STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155181	A. BUILDING -- B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 12/09/24 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Emergency Preparedness survey, Carmel Health & Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare Providers and Suppliers, 42 CFR 483.73. The facility has 188 certified beds and a census of 130. Quality Review completed on 12/11/24	E 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citations**	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of 'Test Generator Under Load' with the Environmental Services Director, Administrator and Assistant Administrator on 12/09/24 at 11:15 a.m., the generator set in service labeled 'Station 2 (Floors)' was exercised less than 30 minutes for twelve of the last twelve months.	E 0041	1 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Indiana Power has reprogramed the generators to run the required 30 min. 2 how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who reside on 200 hall and 300 hall have the potential to be affected by this alleged	12/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyssa Holliday	HFA	12/23/2024

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.

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	The generator was documented as running under load for 20 minutes for each of the last twelve months. Based on interview at the time of record review, the Environmental Services Director stated the generator is scheduled to automatically run each week and agreed that the monthly load testing documentation provided showed the generator did not run for the required 30 minutes for each of the last twelve months. This finding was reviewed with the Administrator, Assistant Administrator and Environmental Services Director at the exit conference.		deficient practice. 3 what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director re-educated on the proper 30 min run time for all 3 generators. Administrator will verify with the maintenance director that all 3 generators are running the proper 30 min. A TELS task is assigned for all the generators to be checked on Fridays and run for 30 min. Results will be reviewed weekly. 4 how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and CarDon Corporate facilities will review all generator paperwork during their annual CQR. 5 by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed on 12/13/24	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 12/09/24 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Life Safety Code survey, Carmel Health & Living Community 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. This one-story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the 700 and 800 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 188 and had a census of 130 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.	K 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citations**	

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K 0353 SS=E Bldg. 01	Quality Review completed on 12/11/24 NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure all sprinkler heads in the facility were not damaged in accordance with LSC 9.7.5. NFPA 13, 2010 Edition, Section 3.6.2.3 defines a pendent sprinkler as a sprinkler designed to be installed in such a way that the water stream is directed downward against the deflector. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff in the kitchen and lower level. Findings include: Based on observation with the Environmental Services Director on 12/09/24 during a tour of the facility, the following was noted: a) at 1:55 p.m., a sprinkler head in the dish area of the kitchen was damaged due to the deflector on the sprinkler head being bent b) at 2:55 p.m., a sprinkler head in lower level corridor by the nursing supply door was damaged due to the deflector on the sprinkler head being bent. Based on interview at the time of each observation, the Environmental Services Director agreed the sprinkler heads in the dish area and	K 0353	1 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Maintenance Supervisor has contracted with PIPE to replace damaged sprinkler heads the week of December 23rd. 2 how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Neither sprinkler head was located in resident care areas. No resident has the potential to be affected. 3 what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A quarterly TELS task has been assigned for the Maintenance Supervisor to confirm all sprinkler heads appear to be working in proper order and are not damaged. See attachment below 4 how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and CarDon Corporate Facilities will audit and inspect all sprinkler	12/31/2024

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	lower leavel were damaged and bent. This finding was reviewed with the Administrator, Assistant Administrator and Environmental Services Director during the exit conference. 3.1-19(b)		heads during their annual CQR and on routine site visits. 5 by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed by 12/31/24	
K 0753 SS=B Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure 1 of over 100 resident room corridor doors was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in	K 0753	1 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; As stated in the 2567 the wrapping paper was remove from the 720 door immediately. 2 how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other resident had the potential of being affected by this alleged practice. 3 what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; This was a seasonal incident.	12/09/2024

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	accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect over 20 residents, staff and visitors in one smoke compartment. Findings include: Based on observations with the Environmental Services Director, Administrator and Assistant Administrator during a tour of the facility at 1:50 p.m. on 12/09/24, the corridor door to resident room 720 was covered over 90 percent with holiday wrapping paper. Based on interview at the time of the observation, the Environmental Services Director stated the decorations were not treated with fire retardant material as far as he knew and agreed the surface of the door was covered more than 90 percent. The Administrator and Environmental Services Director removed the		All residents were notified of safety policy of combustible items and how doors cannot be covered with non-flame retardant material that exceeds 30% of the surface area. 4 how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and This was a isolated incident. Wrapping paper was removed immediately and residents were educated. No other actions required. 5 by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 12/9/24	

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	wrapping paper from the corridor door upon observation. This finding was reviewed with the Administrator, Assistant Administrator and Environmental Services Director the exit conference. 3.1-19(b)			
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months for 1 of 3 generators. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabalized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review of 'Test Generator Under Load' with the Environmental Services Director, Administrator and Assistant Administrator on 12/09/24 at 11:15 a.m., the generator set in service labeled 'Station 2 (Floors)' was exercised less than 30 minutes for twelve of the last twelve months.	K 0918	**K918 The facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months for 1 of 3 generators.** 1 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Indiana Power has reprogramed the generators to run the required 30 min. 2 how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents who reside on 200 hall and 300 hall have the potential to be affected by this alleged deficient practice. 3 what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director	12/13/2024

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	The generator was documented as running under load for 20 minutes for each of the last twelve months. Based on interview at the time of record review, the Environmental Services Director stated the generator is scheduled to automatically run each week and agreed that the monthly load testing documentation provided showed the generator did not run for the required 30 minutes for each of the last twelve months. This finding was reviewed with the Administrator, Assistant Administrator and Environmental Services Director at the exit conference. 3.1-19(b)		re-educated on the proper 30 min run time for all 3 generators. Administrator will verify with the maintenance director that all 3 generators are running the proper 30 min. A TELS task is assigned for all the generators to be checked on Fridays and run for 30 min. Results will be reviewed weekly. 4 how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and CarDon Corporate facilities will review all generator paperwork during their annual CQR. 5 by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed on 12/13/24	