

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/25/2014
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NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/25/14</p> <p>Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Altenheim Health &amp; Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility occupying the A, B and C wings of the first floor of a three story building determined to be of Type II (222) construction with a basement was fully sprinklered except for two closets in the B Wing Unit Manager's Office. The</p>	K010000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010018 SS=E	<p>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 nurses' station in all resident sleeping rooms. The facility has a capacity of 72 and had a census of 71 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for two closets in the B Wing Unit Manager's Office. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the</p>			

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	<p>closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 43 resident sleeping room corridor doors would close, latch and resist the passage of smoke. This deficient practice could affect 14 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Operations during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/25/14, the following was noted:</p> <p>a. the latching mechanism in the corridor door to resident sleeping Room 1116 failed to protrude and latch the door into the door frame.</p> <p>b. the gap between the face of the corridor door to resident sleeping Room 1124 and the door stop measured one inch near the top of the door when closed and latched.</p> <p>Based on interview at the time of the observations, the Director of Plant Operations acknowledged the corridor door to Room 1116 failed to latch into the door frame and the gap for the corridor door to Room 1124 would fail to</p>	K010018	<p>K018 #1.) Door Hardware What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? § New hardware for door of (Room #1116) was purchased from Bradley Lock and Key Service and installed. 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: § An audit tool was created to identify any deficiencies not meeting this standard. Audit was completed on July 17th 2014 and revealed no further deficiencies. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: § A schedule will be developed to audit all resident room doors monthly - x3months, quarterly thereafter. 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 § Maintenance Director or Designee will audit per schedule and all audit results will be brought to QA quarterly. _ By</p>	07/18/2014

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K010038	resist the passage of smoke.  3-1.19(b)  NFPA 101		what date the systemic changes will be completed. § Compliance date will be July 18th , 2014 #2. Door Gaps What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: § New U.L. smoke seal material for door of (Room #1124) was purchased from Granger and installed. 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: § An audit tool was created to identify any deficiencies not meeting this standard. Audit was completed on July 17th, 2014 and revealed no further deficiencies. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: § A schedule will be developed to audit all rooms monthly - x3months, quarterly thereafter. 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 § Maintenance Director or Designee will audit per schedule and all audit results will be brought to QA quarterly. By what date the systemic changes will be completed. § Compliance date will be July 18th , 2014		

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SS=E	<p><b>LIFE SAFETY CODE STANDARD</b> Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 exit accesses was provided with handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. This deficient practice could affect 14 residents, staff and visitors if need to exit the facility from the B Wing.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/25/14, the B Wing exit discharge had a newly constructed forty foot sloping sidewalk which was not provided with handrails. Based on interview at the time of observation, the Director of Plant Operations stated the existing exterior sidewalk to the public way was blocked due to construction, a new sloping sidewalk was constructed to provide access to the public way and acknowledged the newly constructed forty foot sloping sidewalk at the B Wing</p>	K010038	<p>K038 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - JL Walker &amp; Associates has ordered handrails that are currently in fabrication. This work is in progress and should be complete in approximately 4 weeks. Handrail installation will be scheduled upon completion of fabrication process.</p> <p>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; - An audit tool was created to identify any deficiencies not meeting this standard. Audit was completed on July 17th, 2014 and revealed no further deficiencies. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - A schedule will be developed to audit all exit discharges monthly - x3months, quarterly thereafter. 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 - Maintenance Director or Designee will audit per schedule and any deficiencies will be brought to QA quarterly. By</p>	07/18/2014
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K010046 SS=E	<p>exit discharge was not provided with handrails.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1½ hour duration for 1 of 12 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 17 residents, staff and visitors if required to evacuate the facility from the Assisted Living Library exit.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/25/14, the exit discharge at the Assisted Living Library exit was not</p>	K010046	<p>what date the systemic changes will be completed. - July 18th, 2014</p> <p>K046</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>§ Emergency lighting was installed by Electrical Enterprises on Assisted Living Library exit discharge.</p> <p>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;</p> <p>§ All other exits audited to</p>	07/18/2014

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K010056 SS=E	<p>provided with lighting. Based on interview at the time of observation, the Director of Plant Operations stated the first floor Assisted Living area is not separated from the comprehensive care portion of the building with at least a two hour fire resistance rating and acknowledged the aforementioned exit discharge of the facility was not provided with exterior lighting.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>ensure proper lighting exists.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>§ PM quarterly audit tool has been adjusted to include Assisted Living Library exit discharge.</p> <p>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</p> <p>§ Maintenance Director or Designee will audit per schedule and any deficiencies will be brought to QA quarterly.</p> <p>-</p> <p>By what date the systemic changes will be completed.</p> <p>§ Compliance date will be July 18th, 2014</p>		

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	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a sprinkler was installed in 2 of 3 closets in the B Wing Unit Manager's Office to provide coverage for all portions of the building. This deficient practice could affect 14 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/25/14, the two closets nearest the corridor door in the B Wing Unit Manager's Office were not sprinklered. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned closets were not provided with a sprinkler head.</p>	K010056	<p>K056</p> <p>#1.)</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>§ Sprinkler Head was installed in 2 of 3 closets in B wing Unit Manager's office in accordance with NFPA 25 regulation.</p> <p>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;</p> <p>§ An audit tool was created to identify any deficiencies not</p>	07/18/2014

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3.1-19(b) 3.1-19(ff)	<p>2. Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-5.4.2 states deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect 14 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/25/14, the deflector for the one sprinkler head installed in the closet nearest the back wall of the B Wing Unit Manager's Office was aligned perpendicular to the ceiling. Based on interview at the time of observation, the Director of Plant Operations acknowledged the deflector for the aforementioned sprinkler head was not aligned parallel to the ceiling.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>meeting this standard. Audit was completed on July 17th, 2014 and revealed no further deficiencies.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>§ US Automatic will inspect building sprinkler system quarterly.</p> <p>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</p> <p>§ Maintenance Director or Designee will receive quarterly inspection from US Automatic and any deficiencies will be brought to QA quarterly.</p> <p>-</p> <p>By what date the systemic changes will be completed.</p> <p>§ Compliance date will be July 18th , 2014</p>	

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			<p>#2.)</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>§ Sprinkler deflector was re-installed parallel to ceiling roof in B Wing Unit Managers office closet in accordance with NFPA 13 regulation.</p> <p>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;</p> <p>§ An audit tool was created to identify any deficiencies not meeting this standard. Audit was completed on July 17th, 2014 and revealed no further deficiencies.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the</p>	

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			<p>deficient practice does not recur;</p> <p>§ US Automatic will inspect sprinkler system and sprinkler heads quarterly.</p> <p>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</p> <p>§ Maintenance Director or Designee will receive inspection from US Automatic schedule and any deficiencies will be brought to QA quarterly.</p> <p>-</p> <p>By what date the systemic changes will be completed.</p> <p>§ Compliance date will be July 18th , 2014</p>	