DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292				JILDING	ONSTRUCTION	(X3) DATE : COMPL 02/02/	ETED
	PROVIDER OR SUPPLIER AN VILLAGE			2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST IAPOLIS, IN 46220		
(X4) ID		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 DEFICIENCY)	TE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
Bldg		aredness Survey was	E 00	000	This Plan of correction constit		
	Survey Dates: 02/0 Facility Number: 00 Provider Number: 1002	1/24 - 02/02/24 00189 155292 267330			this facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspectively. American Village respectfully requests	s blan on	
	S=C 441.184(c)(2), 482.15(c)(2), 483.475(c)(2),				consideration for a desk review this plan of correction.	w of	
E 0031 SS=C Bldg							
	an emergency pre	paredness communication					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE							

Gina Couch **Executive Director** 03/04/2024

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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ENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPI	
		155292	B. WING		02/02	/2024
NAME OF	PROVIDER OR SUPPLIEI		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	FROVIDER OR SUFFEIL	X.		AST 54TH ST		
AMERIC	AN VILLAGE		INDIAN	NAPOLIS, IN 46220		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		s with Federal, State and				
	local laws and must be reviewed and updated					
	1	ears [annually for LTC				
	_	mmunication plan must				
	include all of the following:					
	(2) Contact inform	nation for the following:				
	, ,	tribal, regional, and local				
	emergency prepa					
	(ii) Other sources					
	(ii) Other sources of assistance.					
	*IFor LTC Facilitie	es at §483.73(c):] (2)				
	Contact information for the following:					
		tribal, regional, and local				
	emergency prepa	-				
		nsing and Certification				
	Agency.					
	(iii) The Office of	the State Long-Term Care				
	Ombudsman.					
	(iv) Other sources	s of assistance.				
	*[For ICE/IIDs at 8	2492 475(a):1 (2) Contact				
	information for the	§483.475(c):] (2) Contact				
		tribal, regional, and local				
	emergency prepa	_				
	(ii) Other sources					
	` '	ensing and Certification				
	Agency.	showing and continuation				
		tection and Advocacy				
	Agency.					
		view and interview, the facility	E 0031	E031 Emergency Officials Cor	ntact	03/08/2024
		emergency preparedness		Information		
		n included all applicable		What corrective action(s) wil	I	
	sources of assistance	ce. This deficient practice		be accomplished for those		
	could affect all occ	upants.		residents found to have beer	า	
				affected by the deficient		
	Findings include:			practice		
				The Long-Term Care Ombuds	man	

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Based on records review and interview with the

with the Maintenance Director, Administrator and

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contact information including

telephone number was added to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/02/2024		
	ROVIDER OR SUPPLIER AN VILLAGE		2026	ET ADDRESS, CITY, STATE, ZIP COD S EAST 54TH ST ANAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
	REGULATORY OR Executive Director and 12:45 p.m., doc communication plan emergency operatio include specific con telephone number, f Long Term Care Or and ED agreed docu communication plan include specific con of the State Long To searched through th program manual thr however the aforem for the State Long To not be located in the survey. This finding was ac Maintenance Direct Executive Director again at the exit con Maintenance Direct	on 02/01/24 between 9:10 a.m. numentation of the part of the facility's ns plan reviewed did not stact information, including for notification of the State inbudsman. The Administrator imentation for the part of the program did not stact information for the facility of the program did not stact information for the office form Care Ombudsman. The ED is e emergency preparedness roughout the afternoon, sentioned contact information form Care Ombudsman could be plan at the time of the		the emergency preparednes communication plan. How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken No residents were affected be alleged deficient practice. All residents, visitors and stathave the potential to be affected by the alleged deficient practice by the alleged deficient practice changes will be made to ensure that the deficient practice does not recur. The Administrator and Exect Director have been educated regarding the emergency preparedness communication requirement of having the state ombudsman contact informating including telephone number. An administrative audit tool of completed to ensure the state ombudsman contact information.	g the the live by the off cted tice. into utive d n plan ate tion will be see tion
				will continue to be located in Emergency operations plan. How the corrective action(s will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be into place The POC QAPI Tool will utilized by ED/designer was	put
				utilized by ED/designee wee 4 weeks, monthly x 6 months	

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		IDENTIFICATION NUMBER 155292	A. BUILDING B. WING	onstruction 	COMPLETED 02/02/2024		
	PROVIDER OR SUPPLIER AN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(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		
				quarterly thereafter for one ye with results reported to the Quassurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	seen ot oe		
K 0000 Bldg. 01							
			K 0000	This Plan of correction constit this facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspect report. American Village respectfully requests consideration for a desk reviet this plan of correction.	of s olan ion etion		

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155292	A. BUILDING <u>01</u> B. WING		COMPLETED 02/02/2024	
	ROVIDER OR SUPPLIER		2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST IAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 0100 SS=E Bldg. 01	rehab wing. The face with smoke detection and in all areas open has battery operated resident sleeping rood detectors hard wired system in 23 of 82 r facility has a capacitation 120 at the time of the All areas where resident sprinklered. As services were sprinklered. As serv	ility has a fire alarm system on on all levels in the corridors on to the corridor. The facility a smoke detectors in 59 of 82 coms. The facility has smoke a to the facility's electrical esident sleeping rooms. The try of 150 and had a census of the facility's electrical esident sleeping rooms. The try of 150 and had a census of the facility survey. In a census of the facility electric and the facility electron of the facility electron, should be included facility. The facility of the	K 0100	K100 General Requirements - Other What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	03/08/2024	
	evacuation of occup	eants. This deficient practice eats and staff in the therapy		The electric range in the thera area power supplied was immediately shut off and the p and wood products in direct contact were removed. The smoke barrier doors on 20	aper	

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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 155292 B. WING 02/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2026 EAST 54TH ST INDIANAPOLIS, IN 46220 AMERICAN VILLAGE (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 Based on observations and interview during a hall latching hardware was tour of the facility with the Maintenance Director adjusted to ensure the 200 hall and Administrator on 02/01/24 between 12:45 p.m. smoke barrier doors near room and 4:30 p.m., the electric range in the therapy 201 latch when closed. How other residents having the area, with power supplied to the appliance, had placed on the electric burners, paper and wood potential to be affected by the products in direct contact with the burners failing same deficient practice will be to minimize the possibility of a fire emergency identified and what corrective relating to the aforementioned appliance. The MD action(s) will be taken and Administrator acknowledged the condition No residents were affected by the stating that the staff know better than to do this. alleged deficient practice. All residents, visitors and staff This finding was acknowledged by the have the potential to be affected Maintenance Director, Administrator and by the alleged deficient practice. Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the What measures will be put into Maintenance Director, Administrator, Executive place or what systemic Director, and Reginal Vice President all present. changes will be made to ensure that the deficient 3.1-19(b) practice does not recur The Therapy department has been 2) Based on observation and interview, the facility educated on facilities practice of failed to maintain latching hardware on 1 of 6 the electric range power being off smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 when not in use and to not have requires existing life safety features obvious to wood or paper items on range. the public if not required by the Code, shall be The Maintenance Director either maintained or removed. This deficient educated regarding smoke barrier practice could affect 15 residents and staff in the doors latching when closing. 200 Hall. A maintenance audit tool will be completed to ensure the smoke Finding include: barrier doors latch when closing and wood or paper items on range Based on observations and interview during a in therapy gym. tour of the facility with the Maintenance Director and Administrator on 02/01/24 between 12:45 p.m. How the corrective action(s) and 4:30 p.m., the smoke barrier doors equipped will be monitored to ensure the with latching hardware, on the 200 Hall near RR# deficient practice will not 201 failed to latch when closed. recur, ie., what quality assurance program will be put This finding was acknowledged by the into place

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED	
		155292	B. W	ING		02/02/	2024	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹		2026 EAST 54TH ST				
AMERIC	AN VILLAGE			INDIANAPOLIS, IN 46220				
(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 OR LSC IDENTIFYING INFORMATION		_	TAG DEFICIENCY)			DATE	
		tor, Administrator and			The POC QAPI Tool will be			
		at the time of discovery and			utilized by ED/designee weekl	-		
	_	nference on 02/02/24 with the			4 weeks, monthly x 6 months,			
		tor, Administrator, Executive			quarterly thereafter for one year			
	Director, and Reginal Vice President all present.				with results reported to the Qu	ality		
2.1.10(1)				Assurance and Performance				
	3.1-19(b)				Improvement Committee over	seen		
				by the Executive Director	- 4			
				If a threshold of 95% is no				
					achieved, an action plan will b			
				developed to ensure complian	ce.			
K 0211	NFPA 101							
SS=E	Means of Egress	- General						
Bldg. 01	Means of Egress - General							
J	_	ays, corridors, exit						
		ocations, and accesses are						
		h Chapter 7, and the means						
		nuously maintained free of						
	1	full use in case of						
	emergency, unles	s modified by 18/19.2.2						
	through 18/19.2.1	1.						
	18.2.1, 19.2.1, 7.1	1.10.1						
	Based on observation	on and interview, the facility	K 0	211	K211 Means of Egress - Gene	eral	03/08/2024	
	failed to ensure 1 of	f over 8 means of egress was			What corrective action(s) wil	I		
	1	ained free of all obstructions			be accomplished for those			
	_	full instant use in the case of			residents found to have beer	1		
	_	ency. This deficient practice			affected by the deficient			
		residents, staff and visitors if			practice			
	needing to exit the	facility.			The charcoal grill and crates v			
					removed from the exit dischar	-		
	Findings include:				sidewalk leading from the dini	ng		
					area exit into the courtyard.			
		ons and interview during a			How other residents having t			
	· ·	with the Maintenance Director			potential to be affected by th			
		on 02/01/24 between 12:45 p.m.			same deficient practice will be			
	_	exit discharge sidewalk leading			identified and what correctiv	е		
	_	a exit (marked a facility exit)			action(s) will be taken			
	into the courtyard c	ontained several crates and a			No residents were affected by	the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		A. BUILDING B. WING	<u>01</u>	COMPLETED 02/02/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE		
	charcoal grill all plasidewalk component MD and Administrate leading to the public that it would need to This finding was act Maintenance Direct Executive Directors again at the exit cont Maintenance Direct Director, and Regin 3.1-19(b)	tof the exit discharge. The tor acknowledged that the exit c way was obstructed stating to be cleared.	IAU	alleged deficient practice. All residents, visitors and state have the potential to be affect by the alleged deficient practice. What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director educated regarding means of egress being maintained free obstructions. A maintenance audit tool will completed to ensure the metegress leading from dining recourtyard be free of all obstructions. How the corrective action(swill be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be into place The POC QAPI Tool will utilized by ED/designee weed 4 weeks, monthly x 6 month quarterly thereafter for one you with results reported to the CAssurance and Performance Improvement Committee over by the Executive Director. If a threshold of 95% is achieved, an action plan will developed to ensure compliance.	aff cted tice. into of e of all I be ans of com to s) e the put I be ckly x s, and rear Quality e erseen not be		
K 0222 SS=F	NFPA 101 Egress Doors						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155292	B. WI	NG		02/02/	/2024
				STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				AST 54TH ST		
AMERICA	AN VILLAGE				APOLIS, IN 46220		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
Bldg. 01	Egress Doors						
-	Doors in a require	d means of egress shall not					
	-	a latch or a lock that					
		f a tool or key from the					
	-	s using one of the following					
	special locking arr	angements:					
	CLINICAL NEEDS	OR SECURITY THREAT					
	LOCKING						
	Where special lock	king arrangements for the					
	clinical security ne	eds of the patient are					
used, only one locking		king device shall be					
■ *		door and provisions shall					
be made for the rapid remo		pid removal of occupants					
1 -		of locks; keying of all					
•		ed by staff at all times; or					
	other such reliable	e means available to the					
	staff at all times.						
	18.2.2.2.5.1, 18.2.	2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENTS						
	-	king arrangements for the					
	_	e patient are used, all of					
		curity Locking requirements					
	•	addition, the locks must be					
		at fail safely so as to					
	-	of power to the device; the					
	• •	ed by a supervised					
	•	r system and the locked					
		by a complete smoke					
		or is constantly monitored					
		ation within the locked					
		he sprinkler and detection					
	-	ged to unlock the doors					
	upon activation.	2.2.5.2. TIA 4.2.4					
	18.2.2.2.5.2, 19.2.						
	DELAYED-EGRES						
	ARRANGEMENTS						
		elayed-egress locking					
systems installed in accordance with							

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		ROVIDER OR SUPPLIER		2026	T ADDRESS, CITY, STATE, ZIP COD EAST 54TH ST ANAPOLIS, IN 46220	
	(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		contents in building an approved, super detection system of automatic sprinkled 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accordate be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detection automatic fire detection automatic fire detection automatic fire detection of the facility of the fac	g low and ordinary hazard gs protected throughout by servised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an sed automatic sprinkler 2.4 attion and interview, the facility of over 8 exterior exit doors were and able to open on first try. ice could affect 30 or more	K 0222	K222 – Egress Doors What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The 300 hall exit door was inspected by IEI and the issue was corrected before the life safety survey exit. The dining room exit door to the courtyard was adjusted and corrected. The 100 hall signage of push and alarm will sound signage been removed.	he here has

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155292	B. W	ING		02/02/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			AST 54TH ST		
AMERIC	AN VILLAGE		INDIANAPOLIS, IN 46220				
	T		1		T	T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG		DATE	
	_	de the door. A quote was			potential to be affected by th	I	
	1 ~	ntractor dated 07/31/23			same deficient practice will I		
	_	ess that the aforementioned			identified and what corrective	'e	
	door had an issue. The facilities Fire Alarm				action(s) will be taken	. 41	
	contractor was called at the time of the survey and notified of the issue with the magnetic lock. The				No residents were affected by	rine	
		_			alleged deficient practice.		
		force the door open,			All residents, visitors and staff	I	
	_	netic locking device and			have the potential to be affect	I	
		at the location to prevent			by the alleged deficient praction	Je.	
	elopement. The issue was corrected before the Survey Exit the next day.				What magazines will be mut in		
(2) The Dining Exit, marked a facility exit, took					What measures will be put in	110	
	excessive force to open. The MD stated that "you				place or what systemic		
	have to lift up and push" to open the door				changes will be made to ensure that the deficient		
	because it was "rusted at the bottom and needs						
	replaced."	ed at the bottom and needs			practice does not recur The Maintenance Director		
	теріасец.				educated regarding exterior e	vit	
	This finding was ac	knowledged by the			doors to be readily accessible	I	
	_	or, Administrator and			able to open.	anu	
		at the time of discovery and			A maintenance audit tool will I	20	
		afterence on 02/02/24 with the			completed to ensure the 300 l	I	
	_	or, Administrator, Executive			exit door and dining room exit	I	
		al Vice President all present.			to be readily accessible and a	I	
	Birector, and regin	ar vice riesiaem an present.			to open.	DIC	
					A maintenance audit tool will I	ne	
	2. The facility failed	d to ensure the delayed egress			completed to ensure the signa		
	1	its were installed in accordance			of "Push here alarm will sound	-	
		3 of 12 exits. LSC 7.2.1.6.1(3)			has been removed from the ex		
		e process shall release the lock			doors that do not have the rele		
		gress within 15 seconds, or 30					
	seconds where appr	oved by the authority having			How the corrective action(s)		
	jurisdiction, upon a	pplication of a force to the			will be monitored to ensure		
		red in 7.2.1.5.10 under all of			deficient practice will not		
	the following conditions:				recur, ie., what quality		
	(a) The force shall not be required to exceed 15 lbf				assurance program will be p	ut	
	(67 N).				into place		
	(b) The force shall i	not be required to be			The POC QAPI Tool will I	oe	
		d for more than 3 seconds.			utilized by ED/designee week		
	(c) The initiation of	the release process shall			4 weeks, monthly x 6 months,		
	activate an audible signal in the vicinity of the				quarterly thereafter for one ye	I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Z4121

Facility ID: 000189

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULTII A. BUILDI B. WING		onstruction 01	(X3) DATE COMPI 02/02	LETED	
	PROVIDER OR SUPPLIEF	2	20	26 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	application of force	as been released by the to the releasing device, y manual means only. This ould all residents.			with results reported to the Q Assurance and Performance Improvement Committee ove by the Executive Director If a threshold of 95% is r achieved, an action plan will developed to ensure complia	rseen not be	
	tour of the facility vand Administrator of and 4:30 p.m., sever facility, such as the the doors reading "I however the doors delayed egress meet the facility were seen to 15 second delayed egres appear to release. The speculated that the second delayed egres appear to release.	ons and interview during a with the Maintenance Director on 02/01/24 between 12:45 p.m. ral exit doors throughout the 100 hall exit, had signage on Push Here Alarm will Sound" did not have a functioning hanism. The doors throughout cured with an electronic keypad red egress. When tested for 15 ess the exit doors did not he MD and Administrator aforementioned signage was need to be removed.					
	Executive Director again at the exit con Maintenance Direct	knowledged by the cor, Administrator and at the time of discovery and afference on 02/02/24 with the cor, Administrator, Executive all Vice President all present.					
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that provided K-tags, k	RKS section any LSC					

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Event ID:

4Z4121

Facility ID: 000189

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155292	B. Wl	NG		02/02/	2024
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			AST 54TH ST		
AMEDIC	AN VILLAGE				IAPOLIS, IN 46220		
AMERIC	AN VILLAGE			INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	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
	Safety Code or NI	FPA standard citation,					
	should be include	d on Form CMS-2567.					
	Based on record rev	view, interview and	K 0	300	K300 Protection - Other		03/08/2024
	observation, the fac	cility failed to ensure			What corrective action(s) wil	l	
	documentation for the preventative maintenance				be accomplished for those		
	of 59 of 59 battery	operated smoke alarms in			residents found to have beer	1	
	resident rooms was	complete. NFPA 101 in			affected by the deficient		
	4.6.12.3 states existing life safety features obvious				practice		
	to the public, if not required by the Code, shall be				All 59 of 59 smoke alarms		
	maintained. NFPA 72, 29.10 Maintenance and				batteries were replaced with d	ate	
	Tests. Fire-warning equipment shall be maintained				recorded.		
	and tested in accordance with the manufacturer's				All 59 of 59 smoke detectors		
	published instructions and per the requirements			received a monthly cl		er	
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,				manufacturer recommendation	ıs.	
	testing, and mainter	nance programs shall satisfy			How other residents having t	he	
	_	this Code and conform to the			potential to be affected by th	е	
		cturer's published instructions.		same deficient practice will be		е	
	_	ice could affect all residents,			identified and what correctiv	е	
	staff, and visitors.				action(s) will be taken		
					No residents were affected by	the	
	Findings include:				alleged deficient practice.		
					All residents, visitors and staff		
		view of the document entitled			have the potential to be affected	ed	
		moke detector inspection			by the alleged deficient practic	е	
	_	interview with the Maintenance			What measures will be put in	to	
	· ·	rator and Executive Director on			place or what systemic		
		2:10 a.m. and 12:45 p.m., there			changes will be made to		
		t or record of when the			ensure that the deficient		
		dent room battery operated			practice does not recur		
		installed or replaced. Based on			The Maintenance Director has	i	
		ne of record review, the			been educated on battery		
		tor stated that he was not			operated smoke alarms record		
		when the batteries were being			keeping of when batteries wer		
	replaced on the battery-operated smoke detectors.				installed or replaced along with	n	
		nmendations on the sticker			monthly cleaning.		
	behind the smoke detector provided for reviews				A maintenance audit tool will b	e	
	called for weekly testing and monthly cleaning.				completed to ensure all		
	· ·	ID stated he was not keeping			battery-operated smoke alarm		
		he monthly cleaning of the			batteries were replaced along		
	battery-operated smoke detectors. Based on				monthly cleaning in accordance	e	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	l í	JILDING	onstruction 01	(X3) DATE COMPL 02/02 /	ETED
	PROVIDER OR SUPPLIER			2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	of 82 resident sleep facility did indeed he detectors. This finding was ac Maintenance Direct Executive Director again at the exit cor Maintenance Direct	during a tour of the facility, 59 ing rooms surveyed within the lave battery operated smoke knowledged by the or, Administrator and at the time of discovery and afference on 02/02/24 with the or, Administrator, Executive all Vice President all present.			How the corrective action(s) will be monitored to ensure to deficient practice will not recur, ie., what quality assurance program will be pinto place The POC QAPI Tool will butilized by ED/designee weekly 4 weeks, monthly x 6 months, quarterly thereafter for one yewith results reported to the Quasurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	the ut De y x and ar ality seen	
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinuction accordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.					

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Event ID:

4Z4121

Facility ID: 000189

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155292	B. Wl	NG		02/02	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			AST 54TH ST		
AMERIC	AN VILLAGE			INDIANAPOLIS, IN 46220			
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Aroo	Automatia Sprinklar					
	Area Separation	Automatic Sprinkler N/A					
	a. Boiler and Fuel-Fired Heater Rooms						
	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms						
	(exceeding 64 gallons)						
	f. Combustible St	orage Rooms/Spaces					
	(over 50 square fo	eet)					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	•	ļ				
		on and interview, the facility	K 0	321	K321 – Hazardous Areas -		03/08/2024
		f 1 400 Hall linen closets was			Enclosure		
	_	er corridor by smoke resistant			What corrective action(s) will l		
		nt practice could affect 20 plus			accomplished for those reside		
	residents and staff	in one smoke compartment.			found to have been affected b	y the	
	Eindings in stude				deficient practice		
	Findings include:				The 400-hall linen closet door	nas	
	Based on observati	ons and interview during a			been repaired. How other residents having the	16	
		with the Maintenance Director			potential to be affected by the		
		on 02/01/24 between 12:45 p.m.			same deficient practice will be		
		corridor door to the 400-hall			identified and what corrective		
	_	ped with a self-closing device			action(s) will be taken		
		n holes near the doorknob.			No residents were affected by	the	
	Based on interview at the time of the observation,				alleged deficient practice.		
	the MD and Admir	istrator agreed the linen closet			All residents, visitors and staff	F	
	corridor door would	d not resist the passage of			have the potential to be affect	ed	
	smoke.				by the alleged deficient practic	се.	
		cknowledged by the			What measures will be put int	o	
		tor, Administrator and			place or what systemic chang		
		at the time of discovery and			will be made to ensure that the		
	Lagain at the exit co	nference on 02/02/24 with the	1		deficient practice does not rec	nir	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		A. BUILDING B. WING	01	COMPLETED 02/02/2024	
		2026 E	ADDRESS, CITY, STATE, ZIP COD EAST 54TH ST NAPOLIS, IN 46220		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director, and Regin			The Maintenance Director educated regarding the 400 h linen closet door to be separa from other corridor by smoke resistant doors. A maintenance audit tool will be completed to ensure the 400 l linen closet door to be free of holes. How the corrective action(s) we monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will put into place The POC QAPI Tool of the be utilized by ED/designee were at 4 weeks, monthly x 6 month and quarterly thereafter for on year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% not achieved, an action plan we be developed to ensure compliance.	ted De nall vill be ent at I be will eekly s, e ene
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cookin appliances such a	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155292	B. W	ING		02/02/2024
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD AST 54TH ST	•
AMERIC	AN VILLAGE				IAPOLIS, IN 46220	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		ance with 18.3.2.5.2,				
	19.3.2.5.2					
	_	open to the corridor in				
	smoke compartments with 30 or fewer patients comply with the conditions under					
	18.3.2.5.3, 19.3.2.5.3, or					
	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.					
	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not					
	be open to the corridor.					
	l '	n 18.3.2.5.4, 19.3.2.5.1				
	through 19.3.2.5.5					
		on and interview, the facility	K 0	324	K324 Cooking Facilities	03/08/2024
	failed to ensure staf	ff had access to the shutoff			What corrective action(s) will	iI e
	switch for 1 of 1 co	ok tops in the therapy area.			be accomplished for those	
	LSC 19.3.2.5.4 state	es within a smoke compartment,			residents found to have been	n
		nercial cooking equipment that			affected by the deficient	
		neals for 30 or fewer persons			practice	
		provided that the cooking			The electric range in the thera	ру
		ith all of the following			area power supplied was	
	conditions:				immediately shut off.	
		ining the cooking equipment			How other residents having	
	is not a sleeping roo				potential to be affected by th	
		ining the cooking equipment			same deficient practice will I	
	_	rom the corridor by partitions			identified and what corrective	e
	1	3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10)			action(s) will be taken	, the
	and (13) are met.	18 01 19.3.2.3.3(1) tilrough (10)			No residents were affected by alleged deficient practice.	uie
	` ′	A switch meeting all of the			All residents, visitors and staff	;
	following is provide	_			have the potential to be affect	
		, or a switch located in a			by the alleged deficient practic	
					by the aneged denoterit practic	~.
	restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff				What measures will be put in	nto
					place or what systemic	
					changes will be made to	
	supervision.				ensure that the deficient	
	_	ice could affect 8 residents and			practice does not recur	

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Event ID:

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Facility ID: 000189

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155292	B. W	NG		02/02/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				AST 54TH ST		
AMERICA	AN VILLAGE				APOLIS, IN 46220		
			<u> </u>		- ,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA"		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	staff in the therapy	area.			The Therapy department has I		
	Findings include:				educated on facilities practice		
	rindings include.				the electric range power being when not in use.	OII	
	Based on observation	ons and interview during a			A maintenance audit tool will b	.	
		with the Maintenance Director			completed to ensure the range		
	and Administrator on 02/01/24 between 12:45 p.m.				therapy gym to be off when no		
	and 4:30 p.m., there was an electric range in the				use.		
	and 4:30 p.m., there was an electric range in the therapy area that was powered on and not in use. The Maintenance Director was asked if staff knew how to deactivate the range when not in use and he was unsure. The Maintenance Director stated				use.		
					How the corrective action(s)		
					will be monitored to ensure t	he I	
					deficient practice will not		
	there was a shut off switch to the electric range. This finding was acknowledged by the				recur, ie., what quality		
					assurance program will be po	ut	
					into place		
	Maintenance Direct	or, Administrator and			The POC QAPI Tool will b	е	
	Executive Director	at the time of discovery and			utilized by ED/designee weekl	уx	
	again at the exit con	ference on 02/02/24 with the			4 weeks, monthly x 6 months,	and	
	Maintenance Direct	or, Administrator, Executive			quarterly thereafter for one yea	ar	
	Director, and Regin	al Vice President all present.			with results reported to the Qu	ality	
					Assurance and Performance		
	3.1-19(b)				Improvement Committee overs	seen	
					by the Executive Director		
					If a threshold of 95% is no	-	
					achieved, an action plan will be		
					developed to ensure complian	ce.	
K 0345	NFPA 101						
SS=C	Fire Alarm System	a - Testing and					
Bldg. 01	Maintenance	1 - Testing and					
Diag. 01	Fire Alarm System	- Testing and					
	Maintenance	r - resumg and					
		n is tested and maintained					
	-	n an approved program					
		e requirements of NFPA 70,					
	National Electric Code, and NFPA 72,						
		n and Signaling Code.					
		n acceptance, maintenance					
	and testing are rea	•					
	9.6.1.3, 9.6.1.5, N	-					

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Event ID:

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Facility ID: 000189

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	î ´	UILDING	01	COMP	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·		2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST APOLIS, IN 46220		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION ID BE OPRIATE	(X5) COMPLETION DATE
	failed to maintain that it had accurate accordance with the 2012 edition, Section - 2010 edition - 2010 edition, Section - 2010 edition -		KO	345	Testing and Maintenance What corrective action(s) be accomplished for tho residents found to have affected by the deficient practice The fire alarm date has be and is correct. How other residents hav potential to be affected is same deficient practice identified and what corre action(s) will be taken. No residents were affecte alleged deficient practice. All residents, visitors and have the potential to be at by the alleged deficient pr What measures will be p place or what systemic changes will be made to ensure that the deficient practice does not recur The Maintenance Director been trained in ensuring t alarm panel has the corre A maintenance audit tool completed to ensure the correct on the fire alarm p How the corrective actio will be monitored to ensure deficient practice will no recur, ie., what quality assurance program will i into place The POC QAPI Tool utilized by ED/designee w 4 weeks, monthly x 6 mor quarterly thereafter for on	e been een reset ing the by the will be ective d by the staff ffected actice. ut into has he fire ct date. will be late is anel. n(s) ure the t be put will be eekly x atths, and	03/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) M		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	ETED
		155292	B. WI	NG		02/02/	2024
				CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD AST 54TH ST		
AMEDICA	AN VILLAGE			INDIANAPOLIS, IN 46220			
AWENIO	AN VILLAGE			INDIAN	AFOLIS, IN 40220		
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					with results reported to the Qu	ality	
					Assurance and Performance		
					Improvement Committee overs	seen	
					by the Executive Director		
					If a threshold of 95% is no	t	
					achieved, an action plan will b	е	
					developed to ensure complian	ce.	
K 0351	NFPA 101						
SS=E	Sprinkler System -						
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING						
	_	nd hospitals where required					
	by construction type	•					
		approved automatic					
	•	n accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.						
	• •	nstruction, alternative					
	•	es are permitted to be					
	·	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.						
		klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	•	sprinkler coverage covers					
	•	t as required by NFPA 13,					
	Standard for Insta	llation of Sprinkler					
	Systems.						
		19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 03	351	K351 Sprinkler System -		03/08/2024
		a complete automatic			Installation		
	•	documentation of fire			What corrective action(s) will		
		vas provided for 1 of 1 canvas			be accomplished for those		
	-	-2010 Edition, Section 8.15.7.1			residents found to have been	1	
		ill be installed under exterior			affected by the deficient		
		te-cocheres, balconies, decks,			practice		
	or similar projection	ns exceeding 4 ft. (1.2 m) in			The canvas canopy attached t	0	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	
		155292	B. W	ING	_	02/02/	2024
)	NOT THE OF STATE	•	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIEF	t			AST 54TH ST		
AMERIC	AN VILLAGE			INDIAN	APOLIS, IN 46220		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		.7.2 states sprinklers shall be			the building outside the 100 ha	all	
	1 -	tted where the canopies, roofs,			east exit has been removed.		
	1 -	conies, decks, or similar			How other residents having		
	projections are constructed with materials that are				potential to be affected by th		
	noncombustible or limited-combustible, or fire				same deficient practice will be		
	retardant. Textiles such as canvas used as an				identified and what correctiv	е	
	awning shall meet NFPA 701, Standard Methods				action(s) will be taken.	41	
	of Fire Tests for Flame Propagation of Textiles and				No residents were affected by	ıne	
	Films. This deficient practice could affect at least 20 residents evacuating the facility.				alleged deficient practice.	,	
	20 residents evacua	ting the facility.			All residents, visitors and staff		
	Findings include:				have the potential to be affect		
	Findings include.				by the alleged deficient practic		
	Raced on observations and interview during a				What measures will be put in	ιτο	
	Based on observations and interview during a tour of the facility with the Maintenance Director				place or what systemic		
	1	on 02/01/24 between 12:45 p.m.			changes will be made to ensure that the deficient		
		e was a canvas canopy attached					
	_	ide the 100 Hall East Exit			practice does not recur The Maintenance Director has		
	I -	proximately 20'X12', which was			been trained in ensuring that	•	
		d on record review no			outside canopies must have		
	_	d be provided to show the			documentation on fire retardar	nt	
		tly flame retardant. At the exit			materials.	ıı	
		2/24 the ED and Regional Vice			How the corrective action(s)		
		t the canopy would likely be			will be monitored to ensure t		
		g the survey exit, a document			deficient practice will not		
		surveyor implying that the			recur, ie., what quality		
		opy was in compliance and			assurance program will be p	ut	
		e retardant. It could not be			into place		
	I	urveyor that the post survey			The POC QAPI Tool will b	oe l	
	documentation was				utilized by ED/designee weekl		
	aforementioned can				4 weeks, monthly x 6 months,	-	
					quarterly thereafter for one ye		
	This finding was ac	knowledged by the			with results reported to the Qu		
	_	or, Administrator and			Assurance and Performance	-	
	Executive Director	at the time of discovery and			Improvement Committee over	seen	
	again at the exit cor	nference on 02/02/24 with the			by the Executive Director		
		tor, Administrator, Executive			If a threshold of 95% is no	ot	
	Director, and Regin	al Vice President all present.			achieved, an action plan will b	е	
					developed to ensure complian		
	3.1-19(b)				l '		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLI A. BUILDING	e construction G <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155292	B. WING		02/02/2024
	PROVIDER OR SUPPLIER		2026	ET ADDRESS, CITY, STATE, ZIP COD 5 EAST 54TH ST IANAPOLIS, IN 46220	•
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler. b) Who provided b) Who provided c) Water system Provide in REMAF coverage for any reautomatic sprinkler systems in accordance at the systems. NFPA 25 states sprinklers material fast-response element for 20 years shall be tested to repeat the property owner shall correct or reparticular. In the property owner shall correct or reparticular accordance in the property owner shall correct or reparticular.	supply source RKS information on non-required or partial r system. and NFPA 25 review and interview, the intain automatic sprinkler are with NFPA 25. LSC 9.7.5 r systems shall be inspected, and in accordance with NFPA Inspection, Testing, and ter-Based Fire Protection, 2011 Edition, Section 5.1.1.1.3 nufactured using ints that have been in service replaced, or representative ted and then retested at IFPA 25, Section 4.1.4.1 states or designated representative ir deficiencies or impairments g the inspection, test and	K 0353	K353 Sprinkler System – Maintenance and Testing What corrective action(s) was be accomplished for those residents found to have be affected by the deficient practice The random sprinkler head sampling was inspected on December 19, 2023. There are two of every type kind of sprinkler head located the spare sprinkler cabinet a with a list of each type of sphead in this facility. How other residents having potential to be affected by	and ed in along rinkler

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB	NO. 0938-039
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	A. BU	LDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/02/2024	
			2026 E	AST 54TH ST		
SUMMARY (EACH DEFICIEN REGULATORY OF Corrections and rep qualified maintenar contractor. NFPA 2 be made for all insp maintenance of the be made available t jurisdiction upon re could affect all resid facility. Findings include: Based on records re with the Maintenan Executive Director and 12:45 p.m., def facility's sprinkler s Summary" section of system inspection re fast response eleme replaced or success 10 years?" Followe sample on file." Ba record review, the M was unaware of the reported deficiency	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION airs shall be performed by ce personnel or a qualified 25, 4.3.1 requires records shall ections, tests, and system components and shall to the authority having quest. This deficient practice dents, staff, and visitors in the view and interview with the ce Director, Administrator and on 02/01/24 between 9:10 a.m. iciencies were noted for the tystem. The "Deficiencies of the 08/2/2023 sprinkler eport stated, "Sprinklers with ints 20 years old or more fully sample tested in the last d by "No record of random sed on interview at the time of MD and ED stated the facility current status regarding this		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) same deficient practice will identified and what correctivaction(s) will be taken. No residents were affected by alleged deficient practice. All residents, visitors and stathave the potential to be affect by the alleged deficient practice by the alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recure. The Maintenance Director has been educated on record keep and on regulations of testing/inspecting sprinkler system. The Maintenance Director has been educated on storing at 12 spare sprinkler heads for easprinkler head type in this fact along with a list of the sprinkler heads being utilized. A maintenance audit tool will	be ve y the ff tted ice. into as eping seleast ach cility er be	(X5) COMPLETION DATE
Maintenance Direct Executive Director again at the exit cor Maintenance Direct Director, and Regin 2. Based on observat failed to ensure 1 of provided with spare	or, Administrator and at the time of discovery and aference on 02/02/24 with the or, Administrator, Executive al Vice President all present. Attion and interview, the facility of 1 sprinkler systems were a sprinkler, a spare sprinkler			sprinkler system are working properly and inspected by ce company. How the corrective action(s will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place The POC QAPI Tool will	rtified) the put be	
	PROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY OR Corrections and rep qualified maintenan contractor. NFPA 2 be made for all insp maintenance of the be made available to jurisdiction upon re could affect all resid facility. Findings include: Based on records re with the Maintenan Executive Director and 12:45 p.m., defi facility's sprinkler s Summary" section of system inspection re fast response eleme replaced or successi 10 years?" Followed sample on file." Ba record review, the M was unaware of the reported deficiency. This finding was ac Maintenance Direct Executive Director again at the exit cor Maintenance Direct Director, and Regin 2. Based on observa failed to ensure 1 of provided with spare	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.	NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155292 PROVIDER OR SUPPLIER AN VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of the 08/2/2023 sprinkler system inspection report stated, "Sprinklers with fast response elements 20 years old or more replaced or successfully sample tested in the last 10 years?" Followed by "No record of random sample on file." Based on interview at the time of record review, the MD and ED stated the facility was unaware of the current status regarding this reported deficiency. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present.	NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155292 PROVIDER OR SUPPLIER SAN VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12:45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of the 08/2/2023 sprinkler system inspection report stated, "Sprinklers with fast response elements 20 years old or more replaced or successfully sample tested in the last 10 years?" Followed by "No record of random sample on file." Based on interview at the time of record review, the MD and ED stated the facility was unaware of the current status regarding this reported deficiency. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present.	NOT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155292 PROVIDER OR SUPPLIER AN VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Corrections and repairs shall be performed by qualified animetneance personnel or a qualified contractor. NFPA 25, 43.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 9:10 a.m. and 12-45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of the 08/2/2023 sprinkler system in specifion report stated, "Sprinklers with fast response elements 20 years old or more replaced or successfully sample tested in the last 10 years?" Followed by "No record of random sample on file." Based on interview at the time of record review, the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator and Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the Maintenance Director, Administrator and Executive Director, Administ	NOT OF DEFICIENCIES OF CORRECTION DESCRIPTION COMBER 155292 STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL ROGULATIONY OR LSC IDENTIFYING INFORMATION Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Based on records review and interview with the with the Maintenance Director, Administrator and Executive Director on 02/01/24 between 91/0 a.m. and 12/45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of the 08/2/2023 sprinkler system inspection report stated, "Sprinklers with fish stresponse clements 20 years old or more replaced or successfully sample tested in the last 10 years?" Followed by "No record of random sample on file." Based on interview at the time of record review, the MD and ED stated the facility was unaware of the current status regarding this reported deficiency. This finding was acknowledged by the Maintenance Director, Administrator and Executive Director, Administrator, Executive Director, and Reginal Vice President all present.

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NFPA 25, Standard for the Inspection, Testing,

and Maintenance of Water-Based Fire Protection

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4 weeks, monthly x 6 months, and

quarterly thereafter for one year

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 02/02/2024		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Systems, 2011 Edit supply of spare sprishall be maintained sprinklers that have any way can be proshall correspond to ratings of the sprinklers shall be at the temperature in which is to be used it of sprinklers. This cabinet to be used it of sprinklers. This call residents and start all residents and start findings include: Based on observation of the facility which is the surveyor that the surveyor that the heads represented 2 sprinkler head in the and kind of sprinkler facility was available for verification. This finding was act Maintenance Direct Executive Director again at the exit con Maint	ion, Section 5.4.1.4 states a inklers (never fewer than six) on the premises so that any been operated or damaged in imptly replaced. The sprinklers the types and temperature ders on the property. The kept in a cabinet located where which they are subjected will at degrees Fahrenheit. A special hall be provided and kept in the in the removal and installation deficient practice could affect on 02/01/24 between 12:45 p.m. was one spare sprinkler room that included only 5 in the most and interview during a with the Maintenance Director on 02/01/24 between 12:45 p.m. was one spare sprinkler room that included only 5 in the most and interview during a with the Maintenance Director on 02/01/24 between 12:45 p.m. was one spare sprinkler and the spare sprinkler and the spare sprinkler and the spare sprinkler cabinet which populates the leat the spare sprinkler cabinet			with results reported to the Quantum Assurance and Performance Improvement Committee oversby the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	seen ot e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155292	B. Wl	NG		02/02/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
K 0355	NFPA 101			1110			BIIIE
SS=E	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extir						
g		guishers are selected,					
		d, and maintained in					
	-	IFPA 10, Standard for					
	Portable Fire Extir						
	18.3.5.12, 19.3.5.	•					
	· ·	on and interview, the facility	K 0	355	K355 Portable Fire Extinguishers 03		03/08/2024
failed to ensure 1 of 1 portable fire extinguishers in		11.0		What corrective actions will be		00,00,202	
		s installed in accordance with			accomplished for those		
		for Portable Fire Extinguishers,			residents found to have been	n	
	2010 Edition. Section	on 6.1.3.4 states portable fire			affected by the deficient		
	extinguishers other	than wheeled extinguishers			practice		
	shall be installed us	ing any of the following			The portable fire extinguisher		
	means. (1) Securely	on a hanger intended for the			located in the therapy gym wa		
	extinguishers. (2) Ir	the bracket supplied by the			secured to the wall.		
	extinguisher manufa	acture. (3) In a listed bracket			How other residents having	the	
	approved for such p	ourpose. (3) In a cabinet or wall			potential to be affected by th	ıe	
	recess. This deficien	nt practice could affect 10			same deficient practice will be	эе	
	residents and staff is	n the Therapy area.			identified and what correctiv	e	
					action(s) will be taken		
	Findings include:				No residents were affected by	the	
					alleged deficient practice.		
		ons and interview during a			All residents, visitors and staff		
	-	vith the Maintenance Director			have the potential to be affect		
		on 02/01/24 between 12:45 p.m.			by the alleged deficient praction		
	•	BC portable fire extinguisher in			What measures will be put in	ıto	
		ar the range, was sitting on			place or what systemic		
	the floor unsecured.				changes will be made to		
					ensure that the deficient		
	This finding was ac				practice does not occur		
		for, Administrator and			Maintenance Director has bee		
		at the time of discovery and			educated on that all portable A		
		afference on 02/02/24 with the			fire extinguishers are to be eith		
		or, Administrator, Executive			securely on a hanger intended		
	Director, and Regin	al Vice President all present.			the extinguishers, in the brack	et	
	2 1 10/4)				supplied by the extinguisher		
	3.1-19(b)				manufacture, in a bracket		
	I		1		approved for such purpose or	ın a	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED	
		155292	B. WI	NG		02/02/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN 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)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		i E	DATE	
K 0363	NEDA 101				wall cabinet/wall recess. A maintenance audit tool will be completed to ensure that portal fire extinguishers are securely attached to 1 of the 3 approve means. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be prin place The POC QAPI Tool will be utilized by ED/designee weekled 4 weeks, monthly x 6 months, quarterly thereafter for one year with results reported to the Quench Assurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	able d the ut pe and ar pality seen	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardour of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material gire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in glammable or rials have positive latching atches are prohibited by					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG <u>01</u>	COM	(X3) DATE SURVEY COMPLETED 02/02/2024	
NAME OF	PROVIDER OR SUPPLIE	R		REET ADDRESS, CITY, STATE, ZIP 126 EAST 54TH ST	COD		
AMERICAN VILLAGE		IN	DIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	SHOULD BE	(X5) COMPLETION DATE	
	apply to auxiliary flammable or con Clearance betwe covering is not explored with a the door closed vapplied. There is closing of the door release when the permitted. Nonrar unlimited height a meeting 19.3.6.3 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. If there are no resting resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMAR fire protection ratic devices, etc. 1. Based on observing all impediment to clost frame and would resistance or control of the c	These requirements do not spaces that do not contain inbustible material. en bottom of door and floor acceding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is ano impediment to the ors. Hold open devices that a door is pushed or pulled are ted protective plates of are permitted. Dutch doors abeled and made of steel or a compliance with 8.3, a compartment is a differ window assemblies are in sprinklered compartments rictions in area or fire as or frames in window. A Parts 403, 418, 460, 482, and a sings, automatics closing and latching into the door exist the passage of smoke. A stice could affect 6 staff and 15	K 0363	K363 – Corridor Door What corrective action accomplished for the found to have been a deficient practice The storage room do Hall hardware has be to SC and latch. The Double doors fro	on(s) will be se residents affected by the or on Rehab een adjusted	03/20/2024	

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Based on observations and interview during a

tour of the facility with the Maintenance Director

and Administrator on 02/01/24 between 12:45 p.m.

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to SC and latch.

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the dining area have been adjusted

The Kitchen into service hall door

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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 02/02/2024 155292 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2026 EAST 54TH ST INDIANAPOLIS, IN 46220 AMERICAN VILLAGE (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 and 4:30 p.m., the following corridor doors failed is scheduled to be delivered and to latch positively into their respective door installed when received by March frames: 20, 2024. a) Storage room door on Rehab Hall with a The Ice room door into the dining self-closing device, failed to SC and latch. room hardware has been adjusted b) Double doors from the kitchen into the dining to SC, latch and not drag. area, with a self-closing device, failed to SC and The clean linen closet door on 200 latch. hall hardware has been adjusted c) Kitchen into service hall door, the MD stated to latch. the doors were being replaced. d) Ice Roo, door into the dining area, with a How other residents having the self-closing device, failed to SC and latch. The potential to be affected by the door appears to be dragging significantly on the same deficient practice will be floor. identified and what corrective e) The Clean Linen closet door on the 200 Hall action(s) will be taken not latching. No residents were affected by the alleged deficient practice. All residents, visitors and staff This finding was acknowledged by the have the potential to be affected Maintenance Director, Administrator and by the alleged deficient practice. Executive Director at the time of discovery and again at the exit conference on 02/02/24 with the What measures will be put into Maintenance Director, Administrator, Executive place or what systemic changes Director, and Reginal Vice President all present. will be made to ensure that the deficient practice does not recur 2. Based on observation and interview, the facility The Maintenance Director failed to ensure 2 of over 50 corridor doors were educated regarding all corridor provided with a means suitable for keeping the doors to have no impediment to door closed, had no impediment to closing, closing and latching into the door latching and would resist the passage of smoke. frame and would resist the This deficient practice could affect 12 residents. passage of smoke. A maintenance audit tool will be Findings include: completed to ensure the storage room door on rehab hall, double Based on observations and interview during a doors from kitchen into the dining tour of the facility with the Maintenance Director area, kitchen into service hall and Administrator on 02/01/24 between 12:45 p.m. door, ice room door into the dining and 4:30 p.m., the corridor door to (1) the Small area and the clean linen closet Therapy on Rehab Hall was propped open with a doors to latch. set of weights. And (2) the Unit Managers Office

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155292		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/02/2024			
	ROVIDER OR SUPPLIER AN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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	
	aforementioned doo self-closing devices time of observation, acknowledged the a	pen with a trashcan. The ors were equipped with Based on interview at the the Maintenance Director forementioned corridor doors ess the obstructions were first			How the corrective action(s) we monitored to ensure the deficie practice will not recur, ie., what quality assurance program will put into place The POC QAPI Tool who be utilized by ED/designee we will a weeks, monthly x 6 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% in not achieved, an action plan who be developed to ensure compliance.	ent t be vill ekly s, e e		
K 0372 SS=E Bldg. 01	Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers shall 1/2-hour fire resist barriers shall be posited barriers shall be posited barriers where an is installed for smoth of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1) Describe any mechanisms of the smoke barriers 19.3.7.3, 8.6.7.1(1)	nall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.	K O	372	K372 Subdivision of Building		03/08/2024	
		smoke barriers walls were	K 03	372	K372 Subdivision of Building Spaces – Smoke Barrier		03/08/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	01	COMPLETED	
		155292	B. W	ING	_	02/02/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			AST 54TH ST		
AMERICA	AN VILLAGE				IAPOLIS, IN 46220		
	T	CTATEMENT OF DEPOSITABLE			· 	OVE	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE	
TAG		in the smoke resistance of	+	TAG		DATE	
		LSC Section 19.3.7.5 requires			Construction		
		•			What corrective action(s) will	ll	
		e constructed in accordance			be accomplished for those	_	
		.5 and shall have a minimum ½			residents found to have been	n	
		ating. LSC Section 8.5.2.1			affected by the deficient		
	_	riers to be continuous from an			practice	Julia	
		utside wall, from a floor to a			The corridor wall near the dou		
	1	oke barrier to a smoke barrier, or			door set on the rehab hall 4x4		
	1 -	ation thereof. 8.5.6.2 requires			hole has been sealed to not a	IIOW	
	1 ~	eles, cable trays, conduits,			the passage of smoke.		
pipes, tubes, vents, wires, and similar items to				The hole in the sprinkler rising)		
accommodate electrical, mechanical, plumbing,				room that measured			
and communications systems that pass through a				approximately 20x20" has been	en		
wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling				repaired.			
					The several penetrations betw		
		of/ceiling of a smoke barrier		1" and 3" located near the service			
		protected by a system or		hall entrance along the wall have			
	_	restricting the movement of		been repaired.			
		ent practice could affect staff		How other residents having the			
	and at least 16 resid	ients and staff.			potential to be affected by the		
	Findings in ded.				same deficient practice will I		
	Findings include:				identified and what corrective	e	
	D	4 :			action(s) will be taken	. 41	
		ons and interview during a			No residents were affected by alleged deficient practice.	rine	
		with the Maintenance Director					
		on 02/01/24 between 12:45 p.m.			f 		
		1) corridor wall near the double ab Hall had a 4"X4" hole and			have the potential to be affect		
					by the alleged deficient praction	ce.	
		letely sealed walls which					
		ssage of smoke. The MD			What measures will be put in	100	
		are of the hole which was			place or what systemic		
		nd (2) approximately a 20"X20"			changes will be made to		
	_	of the Sprinkler Riser Room was			ensure that the deficient		
	observed.				practice does not recur		
	This find:	Iranyolodood by the			The Maintenance Director		
	This finding was ac				educated regarding smoke ba	ırrıer	
		tor, Administrator and			walls to be free of holes.		
		at the time of discovery and			A maintenance audit tool will I		
	_	nference on 02/02/24 with the			completed to ensure the smol		
	Maintenance Direct	tor, Administrator, Executive			barrier wall near double door-	on	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		A. BUILDING B. WING	01	COMPLETED 02/02/2024				
	PROVIDER OR SUPPLIER AN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220					
(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			
	2. Based on observation failed to ensure the passage of wire and 5 smoke barriers was the smoke resistance. Section 19.3.7.5 requestion constructed in accordant shall have a mirrating. LSC Section to be continuous from outside wall, from a smoke barrier to a secombination thereoffor cables, cable trayvents, wires, and sirrelectrical, mechanic communications system floor, or floor/ceiling smoke barrier, or the the roof/ceiling of a be protected by a syrestricting the move practice could affect and staff. Findings include: Based on observation to the facility wand Administrator of and 4:30 p.m., sever discovered in the syndrop ceiling near the Several penetrations.	stems that pass through a wall, g assembly constructed as a rough the ceiling membrane of smoke barrier assembly, shall stem or material capable of ment of smoke. This deficient a staff and at least 16 residents on and interview during a with the Maintenance Director in 02/01/24 between 12:45 p.m. and unsealed penetrations were noke barrier wall above the exercice hall entrance.		rehab hall hole is sealed, the sprinkler riser room to be free holes and the service hall entralong the wall penetrations are sealed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be printo place The POC QAPI Tool will be utilized by ED/designee weekled weeks, monthly x 6 months, quarterly thereafter for one year with results reported to the Quantum Assurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	ance e the ut pe y x and ar ality seen ot e			

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ADDRESS, CITY, STATE, ZIP COD AST 54TH ST APOLIS, IN 46220 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The electrical junction box above the ceiling near the service hall entrance has been covered and longer exposes electrical wiring. 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
	be accomplished for those residents found to have been affected by the deficient practice The electrical junction box above the ceiling near the service hall entrance has been covered and longer exposes electrical wiring. 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 residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/02/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	in the box. Based or observations, the M acknowledged the e provided with a cov. This finding was ac Maintenance Direct Executive Director again at the exit con Maintenance Direct Director, and Regin. 3.1-19(b)	lectrical junction box was not er and had exposed wires.		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director educated regarding electrical junction box to be maintained safe operating condition. A maintenance audit tool will completed to ensure the elect junction box above the ceiling the service hall entrance to be covered with no exposed elect wiring. How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place The POC QAPI Tool will utilized by ED/designee week 4 weeks, monthly x 6 months quarterly thereafter for one ye with results reported to the Q Assurance and Performance Improvement Committee ove by the Executive Director If a threshold of 95% is not achieved, an action plan will indeveloped to ensure compliant.	be trical p near e ctrical the the ty x p and ear uality rseen		
K 0741 SS=F Bldg. 01							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COMPLE			
		155292	B. WING 02/02/2024			02/02/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF I	PROVIDER OR SUPPLIEF	3			AST 54TH ST		
AMERIC	AN VILLAGE				IAPOLIS, IN 46220		
					1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF LIGHTERING DIFFERENCE DEFINITION.			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX				PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		+	TAG	DEFICIENCE	DATE	_
	. , , -	be prohibited in any room,					
	1	ment where flammable					
	1 -	ole gases, or oxygen is					
		d in any other hazardous					
		n area shall be posted with					
	_	O SMOKING or shall be					
		ternational symbol for no					
	smoking.	occupancies where					
	1 ' '						
	smoking is prohibited and signs are prominently placed at all major entrances,						
	secondary signs with language that prohibits						
	smoking shall not be required.						
	(3) Smoking by patients classified as not						
	responsible shall be prohibited.						
	1	ent of 18.7.4(3) shall not					
		patient is under direct					
	supervision.						
		ncombustible material and					
	1 ' '	be provided in all areas					
	where smoking is	*					
	_	ers with self-closing cover					
	1 ' '	n ashtrays can be emptied					
		vailable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4						
		on, records review, and	K 0	741	K741 – Smoking Regulations	03/08/2024	
	interview, the facili	ity failed enforce 1 of 1			What corrective action(s) wi	II	
	non-smoking polici	ies. This deficient practice			be accomplished for those		
	could affect everyo	ne in the facility.			residents found to have been	n	
					affected by the deficient		
	Findings include:				practice		
					The cigarette butts on the gro		
		ons and interview during a			in the smoking area have bee	n	
	_ ·	with the Maintenance Director			removed.		
		on 02/01/24 between 12:45 p.m.			The crates were removed from	n the	
	_	king on and in the property was			entrance door of the building.		
		he fresh smell of cigarette			How other residents having		
		om attached to the Rehab			potential to be affected by the		
	common lounge are	ea. The surveyor visited this			same deficient practice will	be	

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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 02/02/2024 155292 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2026 EAST 54TH ST AMERICAN VILLAGE INDIANAPOLIS, IN 46220 (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 restroom during the record review portion of the identified and what corrective survey and experienced the presence of cigarette action(s) will be taken smoke in the aforementioned restroom. No residents were affected by the Additionally, during the facility tour in the alleged deficient practice. aforementioned lounge area, the smell of cigarette All residents, visitors and staff smoke was evident. The facilities provided have the potential to be affected smoking policy states under General Guidelines, by the alleged deficient practice. line one, "There will be no smoking in the facility by staff or visitors." Furthermore, (2) In the What measures will be put into facilities designated smoking area, more than 50 place or what systemic cigarette butts were on the ground throughout the changes will be made to area. (3) A staff person was observed smoking in ensure that the deficient the vicinity of the 1 designated smoking area and practice does not recur sitting on crates up against the building well All Staff educated regarding the within 8 feet of the facility entrance door. facilities smoking policy. A maintenance audit tool will be This finding was acknowledged by the completed to ensure there are no Maintenance Director, Administrator and cigarette butts in the smoking Executive Director at the time of discovery and area nor any crates against the again at the exit conference on 02/02/24 with the facility back entrance door. Maintenance Director, Administrator, Executive Director, and Reginal Vice President all present. How the corrective action(s) will be monitored to ensure the 3.1-19(b)deficient practice will not recur, ie., what quality assurance program will be put into place The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		lì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155292			01	COMPLETED		
		100282	B. WING 02/02/2024					
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(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	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
K 0761 SS=E								
Bldg. 01	interview, the facilitinspection and testin assembly was comp 19.1.1.4.1.1 commu fire barriers required permitted only in color by approved self-cle (See also Section 8. required to have a fit 8.3.4.2 shall be prot labeled fire door assamblies and their including all frames and sills in accordar NFPA 80, Standard Opening Protectives specified in this Cordoor assemblies shall be sides than annually, a inspection shall be sides to assess the orassembly. NFPA 80 the following items (1) No open holes of either the door or frame intact and secure equipped. (3) The door, frame noncombustible three	r breaks exist in surfaces of	K 0	761	K761 – Maintenance, Inspecti and Testing - Doors What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The oxygen transfilling room of has received an annual inspection has received an annual inspection. How the corrective action(s) will be affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director educated regarding keeping written records of oxygen door inspection. A maintenance audit tool will be completed to ensure the oxygen transfilling room door is on an annual inspection.	door ction. the see see see see see see see see see s	03/08/2024	
	(4) No parts are mis	ssing or broken.			will be monitored to ensure t			
	-	do not exceed clearances			deficient practice will not			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE			ETED	
		155292	B. WING 02/0			02/02/	2024
				CERET	A PROPERTY OF A THE STAN COR		
NAME OF F	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
ANAEDIO	ANI VIII I AOE				AST 54TH ST		
AMERICAN VILLAGE				INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI AN OF CODDECTION		(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'	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	listed in 4.8.4 and 6	5.3.1.7.			recur, ie., what quality		
	(6) The self-closing	device is operational; that is,			assurance program will be po	ut	
		pletely closes when operated			into place		
	from the full open p				The POC QAPI Tool will b	e	
		is installed, the inactive leaf			utilized by ED/designee weekl		
	closes before the ac				4 weeks, monthly x 6 months,	-	
		are operates and secures the			quarterly thereafter for one year		
	door when it is in th	-			with results reported to the Qu		
		vare items that interfere or			Assurance and Performance		
		are not installed on the door or			Improvement Committee overs	seen	
	frame.				by the Executive Director		
		ications to the door assembly			If a threshold of 95% is no	nt	
		ed that void the label.			achieved, an action plan will be		
	-	edge seals, where required, are			developed to ensure complian		
		their presence and integrity.			developed to ensure compilari	oc.	
		ice could affect 20 residents.					
	This deficient pract	ice could affect 20 residents.					
	Findings include:						
	Based on records re	eview and interview with the					
		ce Director, Administrator and					
		on 02/01/24 between 9:10 a.m.					
		documentation of an annual					
	-	re door assembly at the					
	•	g room was available for review.					
		on during the tour the Oxygen					
		as one 90-minute fire door					
	_	interview at the time of					
	-	observation, the MD stated					
		inspection was not completed					
		and was previously unaware a					
	fire door inspection						
	Transfilling Room						
	Transmining Room (u001.					
	This finding was ac	knowledged by the					
	_						
		tor, Administrator and					
		at the time of discovery and					
		nference on 02/02/24 with the					
		tor, Administrator, Executive					
	Director, and Regin	al Vice President all present.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULT A. BUILI B. WING			(X3) DATE SURVEY COMPLETED 02/02/2024			
		100292		STREET ADDRESS, CITY, STATE, ZIP COD				
	PROVIDER OR SUPPLIER AN VILLAGE	S	2	2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LICE DEPOTE THE PROPERTY OF THE PROPERT	PR	EFIX (EACH CORI CROSS-REFE	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION		
K 0781	3.1-19(b) NFPA 101	LSC IDENTIFYING INFORMATION	1	AG		DATE		
SS=E Bldg. 01	Portable Space He Portable Space He Portable space he prohibited in all he except, unless use employee areas we do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation failure to ensure 1 cowere not used in the practice could affect visitors. Findings include: Based on observation of the facility wand Administrator of and 4:30 p.m., a point the Therapy Offictime of the observation of the obs		K 078	What corresponding to the accompanies of the space gym was in the space gym was in the same deficities of the space action (s) where space alleged de All resident	able Space Heaters rective action(s) will plished for those found to have been by the deficient heater in the therap mmediately removed residents having the cient practice will be and what corrective will be taken his were affected by ficient practice. his, visitors and staff botential to be affected	y i. he e e e		
	portable space heate in the facility per th This finding was ac Maintenance Direct Executive Director again at the exit cor Maintenance Direct	knowledged by the or, Administrator and at the time of discovery and ofference on 02/02/24 with the or, Administrator, Executive		What mea place or w changes w ensure tha practice d The Mainte been educ	ged deficient practice sures will be put interpretation what systemic will be made to at the deficient loes not recur enance Director has cated on facilities	to		
	Director, and Regin	al Vice President all present.		practice of	not using space			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155292		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/02/2024			
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(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		
	3.1-19(b)			heaters. A maintenance audit tool will be completed to ensure there are portable space heaters.			
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, ie., what quality assurance program will be pinto place The POC QAPI Tool will butilized by ED/designee week 4 weeks, monthly x 6 months, quarterly thereafter for one yewith results reported to the Quassurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	ut De ly x and ar uality seen		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or	ent - Power Cords and ent - Power Stript are only ent delectrical equipment est that have been elified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), ent care resident rooms that E. Power strips for PCREE er UL 60601-1. Power strips the patient care rooms					

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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 02/02/2024 155292 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2026 EAST 54TH ST AMERICAN VILLAGE INDIANAPOLIS, IN 46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 K 0920 03/08/2024 Based on observation and interview, the facility K920 - Electrical Equipment failed to ensure power strips in the resident rooms Power Cords and Extension Cords were of UL rating of 1363A or 60601-1. Patient What corrective action(s) will care vicinity is defined as a space, within a be accomplished for those location intended for the examination and residents found to have been treatment of patients, extending 6 feet beyond the affected by the deficient normal location of the bed, chair, table, treadmill, practice or other device that supports the patient during The power strips being used in examination and treatment. A patient care vicinity room 201 and 210 have been extends vertically to 7 feet 6 inches above the replaced by power cord that meets floor. This deficient practice affects 10 residents the 1363A or 60601-1 requirement. and staff. How other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on observations and interview during a action(s) will be taken tour of the facility with the Maintenance Director No residents were affected by the and Administrator on 02/01/24 between 12:45 p.m. alleged deficient practice. and 4:30 p.m., the power strips being used in RR# All residents, visitors and staff 201 and RR# 210 lacked a UL rating of 1363A or have the potential to be affected 60601-1 label. Documentation provided during by the alleged deficient practice. records review for facility used power strips did not indicate that they met the aforementioned What measures will be put into requirements for use. A handwritten "1364A" was place or what systemic placed on the provided documentation. However, changes will be made to the manufacturer supplied documentation did not ensure that the deficient

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seem to indicate that the power strips relating to

the supplied documentation met the requirement.

Other power strips were observed in the resident

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practice does not recur

been educated on facilities

The Maintenance Director has

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/02/2024			
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE			2026 E	STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	of 1363A or 60601- This finding was ac Maintenance Direct Executive Director again at the exit cor Maintenance Direct	-		practice using power strimeet the 1363A or 6060 requirement. A maintenance audit too completed to ensure the strips in rooms 201 and been replaced with an a power strip. How the corrective activillation will be monitored to endeficient practice will not recur, ie., what quality assurance program will into place The POC QAPI Too utilized by ED/designee 4 weeks, monthly x 6 mod quarterly thereafter for owith results reported to the Assurance and Performal Improvement Committee by the Executive Director of a threshold of 95% achieved, an action plant developed to ensure corrections.	on(s) sure the ot I be put Will be weekly x onths, and one year he Quality ance e overseen or 6 is not will be			
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in accor Transfilling of High Oxygen Used for lany gas from one prohibited in patie to liquid oxygen co containers over 50 under 11.5.2.3.1 (Fransfilling Cylinders Fransfilling Cylinders Gen from one cylinder to rdance with CGA P-2.5, In Pressure Gaseous Respiration. Transfilling of cylinder to another is Int care rooms. Transfilling Containers or to portable It posi comply with conditions NFPA 99). Transfilling to ainers or to portable						

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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 <u>01</u>		COMPL	COMPLETED	
		155292	B. WING		02/02/2024		
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					AST 54TH ST		
AMERIC	AN VILLAGE			INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG				TAG	DEFICIENCY)	.15	DATE
	containers under	50 psi comply with					
		11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms						
			K 0	927	K927 – Gas Equipment –		03/08/2024
			11 0,27		Transfilling Cylinders		03/00/2021
		n other areas in the facility in a			What corrective action(s) will		
	room that is protect				be accomplished for those		
	_	uction in accordance with 2012		residents found to		n	
		I(1). This deficient practice			affected by the deficient		
	could affect 20 resid	· ·			practice		
	compartment.				The oxygen trans-filling room	1	
					inch in diameter hole in the ce		
	Findings include:				has been repaired.	_	
					How other residents having	the	
	Based on observation	ons and interview during a			potential to be affected by th		
		with the Maintenance Director		same deficient practice will be			
	and Administrator on 02/01/24 between 12:45 p.m.				identified and what corrective		
	and 4:30 p.m., the oxygen trans-filling room had a				action(s) will be taken	•	
	hole in the ceiling measuring approximately 1 inch in diameter. The Maintenance Supervisor stated				No residents were affected by	the	
					alleged deficient practice.	410	
		the hole. The Administrator			All residents, visitors and staff	; ;	
		m and verified the presence of			have the potential to be affect		
	_	-			by the alleged deficient practic		
	the aforementioned hole in the ceiling.				and anogod domoion practice.		
	This finding was acknowledged by the				What measures will be put in	nto	
	Maintenance Director, Administrator and			place or what system		110	
	Executive Director at the time of discovery and				changes will be made to		
	again at the exit conference on 02/02/24 with the				ensure that the deficient		
	Maintenance Director, Administrator, Executive				practice does not recur		
	Director, and Reginal Vice President all present.				The Maintenance Director		
	3.1-19(b)				educated regarding oxygen ro	nom	
					ceiling to be free of holes.		
	17(0)				A maintenance audit tool will be	ne	
					completed to ensure the oxyg		
					room ceiling to be free of hole		
					100111 0011111g to be free of flore	J.	
					How the corrective action(s)		
					How the corrective action(s) will be monitored to ensure the		
					deficient practice will not	,110	
				recur, ie., what quality			
					recui, ie., what quality	ļ	

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AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/02/2024			
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 2026 EAST 54TH ST INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
					assurance program will be printo place The POC QAPI Tool will be utilized by ED/designee week! 4 weeks, monthly x 6 months, quarterly thereafter for one year with results reported to the Question Assurance and Performance Improvement Committee overs by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	oe y x and ar ality seen		

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