	T OF HEALTH AND HU R MEDICARE & MEDI				FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
ALPHA I	HOME - A WATER	S COMMUNITY		NAPOLIS, IN 46222	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION
TAG E 0000	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
Bldg	conducted by the I accordance with 4 Survey Date: 08/2 Facility Number: Provider Number: AIM Number: 100 At this Emergency Home - A Waters compliance with E Requirements for 1 Participating Prov 483.73 The facility has 86 the survey, the cert	29/23 and 08/30/23 000376 155717 0275510 7 Preparedness survey, Alpha Community was found not in Emergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR	E 0000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does n constitute an admission or agreement by this facility of facts alleged or conclusion forth in this statement of deficiencies. The plan of correction and specific corrective actions are prep and/or executed in complia with state and federal laws. This plan of correction constitutes a written allegat of substantial compliance of Federal Medicare and Medicaid requirements.	on ot of the is set ared ince tion
E 0039 SS=C Bldg	MET as evidenced Quality Review co 403.748(d)(2), 44 441.184(d)(2), 48 483.73(d)(2), 48 485.68(d)(2), 48 486.360(d)(2), 48 EP Testing Requ §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4	l by: mpleted on 09/05/23 16.54(d)(2), 418.113(d)(2), 32.15(d)(2), 483.475(d)(2), 4.102(d)(2), 485.625(d)(2), 5.727(d)(2), 485.920(d)(2), 91.12(d)(2), 494.62(d)(2) tirements 418.113(d)(2), §441.184(d)(2), 482.15(d)(2), §483.73(d)(2), §484.102(d)(2), §485.68(d)(2), §485.727(d)(2), §485.920(d)			

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

(X6) DATE 09/21/2023

PRINTED:

09/26/2023

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Any defiency statement 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.

000376

STATEMENT OF DEFICIENCIESX1) PROVIDER/SUPPLIER/CLAND PLAN OF CORRECTIONIDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155717	B. WING			30/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ALPHA	HOME - A WATERS	S COMMUNITY	INDIAN	APOLIS, IN 46222		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG		16.54, CORFs at §485.68,	TAG			DATE
	-	ions" under §485.727,				
	-	920, RHCs/FQHCs at				
	-	RD Facilities at §494.62]:				
	J ,	5 1				
		facility] must conduct				
		the emergency plan				
		cility] must do all of the				
	following:					
	(i) Participate in a	a full-scale exercise that is				
		d every 2 years; or				
		munity-based exercise is				
		onduct a facility-based				
	functional exercis	e every 2 years; or				
		ility] experiences an actual				
		ade emergency that requires				
		emergency plan, the [facility]				
		ngaging in its next required				
		d or individual, facility-based				
	actual event.	e following the onset of the				
		ditional exercise at least				
	• •	posite the year the full-scale				
		cise under paragraph (d)(2)				
		is conducted, that may				
	include, but is not	t limited to the following:				
	• •	scale exercise that is				
		d or individual, facility-based				
	functional exercis					
	(B) A mock disas					
		ercise or workshop that is				
	discussion using	r and includes a group				
	-	emergency scenario, and a				
		atements, directed				
		pared questions designed				
	to challenge an e					
	-	acility's] response to and				
		ntation of all drills, tabletop				

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Event ID: 6

6QWE21 Facility ID: 000376

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If continuation sheet Page

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			(X2) MULTIPLE C A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY		2640 0	ADDRESS, CITY, STATE, ZIP C COLD SPRING RD NAPOLIS, IN 46222	OD	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE /	HOULD BE COMPLETIC
TAG	exercises, and e	R LSC IDENTIFYING INFORMATION mergency events, and revise ergency plan, as needed.	TAG	DEFICIENCY)	DATE
	the patient's hom conduct exercise plan at least ann the following: (i) Participate in community based (A) When a comm accessible, cond based functional (B) If the hospice man-made emergency exempt from eng scale community facility-based fun onset of the emergency exempt from eng scale community facility-based fun onset of the emergency (ii) Conduct an a years, opposite tf functional exercise of this section is include, but is no (A) A second ful community-based functional exercise (B) A mock disa (C) A tabletop ex led by a facilitato discussion using clinically-relevant set of problem st messages, or pre- to challenge an ex-	ospices that provide care in the. The hospice must is to test the emergency ually. The hospice must do a full-scale exercise that is d every 2 years; or munity based exercise is not uct an individual facility exercise every 2 years; or experiences a natural or gency that requires activation y plan, the hospital is aging in its next required full -based exercise or individual ctional exercise following the rgency event. additional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may t limited to the following: I-scale exercise that is d or a facility based se; or ster drill; or xercise or workshop that is r and includes a group a narrated, t emergency scenario, and a atements, directed epared questions designed			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 08/30/2023 155717 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: Event ID: 6QWE21 Facility ID: 000376 Page 4 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
ALPHA	HOME - A WATER	S COMMUNITY		OLD SPRING RD IAPOLIS, IN 46222		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION an annual full-scale exercise	TAG	DEFICIENCY)		DATE
	accessible, cond facility-based fur (B) If the [PRTF, an actual natural that requires acti plan, the [facility] its next required or individual, fac following the ons (ii) Conduct exercise or and t limited to the foll (A) A second ful community-based facility-based fur (B) A m (C) A tableto is led by a facilita discussion, using clinically-relevan set of problem st messages, or pro to challenge an e (iii) Analyze and maintain doo tabletop exercise	Il-scale exercise that is d or individual, a actional exercise; or oock disaster drill; or op exercise or workshop that ator and includes a group g a narrated, t emergency scenario, and a catements, directed epared questions designed				
	conduct exercise plan at least ann organization mus (i) Participate in that is communit	PACE organization must as to test the emergency ually. The PACE st do the following: an annual full-scale exercise				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 08/30/2023 155717 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, 6QWE21 Facility ID: 000376 Page 6 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 08/30/2023 155717 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires 6QWE21 Facility ID: 000376 Page 7 of 33 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

09/26/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ	(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF	PROVIDER OR SUPPLI	ER		T ADDRESS, CITY, STATE, ZIP	COD		
ALPHA I	HOME - A WATER	S COMMUNITY		COLD SPRING RD NAPOLIS, IN 46222			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE				(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETIO	
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THI DEFICIENCY)	EAPPROPRIATE	DATE	
	activation of the	emergency plan, the ICF/IID					
		ngaging in its next required					
		inity-based or individual,					
		nctional exercise following the					
	onset of the eme	-					
		dditional annual exercise					
		, but is not limited to the					
	following:						
	•	-scale exercise that is					
		d or an individual,					
	-	nctional exercise; or					
	(B) A mock disas						
	· ,	kercise or workshop that is					
		or and includes a group					
	discussion, using						
		t emergency scenario, and a					
	-	atements, directed					
		epared questions designed					
	to challenge an e						
	-	ICF/IID's response to and					
		entation of all drills, tabletop					
		mergency events, and revise					
		ergency plan, as needed.					
	*[For HHAs at §4	484.102]					
	(d)(2) Testing. T	he HHA must conduct					
	exercises to test	the emergency plan at					
	least annually. T	he HHA must do the					
	following:						
	(i) Participate in	a full-scale exercise that is					
	community-base	d; or					
	(A) When a	community-based exercise					
	is not accessible	, conduct an annual					
	individual, facility	/-based functional exercise					
	every 2 years; of	r.					
	(B) If the H	HA experiences an actual					
	natural or man-n	nade emergency that requires					
	activation of the	emergency plan, the HHA is					
	exempt from eng	gaging in its next required					
		inity-based or individual,		1			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155717			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	D		
ALPHA I	HOME - A WATER	S COMMUNITY		COLD SPRING RD NAPOLIS, IN 46222			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID		COTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETIO	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	INOLINATE	DATE	
	facility based fun	ctional exercise following the					
	onset of the eme	ergency event.					
		dditional exercise every 2					
		he year the full-scale or					
		se under paragraph (d)(2)(i)					
	of this section is						
		ot limited to the following:					
		d full-scale exercise that is					
		d or an individual,					
		ictional exercise; or					
		disaster drill; or					
	(C) A tableto	op exercise or workshop that					
		ator and includes a group					
	discussion, using	C .					
		t emergency scenario, and a					
		atements, directed					
		epared questions designed					
	to challenge an e						
	(iii) Analyze the I	HHA's response to and					
	maintain docume	entation of all drills, tabletop					
	exercises, and e	mergency events, and revise					
	the HHA's emerg	gency plan, as needed.					
	*[For OPOs at §4	486.360]					
	(d)(2) Testing. T	he OPO must conduct					
		the emergency plan. The					
	OPO must do the	e following:					
	(i) Conduct a par	per-based, tabletop exercise					
	or workshop at le	east annually. A tabletop					
	exercise is led by	y a facilitator and includes a					
	group discussion	n, using a narrated, clinically					
	relevant emerge	ncy scenario, and a set of					
	problem stateme	ents, directed messages, or					
		ons designed to challenge an					
		If the OPO experiences an					
	actual natural or	man-made emergency that					
		on of the emergency plan, the					
		rom engaging in its next					
		exercise following the onset					
	of the emergenc	-					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		x3) date survey completed 08/30/2023
	PROVIDER OR SUPPLII HOME - A WATER		2640	ET ADDRESS, CITY, STATE, ZIP COD COLD SPRING RD ANAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	maintain docume exercises, and e the [RNHCI's an needed. *[RNCHIs at §44 (d)(2) Testing. T exercises to test RNHCI must do (i) Conduct a parat least annually group discussion narrated, clinical scenario, and a s directed messag designed to chal (ii) Analyze the F maintain docume exercises, and e the RNHCI's em Based on record r failed to conduct of plan at least twice unannounced staff procedures. The L following: (i) Participate in a is community-based a. When a community-based a. When a community-based full-scale function the onset of the action the onset of the action	he RNHCI must conduct the emergency plan. The the following: per-based, tabletop exercise . A tabletop exercise is a held by a facilitator, using a ly-relevant emergency set of problem statements, les, or prepared questions lenge an emergency plan. RNHCI's response to and entation of all tabletop mergency events, and revise ergency plan, as needed. eview and interview, the facility exercises to test the emergency per year, including f drills using the emergency TC facility must do the n annual full-scale exercise that ed; or mity-based exercise is not et an annual individual, ctional exercise. hity experiences an actual natural rgency that requires activation plan, the LTC facility is exempt next required full-scale or individual, facility-based aal exercise for 1 year following	E 0039	 E039 – It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff driusing the emergency procedure to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 9/5/2023 the Administrator/Designee and the Maintenance Supervisor/desigr conducted a full scale drill that is community or facility-based annual exercise and completed documentation for the exercise meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED 	lls es nee s to

TERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155717	B. WING		08/30/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIEF		2640 C	COLD SPRING RD	
ALPHA I	HOME - A WATERS	COMMUNITY	INDIAN	NAPOLIS, IN 46222	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	include, but is not l	imited to the following:		a. All residents and all staf	f
	a. A second full-sca	le exercise that is		and visitors have the potential	to
		r an individual, facility-based		be affected but none were.	
	functional exercise.	-		3. MEASURES TO PREVE	NT
	b. A mock disaster			REOCCURRENCE	
		se or workshop that is led by a			the
	-	des a group discussion, using			
				Administrator/Designee inserv	liced
		y relevant emergency scenario,		the DON/Maintenance	
		n statements, directed		Supervisor/designee on the	
		ed questions designed to		requirement that a full scale d	
	challenge an emerg			that is community or facility-ba	ased
	• •	C facility's response to and		exercise must be conducted	
		ation of all drills, tabletop		annually and documentation	
	exercises, and emer	gency events, and revise the		retained to meet set standard	S.
	LTC facility's emer	gency plan, as needed in		b. DON/Maintenance	
	accordance with 42	CFR 483.73(d)(2). This		Supervisor/designee will work	with
	deficient practice co	ould affect all occupants.		the Administrator to ensure a	full
				scale drill that is community o	r
	Findings include:			facility-based exercise is	
	C C			conducted and documented to)
	Based on record rev	view of the facility's emergency		meet set standards. If any	
		r on 08/29/23 at 11:50 a.m. with		issues are discovered, they w	ill he
		rector present, it was noted		addressed and resolved	
		ducted three exercises that			
	-	Table-top exercises, but failed		immediately.	
		•		c. The Administrator will	
	to conduct a full-sc			monitor adherence to the	
		r an individual, facility-based		Emergency Preparedness Po	псу
		Based on an interview at the		Manual and validate the	
		w, the Maintenance Director		documentation is in place.	
		ight all required exercises had		4. MONITORING	
		l that he would discuss this		CORRECTIVE ACTION:	
	-	ility Administrator as soon as		a. At least annually to ensu	
	possible.			compliance, the Administrator	and
				DON/Maintenance	
	During the exit con	ference with the facility		Supervisor/designee will revie	w the
	-	he Maintenance Director on		Emergency Preparedness Po	
	08/30/23 at 12:30 p	.m., no additional information or		Manual and conduct required	
	-	provided contrary to this		exercises and make changes	as
	deficient finding.			necessary to meet set standa	
	serierent midnig.			Those reviews will be docume	
	1		1	I THOSE LEVIEWS WIII DE OOCUME	ancu -

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Event ID: 6QWE21 Facility ID: 000376

If continuation sheet

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155717		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIE			2640 C	ADDRESS, CITY, STATE, ZIP C OLD SPRING RD IAPOLIS, IN 46222	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE IPPROPRIATE	(X5) COMPLETION DATE	
E 0041 SS=F Bidg	482.15(e), 483.73 Hospital CAH and §482.15(e) Cond (e) Emergency and The hospital muss standby power sy emergency plans this section and in procedures plans (i) and (ii) of this §483.73(e), §485 (e) Emergency and The [LTC facility implement emerges systems based of forth in paragraph §482.15(e)(1), §4 Emergency genengenerator must b	B(e), 485.625(e) d LTC Emergency Power ition for Participation: nd standby power systems. t implement emergency and vstems based on the set forth in paragraph (a) of n the policies and set forth in paragraphs (b)(1) section.			as appropriate. The Ad will present the training the Quality Assurance/ Performance Improven meeting. Results and components will be rew the QA/PI Committee w subsequent plans of co developed and implem deemed necessary to a compliance is maintain This plan of correctio constitutes our credit allegation of compliant all regulatory requirer Our date of compliant 9/21/2023.	nent (QA/PI) system viewed by with prrection ented as ensure ed. n ble nce with ments.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	· /		(X3) DATE SURVEY COMPLETED 08/30/2023		
NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY			2640 C	ADDRESS, CITY, STATE, ZIP COD OLD SPRING RD IAPOLIS, IN 46222			
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETIO	
TAG		RET MOST BE FRECEDED BY FOLL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
	Care Facilities C Interim Amendm 12-4, TIA 12-5, a Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built structure or build 482.15(e)(2), §48 Emergency gene The [hospital, CA implement the er inspection, testin requirements fou	ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA nd TIA 12-6), Life Safety and Tentative Interim A 12-1, TIA 12-2, TIA 12-3, nd NFPA 110, when a new or when an existing				DAIL	
	Emergency gene and LTC facilities source to power have a plan for h	33.73(e)(3), §485.625(e)(3) erator fuel. [Hospitals, CAHs s] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the ss it evacuates.					
	§483.73(g), and The standards in this section are a reference by the Federal Register 552(a) and 1 CF the material from You may inspect Information Reso Boulevard, Baltin Archives and Re (NARA). For info	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in approved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain the sources listed below. a copy at the CMS burce Center, 7500 Security nore, MD or at the National cords Administration rmation on the availability of ARA, call 202-741-6030, or					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023
	provider or supplif HOME - A WATER		2640	tt address, city, state, zip cod COLD SPRING RD ANAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETIC DATE
	_of_federal_regu If any changes in incorporated by it document in the announce the ch (1) National Fire Batterymarch Pa Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Hea 2012 edition, iss (ii) Technical inte NFPA 99, issued (iii) TIA 12-3 to N 2012. (iv) TIA 12-3 to N 2013. (vi) TIA 12-5 to N 2013. (vi) TIA 12-5 to N 2014. (vii) NFPA 101, I edition, issued A (viii) NFPA 101, I edition, issued A (viii) TIA 12-1 to 11, 2011. (ix) TIA 12-2 to N 30, 2012. (x) TIA 12-3 to N 22, 2013. (xi) TIA 12-4 to N 22, 2013. (xii) NFPA 110, Standby Power S including TIAs to 2009 Based on record re failed to implement	Protection Association, 1 Irk, 59, www.nfpa.org, alth Care Facilities Code, ued August 11, 2011. erim amendment (TIA) 12-2 to I August 11, 2011. IFPA 99, issued August 9, IFPA 99, issued March 7, FPA 99, issued August 1, IFPA 99, issued March 3, Life Safety Code, 2012	E 0041	E041 – It is the intent of the fato ensure to implement the emergency power system	cility 09/21/20:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLII HOME - A WATER		2640 C	ADDRESS, CITY, STATE, ZIP COD COLD SPRING RD NAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	(X5) COMPLETION DATE
	 110, and Life Safe CFR 483.73(e)(2) affect all occupant Findings include: Based on review of entitled "Emergen Log" documentati twelve-month period Director during re a.m. the facility we testing in February 02/20/23, and 02/2 extremely difficul scribbled out, chart this log. Based or review, the Mainter many of the aforen were not complete Maintenance Mann legible records. During the exit co Administrator and 08/30/23 at 12:30 	h Care Facilities Code, NFPA ety Code in accordance with 42 . This deficient practice could ts. of the facility's documentation cy Generators - Weekly Test on for the most recent iod with the Maintenance cord review on 08/29/23 at 9:34 as missing several weeks of y of 2023 including 02/13/23, 27/23. Record review was t as many of the dates were nged, and out of sequence in a interview at the time of record enance Director advised that mentioned entries in the log ed by him, and the previous did not keep very good or nference with the facility the Maintenance Director on p.m., no additional information or provided contrary to this		inspection, testing and maintenance requirements for in the Health Care Facilities NFPA 110 and Life Safety C accordance with 42 CFR 483 (2) to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On 9/21/2023 the Administrator/Designee inset the Maintenance Supervisor/designee on the requirement that the weekly must be conducted on the emergency generator and documented in the facilities I Safety Binder to meet set standards. b. On 9/21/2023 the Maintenance Supervisor/desi conducted the weekly test to set guidelines and document the facilities Life Safety Bind meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta and visitors have the potentia be affected but none were. 3. MEASURES TO PREV REOCCURRENCE: a. The Maintenance Supervisor/designee will ensi- weekly test is conducted for emergency generator and documented in the life safety binder to meet set standards b. The Administrator will monitor adherence to the Emergency Preparedness P	Code, ode in 3.73(e) NS rviced test Life ignee meet ted in er to FED: aff al to ENT sure a the	

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Event ID: 6QWE21 Facility ID: 000376

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	R MEDICARE & MEDIC						1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	Č, Z	ILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD OLD SPRING RD APOLIS, IN 46222		
							1
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO TAGE DEFICIENCY)		PN BE PRIATE	(X5) COMPLETION DATE
				TAG	Manual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to er compliance, the Administra Maintenance Supervisor/de will review the Emergency Preparedness Policy Manu make changes as necessal meet set standards. Those reviews will be documented appropriate. The Administra present the results at the Q Assurance/ Performance Improvement (QA/PI) meet Results and system compo will be reviewed by the QA/ Committee with subsequent of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance is 9/21/2023.	tor and esignee al and ry to d as ator will uality ing. nents PI t plans d iance with s.	
K 0000							
Bldg. 01	A Life Safety C-1	e Recertification and State	17.04			r.	
	Licensure Survey	was conducted by the Indiana lth in accordance with 42 CFR	K 00	JUU	Preparation and/or execut of this plan of correction i general, or this corrective action in particular, does constitute an admission o agreement by this facility	ion n not r	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155717	B. WING		08/30/2023	
NAME OF	PROVIDER OR SUPPLIE	R		r address, city, state, zip coi COLD SPRING RD)	
ALPHA I	HOME - A WATER	S COMMUNITY		NAPOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Facility Number:			facts alleged or conclus		
	Provider Number:			forth in this statement of		
	AIM Number: 10	0275510		deficiencies. The plan	of	
		Code surgers Alabe House A		correction and specific		
		Code survey, Alpha Home - A y was found not in compliance		corrective actions are p	-	
		s for Participation in		and/or executed in com with state and federal la	-	
	-	d, 42 CFR Subpart 483.90(a),		This plan of correction	IW5.	
		Fire and the 2012 edition of the		constitutes a written all	oration	
	-	ection Association (NFPA) 101,		of substantial complian	-	
		LSC), Chapter 19, Existing		Federal Medicare and		
		pancies and 410 IAC 16.2.		Medicaid requirements.		
		lity was determined to be of				
		struction and fully sprinkled. The				
		larm system with hard wired				
		the corridors, spaces open to				
		in all resident sleeping rooms.				
	-	capacity of 86 and had a census				
	of 58 at the time of	f this visit.				
	All areas where rea	sidents have customary access				
	were sprinkled and	l all areas providing facility				
	-	nkled except for one detached				
	storage shed.					
	Quality Review co	mpleted on 09/05/23				
< 0211	NFPA 101					
SS=E	Means of Egress	- General				
Bldg. 01	Means of Egress					
	-	vays, corridors, exit				
	discharges, exit l	ocations, and accesses are				
	in accordance wi	th Chapter 7, and the means				
	of egress is conti	nuously maintained free of				
		o full use in case of				
		ss modified by 18/19.2.2				
	through 18/19.2.					
	18.2.1, 19.2.1, 7.					
	Based on observat	ion and interview, the facility	K 0211	K211 – It is the intent of	the	09/21/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING CTREET ADDRESS, CUTV, CTATE, JD, COD		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED 08/30/2023		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 2640 COLD SPRING RD INDIANAPOLIS, IN 46222				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	F	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		f 4 means of egress were			facility to ensure corridor mean	s of		
	-	ained free of all obstructions			egress are continuously			
	-	full instant use in the case of			maintained free of all obstruction			
		ency. This deficient practice			or impediments to full instant us	se		
		4 residents, 4 staff and 2			in the case of fire or other			
	visitors if needing	to exit the facility.			emergency to meet set standar 1. CORRECTIVE ACTIONS			
	Findings include:				TAKEN:			
					a. On 9/21/2023 the			
		ons made during a tour of the			Maintenance Supervisor/desigr	nee		
	-	3 at 10:10 a.m., the barrier door			repaired the barrier door set on	the		
	set on the 100 hall	was tested. After the doors			100 hall to ensure it opens and			
		ched into the door frame, the			closes properly to meet set			
		anding on the 100-hall facing			standards. The Administrator			
		o the facility, would not open.			verified the work on 9/21/2023.			
		he Maintenance Director			2. ALL OTHERS WITH			
		r latching hardware and opened			POTENTIAL TO BE AFFECTE	D:		
		was tested a second time, it			a. All residents and all staff			
		en without the Maintenance			and visitors have the potential t			
	-	ljustments to the door. Based			be affected but none were. On			
		the time of the observation, the			9/21/2023 the Maintenance			
		tor agreed that the barrier			Supervisor/designee inspected			
		ctioning properly and could			corridors and exit doors and for	una		
		ress during an emergency the evacuation of the 100 Hall.			no other negative findings.			
		the evacuation of the 100 fian.			3. MEASURES TO PREVEN REOCCURRENCE:	• 1		
	During the exit cor	ference with the facility			a. On 9/21/2023 the			
	-	the Maintenance Director on			Administrator/Designee inservio	red		
		o.m., no additional information or			the Maintenance	JUU		
	-	provided contrary to this			Supervisor/designee on the			
	deficient finding.				requirement that the corridor do	oors		
					must fully operate at all times to			
	3.1-19(b)				meet set standards.			
					b. Maintenance			
					Supervisor/designee will inspec	ct		
					all corridor doors to ensure the			
					fully operate at all times as a pa	·		
					of the facility's monthly Prevent			
					Maintenance Program and			
					document those inspection res	ults		

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Event ID: 6QWE21 Facility ID: 000376

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>01</u>	COMP	(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD			
ALPHA H	HOME - A WATER	S COMMUNITY		COLD SPRING RD NAPOLIS, IN 46222			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETIO	
TAG (0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills	R LSC IDENTIFYING INFORMATION	TAG	as appropriate. If any issue discovered, they will be add and resolved immediately. Maintenance Supervisor/de- will review with the Administ the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results be presented by the Mainten Supervisor/designee to the Administrator monthly and t Administrator will present th inspection results at the mo Quality Assurance/Performa Improvement (QA/PI) meeti Inspection results and syste components will be reviewe the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained. This plan of correction constitutes our credible allegation of compliance w all regulatory requirements Our date of compliance is 9/21/2023.	ressed The signee trator will hance he e hthly ance ng. m d by ion d as e	DATE	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155717	A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023		
	PROVIDER OR SUPPLII HOME - A WATER			2640 C	ADDRESS, CITY, STATE, ZIP COD COLD SPRING RD JAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
	conditions. Fire of and unexpected conditions, at leas The staff is famil aware that drills routine. Where of 9:00 PM and 6:0 announcement r audible alarms. 19.7.1.4 through Based on record r failed to conduct of quarters. LSC 19. conducted quarter conditions. This of and residents. Findings include: Based on record r Director on 08/29. documentation co drill for the fourth and December) of interview at the tin Maintenance Dire was no additional documentation av this survey. During the exit co Administrator and 08/30/23 at 12:30	nay be used instead of	К 0	712	 K712 – It is the intent of the facility to ensure to conduct fire drills on each shift for all 4 quarters to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 9/21/2023 the Administrator/Designee inservit the Maintenance Supervisor/designee on the requirement that fire drills must conducted at unexpected times under varying conditions at leas quarterly on each shift and documented to meet set standards. b. On 9/21/2023 the Maintenance Supervisor/design conducted a fire drill for each o the three shifts and documente the results in the facilities Life Safety Binder to meet set standards. D. On 9/21/2023 the Maintenance Supervisor/design conducted a fire drill for each o the three shifts and documente the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the drills on 9/21/2023. ALL OTHERS WITH POTENTIAL TO BE AFFECTED a. All residents and all staff and visitors have the potential to be affected but none were. 	ced be s st nee f d r D :	09/21/202

	MEDICARE & MEDI			E CONSTRUCTION		OMB NO. 0938-0
	F OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		` ´	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01		PLETED
		155717	B. WING		08/3	80/2023
NAME OF P	ROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD		
) COLD SPRING RD		
ALPHA H	OME - A WATER	S COMMUNITY	INDI	ANAPOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE OPRIATE	COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				3. MEASURES TO PRI	EVENT	
				REOCCURRENCE		
				a. Maintenance		
				Supervisor/designee will e		
				fire drills are conducted at		
				unexpected times under v		
			conditions at least quarter	•		
				each shift and that docum		
				be retained in the facility's		
				Safety Binder as a part of		
				facility's Preventive Mainte		
				Program and document th		
			inspection results as appropr			
				If any issues are discovered, will be addressed and resolve		
				immediately. The Mainter		
				Supervisor/designee will re		
				with the Administrator the		
				inspection results.		
				b. The Administrator wi	ill	
				monitor adherence to the		
				Preventative Maintenance		
				schedule and validate the		
				Preventative Maintenance		
				documentation is in place.		
				4. MONITORING		
				CORRECTIVE ACTION:		
				a. The inspection result	ts will	
				be presented by the Maint		
				Supervisor/designee to the		
				Administrator monthly and		
				Administrator will present		
				inspection results at the m	-	
				Quality Assurance/Perform		
				Improvement (QA/PI) mee	-	
				Inspection results and sys		
				components will be review	-	
				the QA/PI Committee with		
				subsequent plans of corre		
				developed and implement	ed as	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED
NAME OF I	PROVIDER OR SUPPLIE	155717		ADDRESS, CITY, STATE, ZIP COI	08/30/2023
	IOME - A WATER			OLD SPRING RD IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
				deemed necessary to en compliance is maintained This plan of correction constitutes our credible allegation of compliance all regulatory requireme Our date of compliance 9/21/2023.	d. e with ents.
(0741 SS=E Bldg. 01	shall include not provisions: (1) Smoking shall ward, or compart liquids, combusti used or stored ar location, and suc signs that read N posted with the ir smoking. (2) In health care smoking is prohit prominently place secondary signs smoking shall no (3) Smoking by p responsible shall (4) The requirem apply where the supervision. (5) Ashtrays of no safe design shall where smoking is (6) Metal contain devices into whice	tions ons shall be adopted and less than the following I be prohibited in any room, ment where flammable ble gases, or oxygen is nd in any other hazardous h area shall be posted with O SMOKING or shall be nternational symbol for no occupancies where bited and signs are ed at all major entrances, with language that prohibits t be required. atients classified as not be prohibited. ent of 18.7.4(3) shall not batient is under direct oncombustible material and be provided in all areas s permitted. ers with self-closing cover h ashtrays can be emptied vailable to all areas where			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/30/2023 155717 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (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 18.7.4. 19.7.4 1) Based on observation and interview, the facility K 0741 K741 – It is the intent of the 09/21/2023 failed to ensure 1 of 1 facility main entrance area facility to ensure facility main was maintained by disposing cigarette butts in a entrance area is maintained by provided metal or noncombustible container with disposing cigarette butts in a self-closing cover devices. This deficient practice provided metal or noncombustible could affect as many as 4 residents, 10 staff, and 6 container with self-closing cover visitors using the main entrance/exit. devices and to ensure employees are smoking in a designated area Findings include: where approved containers are available and in use to meet set Based on observation during a tour of the facility standards. with the Maintenance Director on 08/30/23 at 9:47 CORRECTIVE ACTIONS 1 a.m., the main entrance to the facility had over 50 TAKEN: cigarette butts disposed on the ground. On 9/21/2023 the а Furthermore, there was no noncombustible Maintenance container with self-closing cover device for Supervisor/Housekeeping cigarette butt disposal in the area. Based on Supervisor/designee picked up the interview at the time of observation, the cigarette butts disposed on the Maintenance Director agree the cigarette butts ground at the main entrance to were on the ground and that there was no meet set standards. The noncombustible container with self-closing cover Administrator verified the work on device for cigarette butt disposal in the area. 9/21/2023. On 9/21/2023 the h During the exit conference with the facility Administrator/Designee inserviced Administrator and the Maintenance Director on Maintenance Director on the 08/30/23 at 12:30 p.m., no additional information or requirement that smoking is evidence could be provided contrary to this allowed in a designated area only deficient finding. and cigarette butts must be put in the metal container with a 3.1-19(b) self-closing device to meet set standards. 2) Based on observations and interview, the 2 ALL OTHERS WITH facility failed to ensure employees were smoking POTENTIAL TO BE AFFECTED: in a designated area where approved containers All residents and all staff а were available and in use. This deficient practice and visitors have the potential to could affect as many as 4 residents, 10 staff, and 6 be affected but none were. The visitors using the main entrance/exit. facility has only one smoking area. Findings include: 3. MEASURES TO PREVENT 6QWE21 Facility ID: 000376

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155717				
NAME OF I	PROVIDER OR SUPPLIE	ĨR		EET ADDRESS, CITY, STATE, ZIP C	OD	
ALPHA H	HOME - A WATER	S COMMUNITY		40 COLD SPRING RD DIANAPOLIS, IN 46222		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	PREFI	CROSS-REFERENCED TO THE A		COMPLETIC DATE
				REOCCURRENCE		
		ions made upon my arrival at		a. Maintenance		
		29/23 at 9:03 a.m. and again on		Supervisor/designee a	nd	
		.m. two female employees were		Housekeeping		
	•	de the main entrance to the		Supervisor/designee w	•	1
		igarettes on both days.		the main entrance of the	-	
	Furthermore, there were no approved containers with self-closing lids available for use, nor was this the facility's designated smoking area. Based on an interview just before the start of record			ensure cigarette butts		
				present and that all err		
				smoking in the designation		
				only as a part of the fa	-	
		3 and again on 08/30/23, when		Smoking Policy and do		
	the Maintenance Director was asked if the main			those inspection result		
		signated smoking area, he		appropriate. If any iss		
		swered that it was not and agreed that		discovered, they will be		
	employees should not be smoking in unauthorized			and resolved immediat	-	
	areas.			Maintenance Supervis	-	
				will review with the Adr	ministrator	
		nference with the facility		the inspection results.		
		the Maintenance Director on		b. The Administrato		
		p.m., no additional information or		monitor adherence to t	-	
		provided contrary to this		Policy and validate the		
	deficient finding.			Preventative Maintena		
	2.1.10(1)			documentation is in pla	ace.	
	3.1-19(b)			4. MONITORING		
				a. The inspection re		
				be presented by the M Supervisor/designee to		
				Administrator monthly		
				Administrator will prese		
				inspection results at th		
				Quality Assurance/Per	-	1
				Improvement (QA/PI) r		1
				Inspection results and	-	
				components will be rev	•	
				the QA/PI Committee v		
				subsequent plans of co		1
				developed and implem		1
				deemed necessary to		
				compliance is maintain		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 08/30/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2640 COLD SPRING RD INDIANAPOLIS, IN 46222				
	-				(¥5)		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
				This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.			
C 0761 SS=E Bldg. 01	Based on observati	on, record review, and	K 0761	K761 – It is the intent of the	09/21/2023		
	inspection and test assemblies were co LSC 19.1.1.4.1.1 dividing fire barrie permitted only in co by approved self-co (See also Section 8 required to have a 8.3.4.2 shall be pro- labeled fire door as assemblies and the including all frame and sills in accorda	ity failed to ensure annual ing of 5 of 5 fire door ompleted in accordance with Communicating openings in rs required by 19.1.1.4.1 shall be orridors and shall be protected losing fire door assemblies. 8.3.) LSC 8.3.3.1 Openings fire protection rating by Table otected by approved, listed, ssemblies and fire window ir accompanying hardware, es, closing devices, anchorage, unce with the requirements of d for Fire Doors and Other		 facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 9/21/2023 the Maintenance Supervisor/designed conducted the annual inspection for the fire door assemblies including the door to the oxygen transfilling room and documented those inspection results on the 	to ee		
	Opening Protective specified in this Co door assemblies sh less than annually, inspection shall be by the AHJ. NFPA assemblies shall be sides to assess the assembly.	es, except as otherwise ode. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection . 80, 5.2.4.1 states fire door e visually inspected from both overall condition of door		 meet set standards. The Administrator verified the inspections and documentation 9/21/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT 	r:)		
	following items sh	or breaks exist in surfaces of		REOCCURRENCE: a. On 9/21/2023 the Administrator/corporate Property Manager inserviced the	/		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI		(X2) MULTIPLE CO	ONSTRUCTION	(Y2) DATE SUBVEY	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	(X3) DATE SURVEY COMPLETED	
		155717	B. WING		08/30/2023	
NAME OF 1	PROVIDER OR SUPPLII	ER		ADDRESS, CITY, STATE, ZIP COD		
	HOME - A WATER			OLD SPRING RD IAPOLIS, IN 46222		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	DOMESTIC DE AN OF CORDECTION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY O	DR LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
		n light frames, and glazing beads		Maintenance Supervisor/desig		
	are intact and secu	arely fastened in place, if so		on the requirement that annual		
	equipped.			testing & inspections of fire doe	or	
		ne, hinges, hardware, and		assemblies, including the door	to	
		nreshold are secured, aligned,		the oxygen transfilling room, m	ust	
		der with no visible signs of		be conducted to ensure proper		
	damage.			operation and documented on		
	(4) No parts are m			Annual Door Inspections log to		
	(5) Door clearance	es do not exceed clearances		meet set standards.		
	listed in 4.8.4 and			b. Maintenance		
		ng device is operational; that is,		Supervisor/designee will condu	ıct	
		mpletely closes when operated		the annual inspection of fire do	or	
	from the fully ope	en position.		assemblies, including the door	to	
	(7) If a coordinate	or is installed, the inactive leaf		the oxygen transfilling room, to	,	
	closes before the a			ensure proper operation and		
	(8) Latching hard	ware operates and secures the		document the inspection result	s	
		the closed position.		on the Annual Door Inspection	log	
		lware items that interfere or		as a part of the facility's Preven	ntive	
	prohibit operation	are not installed on the door or		Maintenance Program and		
	frame.			document those inspection res	ults	
		lifications to the door assembly		as appropriate. If any issues a	are	
	•	ned that void the label.		discovered, they will be addres		
		d edge seals, where required, are		and resolved immediately. The	e	
		y their presence and integrity.		Maintenance Supervisor/desig		
	This deficient practice of the second	ctice could affect all occupants.		will review with the Administrat	or	
				the inspection results.		
	Findings include:			c. The Administrator will		
				monitor adherence to the		
		eview with the Maintenance		Preventative Maintenance		
		/23 at 9:26 a.m., an annual		schedule and validate the		
	-	fire door assemblies was		Preventative Maintenance		
		ew, but specific doors needing an		documentation is in place.		
	-	mitted. When asked if the door		4. MONITORING		
		sfilling room was inspected, the		CORRECTIVE ACTION:		
		ctor stated that it had not.		a. The inspection results wi		
		w at the time of record review,		be presented by the Maintenar	nce	
		Director agreed that the door to		Supervisor/designee to the		
		lling room had not been		Administrator monthly and the		
		he annual fire rated door		Administrator will present the		
	inspection.		1	inspection results at the month		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIE		2640 0	address, city, state, zip cod Cold Spring RD NAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	Administrator and 08/30/23 at 12:30	nference with the facility the Maintenance Director on p.m., no additional information or provided contrary to this		Quality Assurance/Perfor Improvement (QA/PI) me Inspection results and sys components will be review the QA/PI Committee with subsequent plans of correc developed and implement deemed necessary to ensist compliance is maintained This plan of correction constitutes our credible allegation of compliance all regulatory requireme Our date of compliance 9/21/2023.	eting. stem wed by n ection ted as sure • • with nts.	
< 0918 SS=F Bldg. 01	Electrical System System Maintena The generator o source and asso- of supplying serv 10-second criteri monthly test, a p annually confirm safety and critica and testing of the switches are perf NFPA 110. Generator sets a exercised under year in 20-40 day once every 36 m Scheduled test u a complete simul automatic or mar loads, and are co personnel. Maint	as - Essential Electric Syste as - Essential Electric ance and Testing r other alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance e generator and transfer formed in accordance with re inspected weekly, load 30 minutes 12 times a y intervals, and exercised onths for 4 continuous hours. nder load conditions include ated cold start and mual transfer of all EES onducted by competent enance and testing of stored urces (Type 3 EES) are in				

	R MEDICARE & MEDIC			CONTRACTOR		MB NO. 0938-039		
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
ND PLAN	OF CORRECTION			<u>01</u>	_	COMPLETED		
15		155717	B. WING		08/3)/2023		
JAME OF	PROVIDER OR SUPPLIE	2	STRE	ET ADDRESS, CITY, STATE, ZIP	COD			
JAME OF PROVIDER OR SUPPLIER) COLD SPRING RD				
ALPHA	PHA HOME - A WATERS COMMUNITY			INDIANAPOLIS, IN 46222				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		HOULD BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	accordance with I	NFPA 111. Main and feeder						
	circuit breakers a	re inspected annually, and a						
	program for periodically exercising the components is established according to							
	manufacturer req	uirements. Written records						
	of maintenance a	nd testing are maintained						
	and readily availa	ble. EES electrical panels						
	and circuits are m	arked, readily identifiable,						
	and separate from normal power circuits.							
	Minimizing the po	ssibility of damage of the						
	emergency power	r source is a design						
	consideration for	new installations.						
	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,							
	NFPA 111, 700.1	· · · · · ·						
	Based on record review and interview, the facility		K 0918	K918– It is the intent of	K918 – It is the intent of the facility			
		ritten record of weekly		to ensure a written record of weekly inspections for the				
	-	generator was maintained for 3						
		A 99, 6.4.4.1.3 requires onsite			facility's emergency generator is maintained to meet set standards.			
	-	maintained in accordance with						
		rd for Emergency and Standby		1. CORRECTIVE A	CTIONS			
		FPA 110, 8.4.1 requires an						
		Supply System (EPSS)		a. On 9/21/2023 th				
		tenant components, shall be		Administrator inservic				
		nd exercised monthly. NFPA		Maintenance Supervis				
	-	a written record of inspection,		on the requirement to				
	-	ising period, and repairs for the		weekly emergency ge				
		ularly maintained and available		inspection and docum				
	for inspection by the	leficient practice could affect all		results to meet set sta				
	residents, staff, and	-		b. On 9/21/2023 th				
	residents, starr, and	visitors.		Maintenance Supervis	-			
	Findings include:			performed the weekly generator inspection a				
	i mangs menuae.			documented the result				
	Based on record re-	view with the Maintenance		facilities Life Safety Bi				
		23 at 9:26 a.m., documentation of		meet set standards				
		esting for three weeks in		2. ALL OTHERS W	/ІТН			
		vas not available for review.		POTENTIAL TO BE A				
		eks of 02/13/23, 02/20/23, and		a. All residents and				
		n an interview at the time of		and visitors have the				
		Maintenance Director		be affected but none				
			1			1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>01</u>	COM	(X3) DATE SURVEY COMPLETED 08/30/2023	
	PROVIDER OR SUPPLIE		264	EET ADDRESS, CITY, STATE, ZIP CC 0 COLD SPRING RD IANAPOLIS, IN 46222	DD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O acknowledged the generator testing a aforementioned en completed by him, Man did not keep During the exit con Administrator and 08/30/23 at 12:30	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION aforementioned missing weekly dding that many of the tries in the log were not and the previous Maintenance very good or legible records. nference with the facility the Maintenance Director on p.m., no additional information or provided contrary to this	ID PREFIJ TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	PREVENT PRE	(X5) COMPLETIO DATE	
< 0923 SS=E	NFPA 101 Gas Equipment -	Cylinder and Container		Improvement (QA/PI) m Inspection results and s components will be revi the QA/PI Committee w subsequent plans of con developed and impleme deemed necessary to e compliance is maintaine This plan of correction constitutes our credibl allegation of compliance all regulatory requirem Our date of compliance 9/21/2023.	eeeting. system ewed by ith rrection ented as nsure ed. de ce with eents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY			STREET 2 2640 C INDIAN	D		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Storage locations and ventilated in and 5.1.3.3.3. >300 but <3,000 Storage locations enclosure or with space of non- or construction, with that can be secu stored with flamm from combustible sprinklered) or en noncombustible minimum 1/2 hr. Less than or equ In a single smoke cylinders availab	equal to 3,000 cubic feet s are designed, constructed, accordance with 5.1.3.3.2 cubic feet s are outdoors in an in an enclosed interior limited- combustible n door (or gates outdoors) red. Oxidizing gases are not nables, and are separated es by 20 feet (5 feet if inclosed in a cabinet of construction having a fire protection rating. al to 300 cubic feet e compartment, individual le for immediate use in s with an aggregate volume				
	required to be sta Cylinders must b as specified in 17 A precautionary s on each door or y room, where the a minimum "CAL STORED WITHII Storage is planne order of which th supplier. Empty from full cylinders cylinders with int threshold pressu established. Em	sign readable from 5 feet is gate of a cylinder storage sign includes the wording as ITION: OXIDIZING GAS(ES) N NO SMOKING." ed so cylinders are used in ey are received from the cylinders are segregated s. When facility employs egral pressure gauge, a re considered empty is pty cylinders are marked to Cylinders stored in the open				

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155717		(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2640 COLD SPRING RD				
ALPHA I	ALPHA HOME - A WATERS COMMUNITY			INDIAN	NAPOLIS, IN 46222		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIEVING DEORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION
TAG	 11.3.1, 11.3.2, 11 99) Based on observati failed to ensure 2 of gases such as oxyg falling. NFPA 99, 2012 Edition, Sectinon nonflammable gase (300 cubic feet) but (3000 cubic feet) si through 11.3.2.3. If cylinder or contain 11.6.2.3. Section If cylinders shall be print in a proper cylinde practice could affee visitors in the vicinit transfilling room. Findings include: Based on observati with the Maintenar 10:15 a.m., two sm cylinders were star oxygen storage and chained or support cart. Based on inter observation, the M acknowledged the standing upright or storage and transfill chained or support cart. During the exit cor Administrator and 08/30/23 at 12:30 print 	A LSC IDENTIFYING INFORMATION .3.3, 11.3.4, 11.6.5 (NFPA on and interview, the facility of 18 cylinders of nonflammable en were properly secured from Health Care Facilities Code, ion 11.3.2 states storage for es greater than 8.5 cubic meters t less than 85 cubic meters hall comply with 11.3.2.1 NFPA 99, Section 11.3.2.6 states er restraints shall comply with 1.6.2.3(11) states freestanding properly chained or supported r stand or cart. This deficient et 16 residents, 4 staff, and 2 ity of oxygen storage and on during a tour of the facility nee Director on 08/30/23 at hall green portable oxygen ding upright on the floor of the transfilling room and were not ed in a proper cylinder stand or erview at the time of aintenance Director two oxygen cylinders were in the floor of the oxygen ling room and neither was ed in a proper cylinder stand or enview at the facility the Maintenance Director on o.m., no additional information or provided contrary to this	К 0	923	K923 – It is the intent of the facility to ensure cylinders of nonflammable gases such as oxygen are properly secured falling to meet set standards 1. CORRECTIVE ACTION TAKEN: a. On 9/21/2023 the Maintenance Supervisor/Dire of Nursing/designee properly secured the two green portal oxygen cylinders that were standing upright on the floor oxygen room to meet set standards. The Administrato verified the work on 9/21/202 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all sta and visitors have the potentia be affected but none were. O 9/21/2023 DON/Maintenance Supervisor/designee checke areas of the facility and four other negative findings. 3. MEASURES TO PREV REOCCURRENCE: a. On 9/21/2023 the Administrator inserviced the DON/Maintenance Superviso the requirement that cylinder nonflammable gases such as oxygen must be properly sec from falling to meet set standards. b. The Director of Nursing/Maintenance Supervisor will check cylinders of	s from IS ector ole of the or 23. FED : ff al to Dn e d all d no ENT or on rs of s cured	DATE 09/21/2023

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Event ID:

6QWE21 Facility ID: 000376

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155717			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/30/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2640 COLD SPRING RD INDIANAPOLIS, IN 46222				
						Т	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL VR 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) COMPLETI DATE	
	3.1-19(b)			nonflammable gases such oxygen on a weekly basis ensure they are properly s from falling as a part of th facility's Oxygen Policy ar Procedures Program and document those inspectio as appropriate. If any iss discovered, they will be ad and resolved immediately Maintenance Supervisor/o will review with the Admin the inspection results. c. The Administrator w monitor adherence to the Policy & Procedures sche validate the Oxygen Polic Procedures are in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection result be presented by the Main Supervisor/designee to th Administrator monthly and Administrator will present inspection results at the m Quality Assurance/Perforn Improvement (QA/PI) meet Inspection results and sys components will be review the QA/PI Committee with subsequent plans of correct developed and implement deemed necessary to ensis compliance is maintained This plan of correction constitutes our credible allegation of compliance all regulatory requirement Our date of compliance	to secured e ad n results ues are ddressed . The designee istrator ill Oxygen dule and y & lts will tenance e d the the nonthly mance eting. stem ved by n ted as sure		

PARTMENT		FORM APPROVED OMB NO. 0938-039					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER				X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			SURVEY LETED /2023
	ROVIDER OR SUPPLIEF OME - A WATERS		-	2640 C	ADDRESS, CITY, STATE, ZIP COD OLD SPRING RD APOLIS, IN 46222	•	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIEPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
					9/21/2023.		

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

Event ID:

6QWE21 Facility ID: 000376

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