quarterly sprinkler		
	sprinkler system in	spection report available for		inspection reports, but were		
	review in the secon	nd quarter (April, May, and		completed by the new		
		hermore, there was no quarterly		maintenance director for the 4	th	
		spection documentation for the		quarter of 2022 on 11/2/2022.		
		August, and September) of				
				Measures put into place or		
	2022 as well. Based on an interview at the time of					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPLE	CONSTRUCTION	E SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		r í	PLETED		
AND PLAN	OF CORRECTION	155846	A. BUILDING <u>UZ</u> B. WING			1/2023		
		155640	B. WING			1/2023		
NAME OF I	PROVIDER OR SUPPLIE	D	STRE	ET ADDRESS, CITY, STATE, ZIP C	OD			
NAME OF I	ROVIDER OR SUPPLIE	ĸ	616	616 GREEN HOUSE WAY				
RESTOR	RACY OF CARMEL		CAR	MEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH	HOULD BE	COMPLETIO		
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE		
into		Maintenance Director	Into	systemic changes: Th		DITL		
	acknowledged the			Maintenance Director				
	-	ilable to show the sprinkler			•			
		spected during the second and		will conduct quarterly s				
				system inspections and them in the preventativ				
	third quarters of 20)22.						
				maintenance logbook.				
	-	nference with the Maintenance						
		ng Maintenance Director, and						
		istrator via telephone on		Plan to monitor perform				
	-	.m., no additional information or		maintain compliance:				
		provided contrary to this		Maintenance Director	•			
	deficient finding.			will audit sprinkler syst				
				inspections quarterly for				
	3.1-19(b)			quarters and until 1009				
				compliance is maintain				
				compliance trends are	identified,			
				they will be reviewed ir	n QAPI			
				meetings.				
				Date of Compliance:	1/13/23			
0712	NFPA 101							
SS=F	Fire Drills							
Bldg. 02	Fire Drills							
		the transmission of a fire						
	-	simulation of emergency fire						
		rills are held at expected						
	and unexpected	times under varying						
	conditions, at lea	st quarterly on each shift.						
	The staff is famili	ar with procedures and is						
	aware that drills a	are part of established						
		Irills are conducted between						
	9:00 PM and 6:0) AM, a coded						
		nay be used instead of						
	audible alarms.	,						
	19.7.1.4 through	19.7.1.7						
		view and interview, the facility	K 0712	Disclaimer:		01/13/202		
		the full interview, the fulling	K 0/12	Disciulier.		01/13/202		

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY	
RESTOR	RACY OF CARMEL		CARMI	EL, IN 46032	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG		
	 quarters. LSC 19.7 conducted quarteril conditions. This do residents, staff, and Findings include: Based on review w on 01/10/23 at 9:4 following fire drill a) fire drills condu (April, May, or Jun third shifts. b) fire drills condu August, or Septem second shifts. Based on interview the Maintenance D there were no addi documents for revisurvey. During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p 	uarterly fire drills for 2 of 3 2.1.6 requires drills to be y on each shift under varied efficient practice affects all d visitors. with the Maintenance Director 6 a.m., documentation of the s could be provided: cted in the second quarter ne) of 2022 on the second or cted in the third quarter (July, ber) of 2022 on the first or w at the time of record review, Director acknowledged that tional available fire drill tew as of the time of this nference with the Maintenance ng Maintenance Director, and istrator via telephone on .m., no additional information or provided contrary to this		This Plan of Correction constit this facility's written allegation compliance for the deficiencie cited. However, submission of Plan of Correction is not an admission that a deficiency ex or the that one was cited correctly. This Plan of Correct is submitted to meet requirem established by the state and federal law. Alleged deficiency: There we no monthly fire drill reports available for review in the sect and third quarter of 2022. The previous maintenance director not keep record of these drills Corrective Action for resident found to have deficient: The new Maintenance Director sta in September and has comple monthly fire drills in home 6 in September, October, Novemb and December of 2022. Identify other residents havin the same potential deficient: The other 5 homes in the community did not have fire du records available for the 2nd a 3rd quarter, but were complete by the new maintenance director for September, October, Nove and December of 2022.	of s i this i th
				systemic changes: The Maintenance Director or desig	Inee

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	ì í	LDING	DNSTRUCTION 02	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE			616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	•	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
					will conduct monthly fire drill keep them in the preventive maintenance logbook.		
					Plan to monitor performan maintain compliance: The Maintenance Director or des will audit that fire alarm drills conducted monthly for the n months and until 100% of compliance is maintained. If compliance trends are ident they will be reviewed in QAF meetings.	signee s are ext 6 [:] any ified,	
K 0000					Date of Compliance: 1/13/	/23	
Bldg. 03	Licensure Survey Department of Hea 483.90(a). Survey Dates: 01/ Facility Number: Provider Number: AIM Number: 20 At this Life Safety Carmel was found Requirements for I Medicare/Medicai	155846 1362150 Code survey, Restoracy of not in compliance with	K 00	00	This Plan of Correction cons this facility's written allegatic compliance for the deficience cited. However, submission Plan of Correction is not an admission that a deficiency or the that one was cited correctly. This Plan of Corre is submitted to meet require established by the state and federal law.	on of ies of this exists ection ments	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 155846 B. WING 01/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 63 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 10 at the time of this survey. Quality Review completed on 01/17/23 K 0324 **NFPA 101** SS=F **Cooking Facilities** Bldg. 03 **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 LL8021 Event ID: Facility ID: 013753 Page 17 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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02/03/2023

PRINTED: 02/03/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	î î	ILDING	DNSTRUCTION 03	(X3) DATE COMPL 01/11/	ETED
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	 with 30 or fewer p conditions under f Cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the co 18.3.2.5.1 through through 19.3.2.5.5 Based on record rev interview; the facilit kitchen fire suppressemiannually. NFP. Ventilation Control Commercial Cookinstates Maintenance systems and listed of constant or fire-actil listed to extinguish devices. Hood exhad ducts shall be made and certified person having jurisdiction deficient practice of cottage. Findings include: Based on review w on 01/10/23 at 10:0 suppression system kitchen was not ava interview at the tim Maintenance Direct September 0f 2022 man had let the com has since signed a r and they are now of 	in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be rdous areas, but shall not rridor. n 18.3.2.5.4, 19.3.2.5.1	K 01	324	Disclaimer: This Plan of Correction constitut this facility's written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exi or the that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law. Alleged deficiency: Failed to ensure kitchen fire suppression system was inspected semiannually for the kitchen in house 6. Corrective Action for resident found to have deficient: The previous Maintenance man have the contract with the vendor lag The new maintenance director since entered into a new contra- with Nelbud, a fire suppression vendor, and we are now on a semi-annual inspection rotation the kitchen's fire suppression system with the first service	of this ists on ents n t(s) d let pse. has act	01/13/2023

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Event ID: LL8021

Facility ID: 013753

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 03	COM	e survey pleted 1/2023
	PROVIDER OR SUPPLIE		616 GF	ADDRESS, CITY, STATE, ZIP CO REEN HOUSE WAY EL, IN 46032	DD	
RESTOR (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O testing in all six of During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	EL, IN 46032 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AT DEFICIENCY) Scheduled for 2/28/2023 Identify other resident the same potential deficient: All 6 homes community have the sa setup and will be under semi-annual service co in place. Measures put into place systemic changes: The Maintenance Director s services for kitchen fire suppression inspection homes in our communit February 28th, 2023. A have the same kitchen will be under the same semi-annual service co Plan to monitor performaintain compliance: Maintena Director or designee wi the semi-annual mainter completed, as schedule semi-annually. If any m	a. a. b. b. b	(X5) COMPLETION DATE
(0353 SS=F Bldg. 03		- Maintenance and Testing - Maintenance and Testing		inspections occur, it will reviewed and addresse meetings. Date of Compliance:	l be d in QAPI	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 Based on record review and interview, the facility K 0353 Disclaimer: 01/13/2023 failed to provide written documentation or other This Plan of Correction constitutes evidence the sprinkler system components had this facility's written allegation of been inspected and tested for 2 of 4 quarters. LSC compliance for the deficiencies 4.6.12.1 requires any device, equipment or system cited. However, submission of this required for compliance with this Code be Plan of Correction is not an maintained in accordance with applicable NFPA admission that a deficiency exists requirements. Sprinkler systems shall be properly or the that one was cited maintained in accordance with NFPA 25, Standard correctly. This Plan of Correction for the Inspection, Testing, and Maintenance of is submitted to meet requirements Water-Based Fire Protection Systems. NFPA 25, established by the state and 4.3.1 requires records shall be made for all federal law. inspections, tests, and maintenance of the system components and shall be made available to the Alleged deficiency: There were authority having jurisdiction upon request. 4.3.2 no quarterly sprinkler system requires that records shall indicate the procedure inspection reports available for performed (e.g., inspection, test, or maintenance), review in the second and third the organization that performed the work, the guarter of 2022. The previous results, and the date. NFPA 25, 5.2.5 requires that maintenance director did not keep waterflow alarm devices shall be inspected record of these tests. quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical Corrective Action for resident(s) LL8021 Event ID: Facility ID: 013753 Page 20 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

02/03/2023

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 2 03	(X3) DATE SURVEY COMPLETED 01/11/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY		
RESTOR	RACY OF CARMEL	-		EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	 waterflow alarm d to, water motor go 5.3.3.2 requires va switch-type water: tested semiannuall affect all residents facility. Findings include: Based on review v on 01/10/23 at 10: sprinkler system in review in the seco June) of 2022. Fun sprinkler system in third quarter (July 2022 as well. Base record review, the acknowledged the documentation avai system had been in third quarters of 2 During the exit co Director, the visiti the facility Admin 01/11/23 at 1:30 p 	evices including, but not limited ongs, shall be tested quarterly. me-type and pressure flow alarm devices shall be ly. This deficient practice could , staff, and visitors in the vith the Maintenance Director 24 a.m., there was no quarterly aspection report available for and quarter (April, May, and thermore, there was no quarterly aspection documentation for the , August, and September) of ed on an interview at the time of Maintenance Director re was no written ailable to show the sprinkler aspected during the second and		found to have deficient: The new Maintenance Director had completed quarterly sprinkler system inspection for the 4th quarter of 2022 on 11/2/2022 b Koorsen Fire & Security compar- Identify other residents having the same potential deficient: The other 5 homes in the community did not have the 2nd and 3rd quarterly sprinkler inspection reports, but were completed by the new maintenance director for the 4th quarter of 2022 on 11/2/2022. Measures put into place or systemic changes: The Maintenance Director or design will conduct quarterly sprinkler system inspections and keep them in the preventative maintenance logbook. Plan to monitor performance to maintain compliance: The Maintenance Director or design will audit sprinkler system inspections quarterly for the ney quarters and until 100% of compliance is maintained. If any compliance trends are identified they will be reviewed in QAPI meetings.	y ny. g d h ee ee tt 4	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	r í	JILDING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE			616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETIO DATE
K 0712 SS=F Bldg. 03	alarm signal and conditions. Fire d and unexpected f conditions, at lea The staff is famili aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record re failed to conduct q quarters. LSC 19.7 conducted quarterl conditions. This de residents, staff, and Findings include: Based on review w on 01/10/23 at 9:44 following fire drill a) fire drills condu (April, May, or Jun third shifts. b) fire drills condu August, or Septem second shifts. Based on interview the Maintenance D there were no addi	hay be used instead of 19.7.1.7 view and interview, the facility uarterly fire drills for 2 of 3 1.6 requires drills to be y on each shift under varied efficient practice affects all	КО	712	Disclaimer: This Plan of Correction of this facility's written allega compliance for the deficient cited. However, submission Plan of Correction is not a admission that a deficient or the that one was cited correctly. This Plan of Co is submitted to meet requires established by the state a federal law. Alleged deficiency: There no monthly fire drill report available for review in the and third quarter of 2022. previous maintenance dir not keep record of these of Corrective Action for ress found to have deficient: new Maintenance Director	onstitutes ation of encies on of this an cy exists rrection irements and e were s second The ector did drills. sident(s)	01/13/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	•	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	During the exit con Director, the visiting the facility Admin 01/11/23 at 1:30 p.	A LSC IDENTIFYING INFORMATION		 in September and has comp monthly fire drills in home 6 is September, October, Novem and December of 2022. Identify other residents have the same potential deficient. The other 5 homes in the community did not have fire of records available for the 2nd 3rd quarter, but were complete by the new maintenance direct for September, October, Nov- and December of 2022. Measures put into place or systemic changes: The Maintenance Director or des will conduct monthly fire drills keep them in the preventive maintenance Director or des will audit that fire alarm drills conducted monthly for the ne months and until 100% of compliance is maintained. If compliance trends are identifit they will be reviewed in QAP meetings. 	leted in aber /ing t: drill and eted ector /ember ignee s and :e to ignee are ext 6 any fied,	
				Date of Compliance: 1/13/2	23	

Event ID: LL8021 Facility ID: 013753

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) MITT	TIDI E CO	NSTRUCTION	(X3) DATE	SUDVEN
	NT OF DEFICIENCIES					· /	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155846	A. BUILDING <u>O</u> B. WING		04	COMPLETED 01/11/2023	
					DDRESS, CITY, STATE, ZIP COD	• .,	
NAME OF	PROVIDER OR SUPPLIE	ER			EEN HOUSE WAY		
RESTOR	RACY OF CARMEL	-		CARME	L, IN 46032		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	^	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
< 0000							
Bldg. 04							
		le Recertification and State	K 000	0	This Plan of Correction const	itutes	
	Licensure Survey	was conducted by the Indiana			this facility's written allegation	ı of	
	Department of He	alth in accordance with 42 CFR			compliance for the deficiencie	s	
	483.90(a).				cited. However, submission of Plan of Correction is not an	f this	
	Survey Dates: 01/	/10/23 and 01/11/23			admission that a deficiency e or the that one was cited	xists	
	Facility Number:	013753			correctly. This Plan of Correc	tion	
	Provider Number:				is submitted to meet requirem		
	AIM Number: 20	1362150			established by the state and		
	At this Life Safety	Code survey, Restoracy of			federal law.		
		not in compliance with					
	Requirements for	-					
	-	id, 42 CFR Subpart 483.90(a),					
		Fire and the 2012 edition of the					
		ection Association (NFPA) 101,					
		(LSC), Chapter 19, Existing					
		pancies and 410 IAC 16.2.					
	The facility consis	sts of six buildings (01 through					
	06). Each building	g is a one-story cottage					
	determined to be o	of Type V (111) construction and					
		red. Each cottage has a fire alarm					
		e detection in the corridors,					
	areas open to the c	corridors and hard-wired smoke					
	detectors in the res	sident rooms. The entire facility					
	has a capacity of 7	2 and had a census of 63 at the					
	time of this survey	/.					
	All areas where re	sidents have customary access					
		and all areas providing facility					
		nklered, with exception of a					
	-	administration building.					
	-	ntified as Cottage #4. The city of 12 and had a census of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 04 COMPLETED 155846 B. WING 01/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 10 at the time of this survey. This Cottage serves as the Memory Care building for this facility. Quality Review completed on 01/17/23 K 0324 **NFPA 101** SS=F **Cooking Facilities** Bldg. 04 **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, observation, and K 0324 **Disclaimer:** 01/13/2023 interview; the facility failed to ensure 1 of 1 This Plan of Correction constitutes kitchen fire suppression system was inspected this facility's written allegation of semiannually. NFPA 96, 2011 Edition, Standard for compliance for the deficiencies Ventilation Control and Fire Protection of cited. However, submission of this Commercial Cooking Operations, Section 11.2.1 Plan of Correction is not an states Maintenance of the fire-extinguishing admission that a deficiency exists systems and listed exhaust hoods containing a or the that one was cited constant or fire-activated water system that is correctly. This Plan of Correction listed to extinguish a fire in the grease removal is submitted to meet requirements LL8021 Page 25 of 46 Event ID: Facility ID: 013753 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED:

02/03/2023

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 04	(X3) DATE COMPI 01/11	LETED
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY		
RESTOR	RACY OF CARME	-		EL, IN 46032		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	ION D BE DPRIATE	(X5) COMPLETIC
TAG		DR LSC IDENTIFYING INFORMATION naust plenums, and the exhaust	TAG	DEFICIENCY) established by the state ar		DATE
	ducts shall be mad	le by properly trained, qualified, on(s) acceptable to the authority		federal law.	IU	
	having jurisdiction	at lease every six months. This could affect all occupants in the		Alleged deficiency: Faile ensure kitchen fire suppre- system was inspected semiannually for the kitche	ssion	
	Findings include:			house 6.		
	on 01/10/23 at 10: suppression system kitchen was not av interview at the tin Maintenance Dire September 0f 2022 man had let the co- has since signed a and they are now rotation for the kit testing in all six of			Corrective Action for rest found to have deficient: previous Maintenance man the contract with the vende The new maintenance dire since entered into a new c with Nelbud, a fire suppress vendor, and we are now o semi-annual inspection rot the kitchen's fire suppress system with the first service scheduled for 2/28/2023.	The n had let or lapse. ector has contract ssion n a tation for ion ce	
	Director, the visiti the facility Admin 01/11/23 at 1:30 p	nference with the Maintenance ing Maintenance Director, and istrator via telephone on .m., no additional information or provided contrary to this		Identify other residents h the same potential deficient: All 6 homes in a community have the same setup and will be under the semi-annual service contra in place. Measures put into place of systemic changes: The Maintenance Director set of services for kitchen fire suppression inspection for homes in our community for February 28th, 2023. All F have the same kitchen set will be under the same semi-annual service contra	our e kitchen e same act put or up r all 6 or nomes rup and	

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		MB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>04</u>	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE		616 G	TADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY 1EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE
				Plan to monitor performan maintain compliance: Maintenance Director or designee will en the semi-annual maintenan completed, as scheduled semi-annually. If any missa inspections occur, it will be reviewed and addressed in meetings.	isure ice is ed	
K 0353 SS=F Bldg. 04	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testi Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provide		Aaintenance and Testing and standpipe systems d, and maintained in PA 25, Standard for the and Maintaining of otection Systems. lesign, maintenance, g are maintained in a readily available. rstem last checked	8/2023		
	coverage for any automatic sprink 9.7.5, 9.7.7, 9.7.4 Based on record re	RKS information on non-required or partial er system.	K 0353	Disclaimer: This Plan of Correction cor	stitutes	01/13/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	04	COMPLETED
		155846	B. WING		01/11/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				REEN HOUSE WAY	
RESTOR	RACY OF CARMEL	-	CARMI	EL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	evidence the sprin	kler system components had		this facility's written allegation	of
	been inspected and	l tested for 2 of 4 quarters. LSC		compliance for the deficiencies	;
	4.6.12.1 requires a	ny device, equipment or system		cited. However, submission of	this
	required for compl	iance with this Code be		Plan of Correction is not an	
	maintained in acco	rdance with applicable NFPA		admission that a deficiency exi	sts
	requirements. Spr	inkler systems shall be properly		or the that one was cited	
	maintained in acco	rdance with NFPA 25, Standard		correctly. This Plan of Correction	on
	for the Inspection,	Testing, and Maintenance of		is submitted to meet requireme	ents
	Water-Based Fire	Protection Systems. NFPA 25,		established by the state and	
	4.3.1 requires reco	rds shall be made for all		federal law.	
	inspections, tests,	and maintenance of the system			
	components and sl	all be made available to the		Alleged deficiency: There we	re
	authority having ju	risdiction upon request. 4.3.2		no quarterly sprinkler system	
	requires that recor	ds shall indicate the procedure		inspection reports available for	
	performed (e.g., in	spection, test, or maintenance),		review in the second and third	
	the organization th	at performed the work, the		quarter of 2022. The previous	
	results, and the dat	e. NFPA 25, 5.2.5 requires that		maintenance director did not k	
	waterflow alarm d	evices shall be inspected		record of these tests.	
	quarterly to verify	they are free of physical			
	damage. NFPA 25	, 5.3.3.1 requires the mechanical		Corrective Action for residen	t(s)
	waterflow alarm d	evices including, but not limited		found to have deficient: The	
	to, water motor go	ngs, shall be tested quarterly.		new Maintenance Director had	
	5.3.3.2 requires va	ne-type and pressure		completed quarterly sprinkler	
	switch-type water	low alarm devices shall be		system inspection for the 4th	
	tested semiannuall	y. This deficient practice could		quarter of 2022 on 11/2/2022	by
	affect all residents	, staff, and visitors in the		Koorsen Fire & Security compa	
	facility.				
				Identify other residents havin	ıg
	Findings include:			the same potential deficient:	
				The other 5 homes in the	
	Based on review w	vith the Maintenance Director		community did not have the 2r	ıd
	on 01/10/23 at 10:	25 a.m., there was no quarterly		and 3rd quarterly sprinkler	
	sprinkler system in	spection report available for		inspection reports, but were	
	review in the second	nd quarter (April, May, and		completed by the new	
	June) of 2022. Fur	thermore, there was no quarterly		maintenance director for the 4t	íh
		spection documentation for the		quarter of 2022 on 11/2/2022.	
	third quarter (July,	August, and September) of			
		d on an interview at the time of		Measures put into place or	
		Maintenance Director		systemic changes: The	
	acknowledged the			Maintenance Director or design	nee

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>04</u>	(X3) DATE SURVEY COMPLETED 01/11/2023	
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032		
INE STOI				LL, IN 40052		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE (X5) COMPLETION DATE	
	system had been it third quarters of 2 During the exit co Director, the visiti	ailable to show the sprinkler nspected during the second and 022. nference with the Maintenance ng Maintenance Director, and istrator via telephone on		will conduct quarterly sprinkle system inspections and keep them in the preventative maintenance logbook.		
	01/11/23 at 1:30 p	.m., no additional information or provided contrary to this		maintain compliance: The Maintenance Director or desi will audit sprinkler system inspections quarterly for the quarters and until 100% of	gnee next 4	
				compliance is maintained. If compliance trends are identif they will be reviewed in QAP meetings.	ïed,	
				Date of Compliance: 1/13/2	23	
< 0712 SS=F Bldg. 04	alarm signal and conditions. Fire of and unexpected conditions, at lea The staff is famil aware that drills routine. Where of 9:00 PM and 6:0	nay be used instead of				
	Based on record re failed to conduct of	eview and interview, the facility quarterly fire drills for 2 of 3 7.1.6 requires drills to be	K 0712	Disclaimer: This Plan of Correction const this facility's written allegation		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 2 04	(3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
	 conducted quarter conditions. This d residents, staff, an Findings include: Based on review v on 01/10/23 at 9:4 following fire drill a) fire drills condu (April, May, or Ju third shifts. b) fire drills condu August, or Septem second shifts. Based on interview the Maintenance I there were no addid documents for rev survey. During the exit co Director, the visiti the facility Admin 01/11/23 at 1:30 p 	ly on each shift under varied eficient practice affects all		compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exist or the that one was cited correctly. This Plan of Correction is submitted to meet requirement established by the state and federal law. Alleged deficiency: There were no monthly fire drill reports available for review in the second and third quarter of 2022. The previous maintenance director of not keep record of these drills. Corrective Action for residents found to have deficient: The new Maintenance Director starts in September and has completed monthly fire drills in home 6 in September, October, November and December of 2022. Identify other residents having the same potential deficient: The other 5 homes in the community did not have fire drill records available for the 2nd an 3rd quarter, but were completed by the new maintenance director for September, October, Novem and December of 2022. Measures put into place or systemic changes: The Maintenance Director or design will conduct monthly fire drills an keep them in the preventive	his ts n hts his ts n ts his ts his ts his his his his his his his hi

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>04</u>	COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (FACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		RIATE (X5) COMPLETION DATE
				maintenance logbook.	
				Plan to monitor performant maintain compliance: The Maintenance Director or des will audit that fire alarm drills conducted monthly for the n months and until 100% of compliance is maintained. If compliance trends are identit they will be reviewed in QAF meetings.	signee s are ext 6 ² any ified,
K 0000				Date of Compliance: 1/13/	23
Bldg. 05					
	Licensure Survey Department of He 483.90(a). Survey Dates: 01. Facility Number: Provider Number: AIM Number: 20 At this Life Safety Carmel was found Requirements for Medicare/Medicai	155846 1362150 v Code survey, Restoracy of not in compliance with Participation in d, 42 CFR Subpart 483.90(a),	K 0000	This Plan of Correction cons this facility's written allegatic compliance for the deficience cited. However, submission Plan of Correction is not an admission that a deficiency or the that one was cited correctly. This Plan of Corre is submitted to meet require established by the state and federal law.	on of ies of this exists ction ments
	National Fire Prot	Fire and the 2012 edition of the ection Association (NFPA) 101, (LSC), Chapter 19, Existing			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 63 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 01/17/23 K 0324 **NFPA 101** SS=F **Cooking Facilities** Bldg. 05 **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 LL8021 Facility ID: 013753 Page 32 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

02/03/2023

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02/03/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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, observation, and K 0324 **Disclaimer:** 01/13/2023 interview; the facility failed to ensure 1 of 1 This Plan of Correction constitutes kitchen fire suppression system was inspected this facility's written allegation of semiannually. NFPA 96, 2011 Edition, Standard for compliance for the deficiencies Ventilation Control and Fire Protection of cited. However, submission of this Commercial Cooking Operations, Section 11.2.1 Plan of Correction is not an states Maintenance of the fire-extinguishing admission that a deficiency exists systems and listed exhaust hoods containing a or the that one was cited constant or fire-activated water system that is correctly. This Plan of Correction listed to extinguish a fire in the grease removal is submitted to meet requirements devices. Hood exhaust plenums, and the exhaust established by the state and ducts shall be made by properly trained, qualified, federal law. and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This Alleged deficiency: Failed to deficient practice could affect all occupants in the ensure kitchen fire suppression cottage. system was inspected semiannually for the kitchen in Findings include: house 6. Based on review with the Maintenance Director Corrective Action for resident(s) on 01/10/23 at 10:05 a.m., documentation of a fire found to have deficient: The suppression system inspection for the Cottage #5 previous Maintenance man had let kitchen was not available for review. Based on the contract with the vendor lapse. interview at the time of record review, the The new maintenance director has Maintenance Director stated that he was hired in since entered into a new contract September 0f 2022 and the previous Maintenance with Nelbud, a fire suppression man had let the contract with the vendor lapse. He vendor, and we are now on a has since signed a new contract with the vendor, semi-annual inspection rotation for and they are now on a semi-annual inspection the kitchen's fire suppression rotation for the kitchens fire suppression system system with the first service testing in all six of the cottages. scheduled for 2/28/2023. LL8021 Facility ID: 013753 FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>05</u>	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY	
RESTOR	RACY OF CARMEL	-	CARM	EL, IN 46032	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
(0353 00-5	Director, the visiti the facility Admin 01/11/23 at 1:30 p evidence could be deficient finding. 3.1-19(b)	nference with the Maintenance ng Maintenance Director, and istrator via telephone on .m., no additional information or provided contrary to this		Identify other residents havi the same potential deficient: All 6 homes in our community have the same kite setup and will be under the sa semi-annual service contract in place. Measures put into place or systemic changes: The Maintenance Director set up services for kitchen fire suppression inspection for all homes in our community for February 28th, 2023. All hom have the same kitchen setup a will be under the same semi-annual service contract. Plan to monitor performance maintain compliance: Maintenance Director or designee will ensu the semi-annual maintenance completed, as scheduled semi-annually. If any missed inspections occur, it will be reviewed and addressed in Qa meetings.	chen ame put 6 es and e to re is API
SS=F Bldg. 05	Sprinkler System Automatic sprink	 Maintenance and Testing Maintenance and Testing Ier and standpipe systems sted, and maintained in 			

PRINTED: 02/03/2023 FORM APPROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0353 Based on record review and interview, the facility 01/13/2023 **Disclaimer:** failed to provide written documentation or other This Plan of Correction constitutes evidence the sprinkler system components had this facility's written allegation of been inspected and tested for 2 of 4 quarters. LSC compliance for the deficiencies 4.6.12.1 requires any device, equipment or system cited. However, submission of this required for compliance with this Code be Plan of Correction is not an maintained in accordance with applicable NFPA admission that a deficiency exists requirements. Sprinkler systems shall be properly or the that one was cited maintained in accordance with NFPA 25, Standard correctly. This Plan of Correction for the Inspection, Testing, and Maintenance of is submitted to meet requirements Water-Based Fire Protection Systems. NFPA 25, established by the state and 4.3.1 requires records shall be made for all federal law. inspections, tests, and maintenance of the system components and shall be made available to the Alleged deficiency: There were authority having jurisdiction upon request. 4.3.2 no quarterly sprinkler system requires that records shall indicate the procedure inspection reports available for performed (e.g., inspection, test, or maintenance), review in the second and third the organization that performed the work, the quarter of 2022. The previous results, and the date. NFPA 25, 5.2.5 requires that maintenance director did not keep waterflow alarm devices shall be inspected record of these tests. quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical Corrective Action for resident(s) waterflow alarm devices including, but not limited found to have deficient: The to, water motor gongs, shall be tested quarterly. new Maintenance Director had Event ID: LL8021 Facility ID: 013753 Page 35 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C 05	X3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY	
RESTOR	RACY OF CARMEL	-	CARM	EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	switch-type waterf tested semiannuall affect all residents facility. Findings include: Based on review w on 01/10/23 at 10: sprinkler system in review in the secon June) of 2022. Fur sprinkler system in third quarter (July, 2022 as well. Base record review, the acknowledged the documentation ava system had been in third quarters of 20 During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p	ailable to show the sprinkler nspected during the second and		completed quarterly sprinkler system inspection for the 4th quarter of 2022 on 11/2/2022 b Koorsen Fire & Security compa Identify other residents having the same potential deficient: The other 5 homes in the community did not have the 2nd and 3rd quarterly sprinkler inspection reports, but were completed by the new maintenance director for the 4th quarter of 2022 on 11/2/2022. Measures put into place or systemic changes: The Maintenance Director or design will conduct quarterly sprinkler system inspections and keep them in the preventative maintenance logbook. Plan to monitor performance to Maintenance Director or design	ny. g d n iee
	deficient finding. 3.1-19(b)			will audit sprinkler system inspections quarterly for the nex quarters and until 100% of compliance is maintained. If any compliance trends are identified they will be reviewed in QAPI meetings.	у
				Date of Compliance: 1/13/23	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 05 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL **CARMEL. IN 46032** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0712 **NFPA 101** SS=F Fire Drills Bldg. 05 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 K 0712 Disclaimer: 01/13/2023 failed to conduct quarterly fire drills for 3 or 4 This Plan of Correction constitutes quarters. LSC 19.7.1.6 requires drills to be this facility's written allegation of conducted quarterly on each shift under varied compliance for the deficiencies conditions. This deficient practice affects all cited. However, submission of this residents, staff, and visitors. Plan of Correction is not an admission that a deficiency exists Findings include: or the that one was cited correctly. This Plan of Correction Based on review with the Maintenance Director is submitted to meet requirements on 01/10/23 at 9:46 a.m., documentation of the established by the state and following fire drills could be provided: federal law. a) a fire drill conducted in the first quarter (January, February, and March) of 2022 on the Alleged deficiency: There were first shift. no monthly fire drill reports b) fire drills conducted in the second quarter available for review in the second (April, May, or June) of 2022 on the second or and third guarter of 2022. The thirs shifts. previous maintenance director did c) fire drills conducted in the third quarter (July, not keep record of these drills. August, or September) of 2022 on the second or third shifts. Corrective Action for resident(s) Based on interview at the time of record review, found to have deficient: The the Maintenance Director acknowledged that new Maintenance Director started there were no additional available fire drill in September and has completed documents for review as of the time of this monthly fire drills in home 6 in Event ID: LL8021 Facility ID: 013753 If continuation sheet Page 37 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete

02/03/2023

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 05		E SURVEY PLETED
AND FLAN	OF CORRECTION	155846	B. WING	00		1/2023
NAME OF 1	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP	COD	
RESTOR	RACY OF CARME	L		REEN HOUSE WAY EL, IN 46032		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETIC DATE
	survey.			September, October, and December of 202		
	Director, the visiti the facility Admin 01/11/23 at 1:30 p	Inference with the Maintenance ing Maintenance Director, and distrator via telephone on 0.m., no additional information or provided contrary to this		Identify other resident the same potential de The other 5 homes in community did not have records available for to 3rd quarter, but were by the new maintenar for September, Octob and December of 202 Measures put into pl systemic changes: To Maintenance Director will conduct monthly for keep them in the previous and the second maintenance logbook	nts having eficient: the ve fire drill the 2nd and completed nee director er, November 22. ace or the or designee ire drills and ventive	
0000				Plan to monitor performaintain compliance Maintenance Director will audit that fire alarn conducted monthly for months and until 1009 compliance is maintai compliance trends are they will be reviewed meetings.	e: The or designee m drills are r the next 6 % of ined. If any e identified, in QAPI	
3ldg. 06						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 06 B. WING 01/11/2023 155846 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 616 GREEN HOUSE WAY RESTORACY OF CARMEL CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A Life Safety Code Recertification and State K 0000 This Plan of Correction constitutes Licensure Survey was conducted by the Indiana this facility's written allegation of Department of Health in accordance with 42 CFR compliance for the deficiencies 483.90(a). cited. However, submission of this Plan of Correction is not an Survey Dates: 01/10/23 and 01/11/23 admission that a deficiency exists or the that one was cited Facility Number: 013753 correctly. This Plan of Correction Provider Number: 155846 is submitted to meet requirements AIM Number: 201362150 established by the state and federal law. At this Life Safety Code survey, Restoracy of Carmel was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of six buildings (01 through 06). Each building is a one-story cottage determined to be of Type V (111) construction and was fully sprinklered. Each cottage has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The entire facility has a capacity of 72 and had a census of 63 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, with exception of a separate detached administration building. Building 06 is identified as Cottage #6. The cottage has a capacity of 12 and had a census of 9 at the time of this survey. Quality Review completed on 01/17/23 LL8021 Event ID: Facility ID: 013753 Page 39 of 46 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

02/03/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTI A. BUILD B. WING		STRUCTION () 06	COMPL	e survey pleted 1/2023	
	PROVIDER OR SUPPLIE		6	16 GRE	DDRESS, CITY, STATE, ZIP COD EN HOUSE WAY ., IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	(X5) COMPLETION DATE	
< 0324 SS=F Bldg. 06	accordance with Ventilation Contr Commercial Cook appliances such toasters) are use cooking in accord 19.3.2.5.2 * cooking facilitie smoke compartr patients comply 18.3.2.5.3, 19.3.2 * cooking facilitie with 30 or fewer conditions under Cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the co 18.3.2.5.1 throug through 19.3.2.5. Based on record re interview; the faci kitchen fire suppre semiannually. NFI Ventilation Contro Commercial Cook states Maintenance systems and listed constant or fire-ac listed to extinguish devices. Hood exh ducts shall be mad and certified person having jurisdiction	s ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ting equipment (i.e., small as microwaves, hot plates, d for food warming or limited dance with 18.3.2.5.2, s open to the corridor in nents with 30 or fewer with the conditions under 2.5.3, or s in smoke compartments patients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to .3 are not required to be ardous areas, but shall not	K 0324		Disclaimer: This Plan of Correction constitut this facility's written allegation of compliance for the deficiencies cited. However, submission of t Plan of Correction is not an admission that a deficiency exis or the that one was cited correctly. This Plan of Correctio is submitted to meet requirement established by the state and federal law. Alleged deficiency: Failed to ensure kitchen fire suppression	of his sts on nts	01/13/202	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE CO A. BUILDING B. WING	<u>06</u>	(X3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIEI	٤	616 GF	address, city, state, zip cod REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)		N (X5) BE COMPLETIC RIATE DATE
	cottage. Findings include:			system was inspected semiannually for the kitchen house 6.	
	on 01/10/23 at 10:0 suppression system kitchen was not ava interview at the tim Maintenance Direc September 0f 2022 man had let the cor has since signed a r and they are now o rotation for the kitc testing in all six of During the exit con Director, the visitir the facility Admini 01/11/23 at 1:30 p.	ith the Maintenance Director 6 a.m., documentation of a fire inspection for the Cottage #6 inlable for review. Based on e of record review, the tor stated that he was hired in and the previous Maintenance tract with the vendor lapse. He new contract with the vendor, in a semi-annual inspection hens fire suppression system the cottages. ference with the Maintenance g Maintenance Director, and strator via telephone on m., no additional information or provided contrary to this		Corrective Action for resid found to have deficient: T previous Maintenance man the contract with the vendor The new maintenance direct since entered into a new co- with Nelbud, a fire suppressive vendor, and we are now on semi-annual inspection rota the kitchen's fire suppression system with the first service scheduled for 2/28/2023. Identify other residents hat the same potential deficient: All 6 homes in ou community have the same k setup and will be under the semi-annual service contract in place. Measures put into place or systemic changes: The Maintenance Director set up services for kitchen fire suppression inspection for a homes in our community for February 28th, 2023. All ho have the same kitchen setur will be under the same semi-annual service contract Plan to monitor performant maintain compliance: Maintenance	he had let had let had let had let had let had let hapse. Ator has intract sion a tion for on ving ur ditter with the same struct put had been been been been been been been bee

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>06</u>	(X3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	the semi-annual maintenance completed, as scheduled semi-annually. If any missed inspections occur, it will be reviewed and addressed in 0 meetings.	t
< 0353 SS=F Bldg. 06	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testin Water-based Fire Records of syste inspection and te	- Maintenance and Testing - Maintenance and Testing ler and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of Protection Systems. m design, maintenance, sting are maintained in a		Date of Compliance: 1/13/	2023
	a) Date sprinkle b) Who provide c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8 Based on record re failed to provide w evidence the sprin been inspected and 4.6.12.1 requires a required for compl	RKS information on non-required or partial er system.	К 0353	Disclaimer: This Plan of Correction cons this facility's written allegation compliance for the deficienc cited. However, submission Plan of Correction is not an admission that a deficiency of	n of les of this

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/11/2023	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD		
RESTOR	RACY OF CARMEL	-		REEN HOUSE WAY EL, IN 46032		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETI	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	requirements. Spr	inkler systems shall be properly		or the that one was cited		
	maintained in acco	ordance with NFPA 25, Standard		correctly. This Plan of Correction	on	
	for the Inspection,	Testing, and Maintenance of		is submitted to meet requireme	nts	
	Water-Based Fire	Protection Systems. NFPA 25,		established by the state and		
	4.3.1 requires reco	ords shall be made for all		federal law.		
	inspections, tests,	and maintenance of the system				
	components and s	hall be made available to the		Alleged deficiency: There were	e	
	authority having ju	urisdiction upon request. 4.3.2		no quarterly sprinkler system		
	requires that recor	ds shall indicate the procedure		inspection reports available for		
	performed (e.g., ir	nspection, test, or maintenance),		review in the second and third		
	the organization th	nat performed the work, the		quarter of 2022. The previous		
	results, and the da	te. NFPA 25, 5.2.5 requires that		maintenance director did not ke	ер	
	waterflow alarm d	evices shall be inspected		record of these tests.		
	quarterly to verify	they are free of physical				
	damage. NFPA 25	5, 5.3.3.1 requires the mechanical		Corrective Action for resident	:(s)	
	waterflow alarm d	evices including, but not limited		found to have deficient: The		
	to, water motor go	ngs, shall be tested quarterly.		new Maintenance Director had		
	5.3.3.2 requires va	ne-type and pressure		completed quarterly sprinkler		
	switch-type water	flow alarm devices shall be		system inspection for the 4th		
	tested semiannual	ly. This deficient practice could		quarter of 2022 on 11/2/2022 b	ру	
	affect all residents	, staff, and visitors in the		Koorsen Fire & Security compa	iny.	
	facility.					
				Identify other residents having	g	
	Findings include:			the same potential deficient:		
				The other 5 homes in the		
	Based on review w	vith the Maintenance Director		community did not have the 2nd	d	
	on 01/10/23 at 10:	27 a.m., there was no quarterly		and 3rd quarterly sprinkler		
	sprinkler system in	nspection report available for		inspection reports, but were		
	review in the seco	nd quarter (April, May, and		completed by the new		
	June) of 2022. Fu	thermore, there was no quarterly		maintenance director for the 4th	n	
	sprinkler system in	nspection documentation for the		quarter of 2022 on 11/2/2022.		
		, August, and September) of				
	2022 as well. Base	ed on an interview at the time of		Measures put into place or		
	record review, the	Maintenance Director		systemic changes: The		
	acknowledged the	re was no written		Maintenance Director or design	iee	
	documentation ava	ailable to show the sprinkler		will conduct quarterly sprinkler		
	system had been in	nspected during the second and		system inspections and keep		
	third quarters of 2	022.		them in the preventative		
				maintenance logbook.		
	During the exit co	nference with the Maintenance		_		

	R MEDICARE & MEDI					1B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	(X2) MULTIPLE C A. BUILDING B. WING	<u>06</u>	COMP	te survey 1pleted 11/2023	
	PROVIDER OR SUPPLIE		616 G	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY IEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE	
	the facility Admin 01/11/23 at 1:30 p	ng Maintenance Director, and histrator via telephone on h.m., no additional information or provided contrary to this		Plan to monitor performan maintain compliance: The Maintenance Director or des will audit sprinkler system inspections quarterly for the quarters and until 100% of compliance is maintained. If compliance trends are ident they will be reviewed in QAF meetings.	signee next 4 any ified,		
K 0712 SS=F Bldg. 06		the transmission of a fire simulation of emergency fire		Date of Compliance: 1/13/	23		
	conditions. Fire of and unexpected conditions, at lea The staff is famil aware that drills routine. Where of 9:00 PM and 6:0 announcement m audible alarms. 19.7.1.4 through Based on record m failed to conduct of quarters. LSC 19.7 conducted quarter	drills are held at expected times under varying ast quarterly on each shift. iar with procedures and is are part of established drills are conducted between 0 AM, a coded may be used instead of 19.7.1.7 eview and interview, the facility quarterly fire drills for 2 of 3 7.1.6 requires drills to be ly on each shift under varied efficient practice affects all	K 0712	Disclaimer: This Plan of Correction cons this facility's written allegatic compliance for the deficience cited. However, submission Plan of Correction is not an admission that a deficiency or the that one was cited	on of ies of this	01/13/202:	

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155846	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>06</u>	(X3) DATE SURVEY COMPLETED 01/11/2023
	PROVIDER OR SUPPLIE		616 GI	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY IEL, IN 46032	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLET
TAG	Based on review w on 01/10/23 at 9:4 following fire drill a) fire drills condu (April, May, or Jun third shifts. b) fire drills condu August, or Septem second shifts. Based on interview the Maintenance E there were no addi documents for revisurvey. During the exit con Director, the visiti the facility Admin 01/11/23 at 1:30 p	R LSC IDENTIFYING INFORMATION with the Maintenance Director 6 a.m., documentation of the s could be provided: cted in the second quarter ne) of 2022 on the second or cted in the third quarter (July, ber) of 2022 on the first or w at the time of record review, birector acknowledged that tional available fire drill tew as of the time of this anference with the Maintenance ng Maintenance Director, and istrator via telephone on .m., no additional information or provided contrary to this	TAG	 correctly. This Plan of Correctis submitted to meet requirer established by the state and federal law. Alleged deficiency: There we no monthly fire drill reports available for review in the se and third quarter of 2022. The previous maintenance directed not keep record of these drill Corrective Action for resider found to have deficient: The new Maintenance Director st in September and has complemonthly fire drills in home 6 is September, October, Novem and December of 2022. Identify other residents have the same potential deficient. The other 5 homes in the community did not have fire of records available for the 2nd 3rd quarter, but were complement by the new maintenance director or des will conduct monthly fire drills keep them in the preventive maintenance logbook. Plan to monitor performance in the compliance: The 	ction ments vere cond ne or did s. ent(s) ee arted leted n ber ving t: drill and eted ector vember

	` OF HEALTH AND HUI MEDICARE & MEDIC						TED: 02/03/2023 RM APPROVED B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	È Í	JILDING	DNSTRUCTION 06	(X3) DATE COMPL 01/11/	ETED
	ROVIDER OR SUPPLIEF	2	-	616 GF	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) Maintenance Director or desig will audit that fire alarm drills a conducted monthly for the nex months and until 100% of compliance is maintained. If a compliance trends are identifit they will be reviewed in QAPI meetings.	gnee are xt 6 any ed,	(X5) COMPLETION DATE

LL8021 Facility ID: 013753

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