PRINTED: 09/20/2022

	r of health and hui R medicare & medic						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155409 B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/01/2022				
	PROVIDER OR SUPPLIEF			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the Irraccordance with 42 Survey Date: 09/01 Facility Number: 0 Provider Number: 100 At this Emergency Waters of Indianape compliance with Er Requirements for M Participating Provid 483.73. The facility has 81 the survey, the cens Quality Review cor	200537 155409 267270 Preparedness survey, The olis was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of sus was 72. mpleted on 09/06/22 42 CFR Subpart 483.73 is NOT	E 00	000	Preparation or execution of the plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and Statelaw. The plan of correction is submitted in order to respond the allegation of noncompliar cited during the Life Safety Conception and Emergency Preparedness Survey completed on September 1, 2 Please accept this plan of correction as the provider's credible allegation of compliar We respectfully request a decreview.	ement the set es that to noce code coy 2022.	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power sy	(e), 485.625(e) LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of					

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

procedures plan set forth in paragraphs (b)(1)

this section and in the policies and

(i) and (ii) of this section.

§483.73(e), §485.625(e)

TITLE (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.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/01/2022
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COE KEYSTONE AVE IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	(e) Emergency and The [LTC facility a implement emerge systems based or forth in paragraph §482.15(e)(1), §4 Emergency gener generator must be the location required Care Facilities Coulterim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure or buildin 482.15(e)(2), §48 Emergency generation The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §48 Emergency generand LTC facilities source to power end LTC facilities source to power end the power systems of emergency, unless *[For hospitals at §483.73(g), and County facilities at §483.73(g	and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The elocated in accordance with rements found in the Health ide (NFPA 99 and Tentative rints TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must regency power system ig, and [maintenance] ind in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs ig that maintain an onsite fuel emergency generators must iow it will keep emergency interval in the service of the service			
l .	I mus session are al	-p sa isi missi polanon by	1	Î.	I

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Event ID:

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Facility ID: 000537

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	OF CORRECTION	IDENTIFICATION NUMBER 155409	A. BUILDING B. WING		COMP	LETED 1/2022
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP CO S KEYSTONE AVE NAPOLIS, IN 46227	DD .	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Federal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resoult Boulevard, Baltimous Archives and Reconstruction (NARA). For information this material at NA go to: http://www.archive.of_federal_regular in the Fannounce the charan (1) National Fire Patterymarch Park Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issued (iii) Tla 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-5 to NF 2014. (vii) NFPA 101, Lift edition, issued Aug (viii) TIA 12-1 to NF 11, 2011. (ix) TIA 12-2 to NF 30, 2012.	arce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or as gov/federal_register/code ations/ibr_locations.html. this edition of the Code are ference, CMS will publish a ederal Register to nges. Trotection Association, 1 (C), www.nfpa.org, and August 11, 2011. Im amendment (TIA) 12-2 to August 11, 2011. Im Augu				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BU	A. BUILDING CC			SURVEY ETED /2022	
	PROVIDER OR SUPPLIER			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	(12	DATE
TAG	22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to c 2009 Based on record rev interview; the facili emergency power s maintenance require Care Facilities Code Code in accordance	tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view, observation and ty failed to implement the ystem inspection, testing and ements found in the Health e, NFPA 110, and Life Safety with 42 CFR 483.73(e)(2). ice could affect all residents,	E 00		CORRECTIVE ACTION TAKEN: a. The Maintenance Supervisor/designee conducte the thirty six month period emergency generator test for continuous hours and docume the results in the facilities Life Safety Binder to meet set standards.	ed four ented	10/18/2022
	Director from 8:35 thirty-six month per testing documentati for the natural gas f not available for rev time of record revie stated the facility had emergency generated of supplemental load	view with the Maintenance a.m. to 11:15 a.m. on 09/01/22, riod emergency generator on for four continuous hours ired emergency generator was view. Based on interview at the ew, the Maintenance Director as one natural gas fired or and agreed documentation d testing for four hours within the year period was not			2. ALL OTHERS WITH POTENTIAL TO BE AFFECTI a. All residents and all star and visitors have the potential be affected but none were. 3. MEASURES TO PREVI REOCCURRENCE: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that a thirty six m period emergency generator t	ff I to ENT	
	available for review the Maintenance Di facility from 11:15 the facility has one generator located in near the south exit of manufacturer's name could not be determent.	v. Based on observations with rector during a tour of the a.m. to 12:30 p.m. on 09/01/22, natural gas fired emergency side the Maintenance Office door for the facility. The eplate rating for the generator			for four continuous hours must conducted on the facilities emergency generator every the years to meet set standards. b. The Maintenance Supervisor/designee will ensurthirty-six-month period emergence generator test for four continual hours is conducted every three years and documented in the safety binder to meet set.	et be nree ure a ency ious	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIER		3895	FADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	conference.			standards. c. The Administrator will monitor adherence to the Emergency Preparedness Polymanual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to enscompliance, the Administrato Maintenance Supervisor/desi will review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrato present the training results at Quality Assurance/ Performa Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/P Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliatis maintained.	sure r and ignee and to as or will the nce g. ents I	
K 0000						
Bldg. 01	Licensure Survey w	00537	K 0000	Preparation or execution of the plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	ement the set	

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Event ID:

297021

Facility ID: 000537

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/01/2022	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE	
WATERS	OF INDIANAPOLI	S, THE	INDIAN	NAPOLIS, IN 46227	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	AIM Number: 1002		IAG	required by Federal and State	
	Indianapolis was for Requirements for Parameter Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one story facility Type V (000) const. The facility has a find detection in the corrithe corridor. The fasmoke detectors in a smoke detectors in a smoke detector.	the tensor of the extra the tensor of the extra the 2012 Edition of the extra Association (NFPA) 101, and a sociation (NFPA) 101, and a sociation (NFPA) 101, and a sociation and 410 IAC 16.2. It was determined to be of ruction and fully sprinklered, are alarm system with smoke ridors and in all areas open to include the social treatment of		law. The plan of correction is submitted in order to respond the allegation of noncompliant cited during the Life Safety Correctification and Emergenc Preparedness Survey completed on September 1, 2 Please accept this plan of correction as the provider's credible allegation of compliar We respectfully request a des review.	ce ode y 022.
	were sprinklered. T building providing s	dents have customary access The facility has one detached storage and a detached in were each not sprinklered.			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirem General Requirem List in the REMAR Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard cit on Form CMS-256	nents - Other nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included			
	failed to maintain la	on and interview, the facility utching hardware on 1 of 2 e Main Dining Room and	K 0100	1. CORRECTIVE ACTION TAKEN: a. The Maintenance	S 10/18/2022

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DEPARTMENT OF HEALTH AND HUMAN 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 09/01/2022 155409 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227 WATERS OF INDIANAPOLIS, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to install and maintain a door closing Supervisor/designee installed the coordinator for doors in 1 of 1 door sets to the latching hardware on the door Main Dining which are equipped with an astragal frame for the west door in the per 4.6.12.3. LSC 4.6.12.3 requires existing life corridor door set serving as the safety features obvious to the public if not entrance to the Main Dining Room required by the Code, shall be either maintained or to allow the door to latch into the removed. This deficient practice could affect over door frame. The maintenance 20 residents, staff and visitors in the Main Dining supervisor/designee also installed Room. a door closing coordinator to ensure the door with the astragal Findings include: always closes last on the west door in the door set to meet set Based on observations with the Maintenance standards. Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, the latching **ALL OTHERS WITH** hardware on the door frame for the west door in POTENTIAL TO BE AFFECTED: the corridor door set serving as the entrance to All residents and all staff the Main Dining Room by the center nurse's and visitors have the potential to station was removed and not in place to allow the be affected but none were. The latching mechanism on the door to latch into the Maintenance Supervisor/designee door frame. In addition, the west door in the door inspected all smoke barrier doors set was also equipped with an astragal but the throughout the facility and found door set was not provided with a door closing no other negative findings. coordinator to ensure the door equipped with the **MEASURES TO PREVENT** astragal always closes last. Each door in the door REOCCURRENCE: set was held in the open position with a wall The Administrator mounted magnetic releasing device set to release inserviced the Maintenance with fire alarm system activation. Based on Supervisor/designee on the interview at the time of the observations, the requirement that latching hardware Maintenance Director agreed the west door in the on smoke barrier doors must be door set had missing latching hardware on the maintained and in good working door frame and the door set was not equipped condition to meet set standards. with a door closing coordinator. b. Maintenance Supervisor/designee will inspect This finding was reviewed with the Administrator

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conference.

3.1-19(b)

and the Maintenance Director during the exit

Event ID:

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all smoke barrier doors throughout

the facility monthly to ensure they

facility's Preventive Maintenance Program and document those

are maintained and in good working condition as a part of the

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 09/01/2022
	ROVIDER OR SUPPLIER		389	EET ADDRESS, CITY, STATE, ZIP COD 5 S KEYSTONE AVE DIANAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	(X5) COMPLETION DATE
K 0300	NFPA 101			inspection results as approprised any issues are discovered will be addressed and resolvimmediately. The Maintena Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results be presented by the Mainter Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monitory Quality Assurance/Performation Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained.	riate. , they /ed nce riew s will nance ne e nthly ince ng. m d by ion d as
SS=F Bldg. 01	Protection - Other Protection - Other List in the REMAR Section 18.3 and requirements that provided K-tags, b information, along	KS section any LSC			

WATERS OF INDIANAPOLIS, THE

PRINTED: 09/20/2022

EPARTMENT OF HEALTH AND HUN	FORM APPROVED		
ENTERS FOR MEDICARE & MEDICA	AID 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 <u>01</u>	COMPLETED
	155409	B. WING	09/01/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KFYSTONE AVE	

INDIANAPOLIS, IN 46227

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	should be included on Form CMS-2567.			
	Based on record review, observation and	K 0300	1) CORRECTIVE ACTIONS	10/18/2022
	interview; the facility failed to ensure		TAKEN:	
	documentation for the preventative maintenance		a) The Maintenance	
	of all battery operated smoke alarms in resident		Supervisor/designee cleaned the	
	rooms was complete. NFPA 101 in 4.6.12.3 states		battery operated smoke detectors	
	existing life safety features obvious to the public,		in all resident rooms to meet set	
	if not required by the Code, shall be maintained.		standards.	
	NFPA 72, National Fire Alarm and Signaling Code,			
	2010 Edition, 29.10 Maintenance and Tests states		2) ALL OTHERS WITH	
	fire-warning equipment shall be maintained and		POTENTIAL TO BE AFFECTED:	
	tested in accordance with the manufacturer's		a) All residents and all staff	
	published instructions and per the requirements		and visitors have the potential to	
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,		be affected but none were.	
	testing, and maintenance programs shall satisfy		3) MEASURES TO PREVENT	
	the requirements of this Code and conform to the		REOCCURRENCE:	
	equipment manufacturer's published instructions.		a) The Administrator	
	This deficient practice could affect all residents,		inserviced the Maintenance	
	staff, and visitors.		Supervisor/designee on the	
			requirement that battery operated	
	Findings include:		smoke alarms must be maintained	
	_		per manufacture's guidelines and	
	Based on review of "Battery Operated Smoke		documentation retained at the	
	Detector Maintenance Log" documentation for		facility to meet set standards.	
	2021 and 2022 with the Maintenance Director		b) Maintenance	
	during record review from 8:35 a.m. to 11:15 a.m.		Supervisor/designee will clean the	
	on 09/01/22, resident room battery operated smoke		battery-operated smoke detectors	
	detector preventive maintenance documentation		once per month and document the	
	for the most recent twelve month period did not		results on the Battery-Operated	
	include cleaning documentation. Based on		Smoke Detector Maintenance Log	
	interview at the time of record review, the		to be filed in the Life Safety Binder	
	Maintenance Director agreed monthly testing		as a part of the facility's Preventive	
	documentation for the detectors did not include		Maintenance Program. If any	
	detector cleaning. Based on observations with		issues are discovered, they will be	
	the Maintenance Director at 12:45 p.m. on		addressed and resolved	
	09/01/22, manufacturer's documentation affixed to		immediately. The Maintenance	
	the First Alert Model 0827 battery operated smoke		Supervisor/designee will review	
	detector installed on the ceiling in resident		with the Administrator the	
	sleeping Room L-1 stated to clean the detector's		inspection results.	
	4 D 1 '4 ' 44	1	1 \	1

sensor once per month. Based on interview at the

The Administrator will

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED		
		155409	B. WING			09/01/2022		
				_				
NAME OF 1	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
					KEYSTONE AVE			
WATERS	S OF INDIANAPOLI	IS, THE		INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DEAN OF CORDECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE	
		tions, the Maintenance			monitor adherence to the			
		facility has the same type of			Preventative Maintenance			
		noke detector installed in all			schedule and validate the			
	resident sleeping ro				Preventative Maintenance			
					documentation is in place.			
	This finding was re	eviewed with the Administrator			4) MONITORING			
		ce Director during the exit			CORRECTIVE ACTION:			
	conference.				a) The inspection results	will		
					be presented by the Mainten			
	3.1-19(b)				Supervisor/designee to the			
					Administrator monthly and th	e		
					Administrator will present the			
					inspection results at the mon			
					Quality Assurance/Performar	-		
					Improvement (QA/PI) meetin			
					Inspection results and system	-		
					components will be reviewed			
					the QA/PI Committee with	Dy		
					subsequent plans of correction	าท		
					developed and implemented			
					deemed necessary to ensure			
					compliance is maintained.			
					Compliance is maintained.			
K 0321	NFPA 101							
SS=E	Hazardous Areas	- Enclosure						
Bldg. 01	Hazardous Areas							
ug. v .		are protected by a fire						
		our fire resistance rating						
	_	rated doors) or an						
	`	inguishing system in						
		3.7.1 or 19.3.5.9. When the						
		tic fire extinguishing system						
		e areas shall be separated						
		s by smoke resisting						
		ors in accordance with 8.4.						
	Doors shall be se							
		and permitted to have						
	_	applied protective plates that						
	I HOLLIAGO OL HEIG-	applied protective plates triat	1		i		1	

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the door.

do not exceed 48 inches from the bottom of

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155409	A. BUILDING B. WING	01	COMPLETED 09/01/2022
		100400			00/01/2022
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE	
WATERS	S OF INDIANAPOLI	IS, THE		NAPOLIS, IN 46227	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		and zone locations of			
		that are deficient in			
	REMARKS. 19.3.2.1, 19.3.5.9				
	19.3.2.1, 19.3.3.9				
	Area	Automatic Sprinkler			
		N/A			
	a. Boiler and Fuel	l-Fired Heater Rooms			
	b. Laundries (larg	er than 100 square feet)			
	c. Repair, Mainter	nance, and Paint Shops			
	d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms				
	(exceeding 64 gal	•			
		orage Rooms/Spaces			
	(over 50 square fe	cet) classified as Severe			
	Hazard - see K32				
		on and interview, the facility	K 0321	1. CORRECTIVE ACTION	IS 10/18/2022
		f over 12 hazardous areas such	10321	TAKEN:	10/10/2022
		rooms, soiled linen rooms		a. The Maintenance	
	(exceeding 64 gallo	ons) and Laundries (larger than		Supervisor/designee sealed the	ne
	100 square feet) we	ere separated from other spaces		annular space surrounding a	one
	by smoke resistant	partitions and doors. Doors		inch in diameter water line wh	ich
	1	g or automatic closing in		penetrated the back wall of th	
		2.1.8. This deficient practice		Mechanical Room near the ce	nter
	could affect over 20	0 residents, staff and visitors.		nurses station with a 1 hour fi	re
				rated material to meet set	
	Findings include:			standards.	
	Raced on observati	ons with the Maintenance		b. The Maintenance	20.3
		our of the facility from 11:15		Supervisor/designee sealed the inch hole in the ceiling next to	I
	_	on 09/01/22, the following was		sprinkler in the soiled utility ro	I
	noted:	on 05.01.22, the following was		near the entrance door to Hop	
		e surrounding a one inch in		Hall with a 1 hour fire rated	·
	_	which penetrated the back wall		material to meet set	
		Room near the center nurse's		standards.	
	station was not fire	stopped. The room contained		c. The Maintenance	
	two natural gas fire			Supervisor/designee sealed the	ne

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b. a three inch hole was noted in the ceiling next

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one inch in diameter open ended

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		l í				(X3) DATE SURVEY COMPLETED 09/01/2022	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF INDIANAPOLI	S, THE			KEYSTONE AVE APOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		in the soiled utility room near			conduit that penetrated the ce	iling	
		Hope Hall which exposed the			of the Laundry room behind th		
	attic above.				washing machine with a 1 hou	ır fire	
		neter open ended conduit ng of the Laundry room behind			rated material to meet set standards.		
	the washing machin				2. ALL OTHERS WITH		
	Based on interview				POTENTIAL TO BE AFFECTI	ED:	
	observations, the M	aintenance Director agreed			a. All residents and all sta	ff	
		walls and ceiling of the			and visitors have the potential		
		ms did not separate these			be affected but none were. The		
		m other spaces with smoke			Maintenance Supervisor/design		
	resistant partitions and doors. This finding was reviewed with the Administrator				inspected all hazardous areas		
					penetrations and found no oth negative findings.	ei	
		e Director during the exit			3. MEASURES TO PREVE	NT	
	conference.				REOCCURRENCE:		
					a. The Administrator		
	3.1-19(b)				inserviced the Maintenance		
					Supervisor/designee on the		
					requirement that all hazardous		
					areas must be maintained and	d free	
					of penetrations to meet set		
					standards. b. Maintenance		
					Supervisor/designee will inspe	ect	
					all hazardous areas throughou		
					facility monthly for penetration		
					a part of the facility's Preventi		
					Maintenance Program and		
					document those inspection re-		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. The Maintenance Supervisor/design		
					will review with the Administra	•	
					the inspection results.	.coi	
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
			1		schedule and validate the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BUILDING B. WING	01	COMPLETED 09/01/2022	
	ROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cooking * residential cooking appliances such as toasters) are used cooking in accordant 19.3.2.5.2 * cooking facilities smoke compartments comply wing the same accordant 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer pacconditions under 1	FPA 96, Standard for and Fire Protection of ng Operations, unless: ng equipment (i.e., small smicrowaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in the smith 30 or fewer the the conditions under		Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results who be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	hlly ce I. by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/01/2022 155409 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227 WATERS OF INDIANAPOLIS, THE (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 NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility K 0324 1. CORRECTIVE ACTIONS 10/18/2022 failed to ensure 1 of 1 kitchen range hood exhaust TAKEN: systems was maintained in proper working order. a. A Certified Contractor installed NFPA 96, Standard for Ventilation Control and the fan hinge kits on the range Fire Protection of Commercial Cooking hood exhaust systems to meet Operations, 2011 Edition, Section 7.8.2.1(8) set standards. requires rooftop terminations to be arranged with 2. ALL OTHERS WITH or provided with a hinged upblast fan supplied POTENTIAL TO BE AFFECTED: with flexible weatherproof electrical cable and a. All residents and all staff and service hold-open retainer to permit inspection visitors have the potential to be and cleaning that is listed for commercial cooking affected but none were. The equipment. This deficient practice could affect facility has only one kitchen. over two kitchen staff. 3. MEASURES TO PREVENT REOCCURRENCE: Findings include: a. The Administrator inserviced the Maintenance Based on review of the kitchen range hood Supervisor/designee on the system contractor's "Job Service Report" requirement that the kitchen range inspection documentation dated 03/07/22 with the hood exhaust system must be Maintenance Director during record review from maintained in proper working 8:35 a.m. to 11:15 a.m. on 09/01/22, the range hood condition to meet set standards. exhaust system fans needs hinge kits. The b. Maintenance "Noticed Areas of Concerns/Deficiencies" section Supervisor/designee will inspect of the 03/07/22 report stated "need fan hinges" the kitchen hood system monthly and the "Comments" section of the report stated to ensure the kitchen hood "Both fans need hinge kits". Based on interview exhaust system is properly at the time of record review, the Maintenance maintained as a part of the Director stated he was not aware of any recent facility's Preventive Maintenance hinge kit installation and stated hinge kit Program and document those installation documentation on or after 03/07/22 inspection results as appropriate. was not available for review at the time of the If any issues are discovered, they survey. will be addressed and resolved immediately. The Maintenance This finding was reviewed with the Administrator Supervisor/designee will review

and the Maintenance Director during the exit

with the Administrator the

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 155409 S. WING	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE INDIANAPOLIS, IN 46227 INSPECTION OF SURPECTION OF COMPLETION DATE ORDER TO SURPECTION OF SURPECTION DATE Inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 NEPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227 INDIANAPOL			155409	B. WI	NG		09/01/	/2022
WATERS OF INDIANAPOLIS, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION Conference. 3.1-19(h) AMONITORING CORRECTIVE ACTION: A MONITORING CORRECTIVE ACTION: A MONITORING CORRECTIVE ACTION: A The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the m								
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Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						Maintenance schedule and		
R 0362 SS=E Bldg. 01 NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						validate the Preventative		
A. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						Maintenance documentation is	s in	
ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Bldg. 01 Corridors - Construction of Walls Corridors - Construction of Walls Corridors are separated from use areas by						place.		
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presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						ACTION:		
Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362						a. The inspection results will b	е	
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Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by							-	
Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. K 0362 SS=E Corridors - Construction of Walls Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						-		
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SS=E Corridors - Construction of Walls Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by						compliance is maintained.		
SS=E Corridors - Construction of Walls Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by	V 0363	NEDA 404						
Bldg. 01 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by			uction of Mallo					
2012 EXISTING Corridors are separated from use areas by								
Corridors are separated from use areas by	Diag. 01		uction of waiis					
			arated from use areas by					
		•						
resistance rating. In fully sprinklered smoke								
compartments, partitions are only required to								
resist the transfer of smoke. In								
nonsprinklered buildings, walls extend to the								
underside of the floor or roof deck above the								
ceiling. Corridor walls may terminate at the								
underside of ceilings where specifically		-	-					
permitted by Code.			- ·					

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Event ID:

Fixed fire window assemblies in corridor walls

297021

Facility ID: 000537

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
		155409	B. Wl	NG		09/01/2022	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹		l	KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S, THE		INDIANAPOLIS, IN 46227			
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	are in accordance	with Section 8.3, but in					
	sprinklered compa	artments there are no					
	restrictions in area	a or fire resistance of glass					
	or frames.						
	If the walls have a	a fire resistance rating, give					
	the rating						
		nderside of the ceiling, give					
	I	n REMARKS, describing the					
	ceiling throughout						
	19.3.6.2, 19.3.6.2.7						
		on and interview, the facility	K 0	362	1. CORRECTIVE ACTION	S	10/18/2022
	failed to ensure corridor walls in 1 of 4 smoke				TAKEN:		
		e facility were constructed to			a. The Maintenance		
		f smoke. This deficient			Supervisor/designee repaired		
	-	et over 20 residents, staff and			hole in the corridor wall just at		
	L-6 and L-7.	ity of resident sleeping Room			the floor between resident slee		
	L-6 and L-7.				room L-6 and L-7 with a one h	our	
	Findings include:				fire rated material to meet set		
	Findings include.				standards.		
	Based on observation	ons with the Maintenance			2. ALL OTHERS WITH		
	Director during a to	our of the facility from 11:15			POTENTIAL TO BE AFFECTE	ED:	
	a.m. to 12:30 p.m.	on 09/01/22, an eight inch long			a. All residents and all staf	f	
	by five inch high ga	ash was noted in the corridor			and visitors have the potential	to	
	wall just above the	floor between resident			be affected but none were. The		
	sleeping Room L-6	and L-7 which would not resist			Maintenance Supervisor/desig	jnee	
	the passage of smol	ke. Based on interview at the			inspected all other areas		
		tions, the Maintenance			throughout the facility and four	nd	
	_	opening in the corridor wall			no other negative findings.		
	would not resist the	e passage of smoke.			3. MEASURES TO PREVE	ENT	
					REOCCURRENCE:		
		eviewed with the Administrator			a. The Administrator		
		ce Director during the exit			inserviced the Maintenance		
	conference.				Supervisor/designee on the		
					requirement that all corridor w		
	3.1-19(b)				throughout the facility must be		
					maintained in good condition t	0	
					meet set standards.		İ

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If continuation sheet

b. MaintenanceSupervisor/designee will inspect

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/01/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				all corridor walls throughout the facility monthly to ensure they remain in good condition as a of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues discovered, they will be addresund resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results where the presented by the Maintenance supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	part sults are ssed e gnee tor vill nnce hly ce .		
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and						

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Equipment using gas or related gas piping

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 ${\it Facility ID:} \quad 000537$

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIEI		STREET 3895 S INDIAN			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	Code, electrical we complies with NFI Code. Existing ins service provided in 18.5.1.1, 19.5.1.1 Based on observating failed to ensure 1 of were maintained in LSC 19.5.1.1 required 9.1. LSC 9.1.2 required equipment to compute Electrical Code. Note 314.28(3) (c) states provided with coversuitable for the commetal covers shall of requirements of 250 could affect over 5 the vicinity of Room Findings include: Based on observation birector during a total means a to	on and interview, the facility of 1 electrical junction boxes a safe operating condition. The section wires electrical wiring and the section with the section with the section with the section boxes shall be the section boxes shall be the section boxes with the box and ditions of use. Where used, comply with the grounding to the section of the facility from the section of the facility from 11:15 to the section of the facility from 11:15 to the section of resident sleeping the section of resident sleeping the section of the observations, the section of the observations, the section of the observations of the spliced which exposed the spliced	K 0511	1. CORRECTIVE ACTIONS TAKEN: a. The Maintenance Supervisor/designee installed cover on the electrical junction mounted in the attic above the attic access door in the restroct of resident sleeping room L3 to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staff and visitors have the potential be affected but none were. The Maintenance Supervisor/design inspected all electrical junction boxes throughout the facility to ensure they are maintained and a safe operating condition and found no other negative finding 3. MEASURES TO PREVERENCE: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that electrical junction boxes must be maintained and a safe operating condition to me set standards. b. Maintenance Supervisor/designee will inspectable electric junction boxes throughout the facility monthly all electric junction boxes throughout the facility monthly monthly all electric junction boxes throughout the facility monthly monthly all electric junction boxes throughout the facility monthly monthly all electric junction boxes throughout the facility monthly all electric junction boxes throughout the facility monthly all electric junction all electric junction all electric junct	a box com co com co com co	

ensure they are maintained and in

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	OF CORRECTION	IDENTIFICATION NUMBER 155409	A. BUILDING B. WING	01	COMPLETED 09/01/2022
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0761 SS=F Bldg. 01	3.1-19(b)			safe operating condition as a of the facility's Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrative inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results where the presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	sults are ssed ne gnee stor vill ince shly ce l. by
Diag. 01	interview; the facilit	riew, observation and ty failed to ensure annual ng of all fire door assemblies	K 0761	CORRECTIVE ACTION TAKEN: The Maintenance	10/18/2022

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MUI A. BUII B. WIN	LDING	ONSTRUCTION 01	(X3) DATE COMPL 09/01	ETED
NAME OF I	PROVIDER OR SUPPLIER	· ?			ADDRESS, CITY, STATE, ZIP COD	•	
WATERS	S OF INDIANAPOLI	S, THE			KEYSTONE AVE IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	accordance of LSC 19.1.1.4.1.1.			Supervisor/designee conducte		
		enings in dividing fire barriers			the annual testing and inspect	tions	
		4.1 shall be permitted only in			of required fire rated doors		
		be protected by approved			including the oxygen storage i		
	_	or assemblies. (See also Section			and documented those inspec	tion	
		Openings required to have a fire			results on the Annual Door		
		Table 8.3.4.2 shall be			Inspections log to meet set		
		wed, listed, labeled fire door window assemblies and their			standards. 2. ALL OTHERS WITH		
		lware, including all frames,				-D.	
					a. All residents and all state		
	closing devices, anchorage, and sills in accordance with the requirements of NFPA 80,				a. All residents and all state and visitors have the potential		
		oors and Other Opening			be affected but none were.	lo	
		as otherwise specified in this			3. MEASURES TO PREVI	ENT	
	Code. NFPA 80 5.2.1 states fire door assemblies				REOCCURRENCE:	-14 1	
		and tested not less than			a. The Administrator/corpo	orate	
	_	tten record of the inspection			Property Manager inserviced		
	1 -	kept for inspection by the			Maintenance Supervisor/desig		
		2.3.1 states functional testing of			on the requirement that annua	-	
		ow assemblies shall be			testing & inspections of fire ra		
		iduals with knowledge and			doors must be conducted and		
	1 -	e operating components of			documented on the Annual Do	oor	
	the type of door bei	ing subject to testing. NFPA			Inspections log and maintaine	d at	
	80, 5.2.4.1 states fir	re door assemblies shall be			the facility to meet set standar		
	visually inspected f	from both sides to assess the			b. The Maintenance		
	overall condition of	f door assembly.			Supervisor/designee will cond	uct	
					the annual door inspections a	nd	
		5.2.4.2 states as a minimum, the			document the inspection resul	lts	
	following items sha				on the Annual Door Inspectior	n log	
		or breaks exist in surfaces of			as a part of the facility's Preve	entive	
	either the door or fr				Maintenance Program and		
		light frames, and glazing beads			document those inspection re-		
		rely fastened in place, if so			as appropriate. If any issues		
	equipped.				discovered, they will be addre		
		e, hinges, hardware, and			and resolved immediately. Th		
		reshold are secured, aligned,			Maintenance Supervisor/desig	-	
	1	er with no visible signs of			will review with the Administra	itor	
	damage.				the inspection results.		
	(4) No parts are mis				c. The Administrator will		
	(5) Door clearances	s do not exceed clearances			monitor adherence to the		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155409	B. W	NG		09/01/	2022
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
VA/A TED	OF INDIANADOLI	O TUE			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	5, THE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· L	DATE
	listed in 4.8.4 and 6	5.3.1.7.			Preventative Maintenance		
	(6) The self-closing	device is operational; that is,			schedule and validate the		
	the active door com	pletely closes when operated			Preventative Maintenance		
	from the full open p				documentation is in place.		
	(7) If a coordinator is installed, the inactive leaf				4. MONITORING		
	closes before the active leaf.				CORRECTIVE ACTION:		
		are operates and secures the			a. The inspection results w	rill	
	door when it is in the closed position.				be presented by the Maintena		
	(9) Auxiliary hardware items that interfere or				Supervisor/designee to the		
	prohibit operation are not installed on the door or				Administrator monthly and the		
	frame.				Administrator will present the		
	(10) No field modif	ications to the door assembly			inspection results at the month	ıly	
		ed that void the label.			Quality Assurance/Performand	-	
	(11) Gasketing and edge seals, where required, are				Improvement (QA/PI) meeting		
	inspected to verify their presence and integrity.				Inspection results and system		
		ice could affect all residents,			components will be reviewed by	οV	
	staff and visitors.	,			the QA/PI Committee with	,	
					subsequent plans of correction	1	
	Findings include:				developed and implemented a		
					deemed necessary to ensure		
	Based on record rev	view with the Maintenance			compliance is maintained.		
	Director from 8:35	a.m. to 11:15 a.m. on 09/01/22,			·		
	annual inspection d	ocumentation of fire door					
	-	cility within the most recent					
		d was not available for review.					
	Based on interview	at the time of record review,					
		rector stated the facility has					
		room located inside the					
		annual fire door inspection					
	documentation for t	he corridor door to the room					
	was not available fo	or review. The Maintenance					
	Director stated he h	ad been working on fire door					
		facility but it was not available					
		ne of the survey. Based on					
		ne Maintenance Director					
	during a tour of the facility from 11:15 a.m. to 12:30						
	p.m. on 09/01/22, a single leaf fire-rated corridor						
	door to the oxygen storage and transfilling room						
		e's station was noted. The					
		with a 90 minute fire resistance					
	1 11		1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155409	B. W	ING		09/01/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	-			KEYSTONE AVE		
WATERS	OF INDIANAPOLIS	S, THE			APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	to the hinge side of the door.					
		s and fourteen 'E' type oxygen					
		ed in the room. In addition,					
	90-minute fire resistance rating labels were affixed						
	to the hinge sides of the corridor door sets in the						
	Faith Hall and the Love Hall. A one-hour fire						
	resistance rating label was affixed to the corridor door to the Mechanical Room by the center						
	nurse's station which contained two natural gas						
	fired water heaters.	ii contained two natural gas					
	med water neaters.						
	This finding was rev	viewed with the Administrator					
	and the Maintenanc	e Director during the exit					
	conference.						
	2.1.10(1)					ļ	
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01	Electrical Systems	s - Essential Electric					
	System Maintenar	nce and Testing					
	The generator or	other alternate power					
		ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	•	nis capability for the life					
		branches. Maintenance					
	_	generator and transfer					
	NFPA 110.	rmed in accordance with					
		e inspected weekly,					
		pad 30 minutes 12 times a					
		intervals, and exercised					
		nths for 4 continuous hours.					
	_	der load conditions include					
	a complete simula						
	-	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
			1		i e e e e e e e e e e e e e e e e e e e		1

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i '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409		JILDING	onstruction 01	(X3) DATE COMPL 09/01/	ETED
	ROVIDER OR SUPPLIER			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accordance with Noriccuit breakers are program for period components is estimanufacturer requof maintenance are and readily availal and circuits are meand separate from Minimizing the posterior emergency power consideration for reference of the following the posterior of the facility period emergency generated and NFPA 110. Code, 2012 Edition 1 and Type 2 essent sources (EPSS) shath Class X, Level 1 generated s	(NFPA 99), NFPA 110,	K 0	918	1. CORRECTIVE ACTION TAKEN: a. The Maintenance Supervisor/designee conducte the thirty six month period emergency generator test for t continuous hours and docume the results in the facilities Life Safety Binder to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTE a. All residents and all staf and visitors have the potential be affected but none were. 3. MEASURES TO PREVE REOCCURRENCE: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that a thirty six me period emergency generator to for four continuous hours is required to meet set standards b. The Maintenance	od four inted ED: f to ENT	10/18/2022

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BUILDING B. WING	01	COMPLETED 09/01/2022	
	ROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director from 8:35 at thirty-six month per testing documentation for the natural gas from a variable for reviews tated the facility has emergency generated of supplemental load the most recent threavailable for review the Maintenance Diffacility from 11:15 at the facility has one regenerator located in near the south exit of manufacturer's name could not be determined.	iew with the Maintenance a.m. to 11:15 a.m. on 09/01/22, iod emergency generator on for four continuous hours ired emergency generator was riew. Based on interview at the w, the Maintenance Director is one natural gas fired or and agreed documentation d testing for four hours within e year period was not . Based on observations with rector during a tour of the a.m. to 12:30 p.m. on 09/01/22, natural gas fired emergency side the Maintenance Office loor for the facility. The eplate rating for the generator ined. viewed with the Administrator e Director during the exit		Supervisor/designee will ensure thirty six month period emerge generator test for four continuation hours is conducted every three years and documented in the safety binder to meet set standards. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results who be presented by the Maintenan Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performant Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of corrections.	ency ous e life vill nce hly ce l.
	3.1-19(b)			developed and implemented a deemed necessary to ensure compliance is maintained.	as
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or eq Storage locations	Cylinder and Container Cylinder and Container yeal to 3,000 cubic feet are designed, constructed, ccordance with 5.1.3.3.2			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155409	B. Wl	ING		09/01/	/2022
				·			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					KEYSTONE AVE		
WATERS	s of Indianapoli	S, THE		INDIAN	APOLIS, IN 46227		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	>300 but <3,000 d	cubic feet					
	Storage locations	are outdoors in an					
	enclosure or withi	n an enclosed interior					
	space of non- or li	imited- combustible					
	construction, with	door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		s by 20 feet (5 feet if					
		closed in a cabinet of					
	noncombustible construction having a						
	minimum 1/2 hr. fire protection rating.						
	Less than or equal to 300 cubic feet						
	In a single smoke compartment, individual						
	cylinders available for immediate use in						
	patient care areas with an aggregate volume						
		ual to 300 cubic feet are not					
		red in an enclosure.					
		e handled with precautions					
	as specified in 11.						
	· ·	ign readable from 5 feet is					
		ate of a cylinder storage					
	_	sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN	I NO SMOKING."					
	Storage is planne	d so cylinders are used in					
	order of which the	ey are received from the					
	supplier. Empty of	cylinders are segregated					
	from full cylinders	. When facility employs					
		gral pressure gauge, a					
	l -	e considered empty is					
	established. Emp	oty cylinders are marked to					
		Cylinders stored in the open					
	are protected fron	-					
	I	.3.3, 11.3.4, 11.6.5 (NFPA					
	99)						
	. '	on and interview, the facility	K 0	923	1. CORRECTIVE ACTION	S	10/18/2022
		f 14 cylinders of nonflammable			TAKEN:		
	gases such as oxyge	en were properly secured from			a. The Director of		
		ygen storage areas. NFPA 99,			Nursing/designee secured the	four	
		ies Code, 2012 Edition, Section			E type oxygen cylinders in the		

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CENTERS FOR	OM	OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	G <u>01</u>	COMPI	COMPLETED	
		155409	B. WING		09/01/	09/01/2022	
NAME OF	DD OVAIDED OD CLIDDI IEI		STRE	EET ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			3895	5 S KEYSTONE AVE			
WATERS OF INDIANAPOLIS, THE			INDI	IANAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	1	ge for nonflammable gases		oxygen storage/trans-filling r	oom		
	equal to or greater than 85 cubic meters (3000		across from the entrance				
		mply with 5.1.3.3.2 and 5.1.3.3.3.		Main Dining Room to meet s	et		
	NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room across from the			standards.			
				2. ALL OTHERS WITH			
				POTENTIAL TO BE AFFECT	TED:		
				a. All residents and all staf			
				and visitors have the potenti	al to		
				be affected but none were.	The		
				DON/designee checked all a	areas		
	entrance to the Main Dining Room.			of the facility for improperly stored			
					oxygen cylinders and containers		
	Findings include:			and found no other negative			
				findings.			
	Based on observati	ons with the Maintenance		3. MEASURES TO PRE	√ENT		
	Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 09/01/22, four of fourteen 'E' type oxygen cylinders were freestanding on the			REOCCURRENCE:			
				a. The Administrator			
				inserviced the DON/designe	e and		
	floor in the oxygen storage and transfilling room			all other nursing staff on the			
	across from the entrance to the Main Dining			requirement that oxygen cyli			
	Room and were not properly secured from falling.				and liquid oxygen containers must		
	Six liquid oxygen containers and fourteen 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the four oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling in the oxygen			be restrained and in the prop			
				storage areas to meet set	701		
				standards.			
				b. The Director of			
				Nursing/designee will inspec	nt all		
					,t all		
	storage and transfil			oxygen cylinders and liquid	ut the		
	Storage and transfill	ming 100m.		oxygen containers throughout			
	This finding was	viewed with the Administrator		facility weekly to ensure they			
	This finding was reviewed with the Administrator and the Maintenance Director during the exit			restrained and properly store			
				a part of the facility's Oxyger			
	conference.			Policy and Procedures Prog			
	2.1.10(1)			and document those inspect			
	3.1-19(b)			results as appropriate. If ar	-		
				issues are discovered, they	will be		
				addressed and resolved			

immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.

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AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP O		01	(X3) DATE SURVEY COMPLETED 09/01/2022 COD	
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) C. The Administrator will monitor adherence to the Oxy Policy & Procedures schedule validate the Oxygen Policy & Procedures are in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results who be presented by the Maintena Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	gen e and vill ince hly ce j. by	(X5) COMPLETION DATE

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