PRINTED: 09/18/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 155196  NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY  INDIANAPOLIS, IN 46237  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Bldg  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health Provider Number: 100290000  SUMPLETION DATE  X2) MULTIPLE CONSTRUCTION A. BUILDING  STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237  ID PROVIDERS PLANGE CORRECTION GROWN AVE INDIANAPOLIS, IN 46237  (X5) COMPLETION DATE  E 0000  Bldg  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204	CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
ALTENHEIM HEALTH & LIVING COMMUNITY  (X4) ID  PREFIX TAG  AN Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 2 CFR 483.73.  Survey Date: 08/01/24  Facility Number: 000103 PROVIDER PRANOF CORRECTION ID PREFIX PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  AND PROVIDERS PLAN OF CORRECTION (CASH)			IDENTIFICATION NUMBER	A. BU	JILDING	ONSTRUCTION	COMPLETED	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Bidg  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 08/01/24  Facility Number: 000103  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  E 0000  Aug 20th, 2024  E 0000  Aug 20th, 2024  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street				•	3525 E	HANNA AVE		
An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 08/01/24  Facility Number: 000103 Provider Number: 155196  E 0000  Aug 20th, 2024  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street	PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
At this Emergency Preparedness survey, Altenheim Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  The facility has 87 certified beds. At the time of the survey, the census was 84.  Quality Review completed on 08/06/24  Quality Review completed on 08/06/24  At this Emergency Preparedness ground in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 1st, 2024. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance. We allege substantial compliance on August 20, 2024. We are requesting a desk review for this plan of correction.  If you have any further questions, please do not hesitate to contact me at 317-788-4261.  Sincerely,		conducted by the In accordance with 42  Survey Date: 08/01.  Facility Number: 0 Provider Number: AIM Number: 100.  At this Emergency: Altenheim Health & in compliance with Requirements for M Participating Provided 483.73.  The facility has 87 of the survey, the censure of the survey of the survey in the surve	diana Department of Health in CFR 483.73.  /24  00103 155196 290000  Preparedness survey, & Living Community was found Emergency Preparedness fedicare and Medicaid ders and Suppliers, 42 CFR  certified beds. At the time of the sus was 84.	E 00	000	Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Complian Event ID Number: CNLW21 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licens Survey conducted on August 2024. This letter is to inform y that the plan of correction attached is to serve as Altenhe Health & Living Community credible allegation of complian We allege substantial complia on August 20, 2024. We are requesting a desk review for th plan of correction.  If you have any further questic please do not hesitate to conta me at 317-788-4261.	of sure 1st, you eim nce. nce	

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

(X6) DATE

Deborah Baah, HFA

TITLE

Deborah Baah Administrator 09/12/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CNLW21 Facility ID: 000103 If continuation sheet Page 1 of 24

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	LETED
		155196	B. WI	NG		08/01	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIER	3		3525 E HANNA AVE			
ALTENH	IEIM HEALTH & LIV	ING COMMUNITY	INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Administrator		
					Altenheim Health and Living		
K 0000							
Bldg. 01							
Diag. 01	A Life Safety Code	Recertification and State	K 0	000	Aug 20th, 2024		
	-	vas conducted by the Indiana	I K U	000	7 kg 20th, 2024		
		lth in accordance with 42 CFR					
	483.90(a).				Brenda Buroker, Director		
					Long-Term Care Division		
	Survey Date: 08/01	/24			Indiana State Department of		
				Health			
	Facility Number: 0	000103			2 North Meridian Street		
	Provider Number: 155196				Indianapolis, IN 46204		
	AIM Number: 100	290000					
					Re: Allegation of Complian	nce	
	At this Life Safety	Code survey, Altenheim Health					
	& Living Commun	ity was found not in compliance			Event ID Number: CNLW21		
	with Requirements	for Participation in					
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),			Dear Mrs. Buroker:		
	Life Safety from Fi	re and the 2012 Edition of the					
		ction Association (NFPA) 101,			Please find enclosed the Plan	of	
	1	LSC), Chapter 19, Existing			Correction for the State Licens	sure	
	Health Care Occup	ancies and 410 IAC 16.2.			Survey conducted on August	1st,	
					2024. This letter is to inform y	ou/	
	1	ts of Building 01 and Building			that the plan of correction		
		nsists of the A, B and C wings			attached is to serve as Altenho	eim	
		a three story building with a			Health & Living Community		
		determined to be of Type II			credible allegation of compliar		
	· ′	and was fully sprinklered. The			We allege substantial complia	nce	
	· ·	arm system with smoke			on August 20, 2024. We are		
		els in the corridors and in all			requesting a desk review for the	nis	
	_	orridor. The facility has smoke			plan of correction.		
		d to the building electrical					
		and C wings. The facility has a			If you have any further question		
		had a census of 84 at the time			please do not hesitate to conta	act	
	of this survey.				me at 317-788-4261.		İ

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All areas where residents have customary access

Event ID:

CNLW21 Facility ID: 000103

Sincerely,

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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 155196 B. WING 08/01/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE were sprinklered. All areas providing facility services were sprinklered. Deborah Baah, HFA Quality Review completed on 08/06/24 Administrator Altenheim Health and Living K 0100 **NFPA 101** SS=D General Requirements - Other Bldg. 01 Based on observation and interview, the facility K 0100 Submission of this plan of 08/20/2024 failed to ensure 1 of 3 doors to the kitchen had no correction in no way constitutes impediment to closing and latching into the door an admission by Altenheim Health frame. LSC 4.6.12.3 requires existing life safety and Living or its management features obvious to the public if not required by company that the allegations the Code, shall be either maintained or removed. contained in the survey report is a This deficient practice could affect over 2 staff true and accurate portrayal of the and visitors. provision of nursing care or other services provided in this facility. Findings include: The Plan of Correction is prepared and executed solely because it is Based on observations with the Regional required by Federal and State Maintenance Director, the Maintenance Director Law. and the Assistant Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on This statement of deficiencies and 08/01/24, one of three doors to the kitchen failed plan of correction will be reviewed to fully self-close and latch into the door frame at the Monthly Quality when tested to close multiple times. The door was Assurance/Assessment located just inside the entrance to the service Committee meeting. corridor nearest the elevator. The service corridor was not marked as a facility exit with an exit sign. The door was equipped with a wall mounted magnetic holding device set to release the door to close with fire alarm system activation and a self closing device. Based on interview at the time of K 100 the observations, the Regional Maintenance Director and the Maintenance Director agreed the I. The corrective actions to be aforementioned kitchen door failed to fully accomplished for those self-close and latch into the door frame when residents found to have been tested to close multiple times. affected by the deficient practice.

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Event ID:

CNLW21

Facility ID: 000103

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 08/01/2024			
	PROVIDER OR SUPPLIEF	ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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 (X5) D BE COMPLETION DATE DATE			
AAG	These findings were Director, the Regio Maintenance Direct	e reviewed with the Executive nal Maintenance Director, the tor and the Assistant tor during the exit conference.		Observation – The common failed to ensure that the king corridor door leading to the shut and latched properly. Maintenance Supervisor hadjusted the door so it will properly.  II. The facility will ident other residents that may potentially be affected by deficient practice.  Staff and Residents in the community have the poter be affected by this deficient practice.  III. The facility will put in place the following system changes to ensure that the deficient practice does not recur.  There is a current TELS to inspect all fire doors to enthey latch properly. See at TELS task Labeled "Altent Corridor Door Inspection Task"  IV The facility will monitate corrective action by implementing the following measures.  CarDon Corporate Facilities.	unity tchen e outside The nas I latch  ify y the  ntial to nt  to ematic he ot  ask to sure attached heim FELS  itor  ng  es will			
				inspect this door during th	eir			

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Event ID:

CNLW21 Facility ID: 000103

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING			(X3) DATE SURVEY  COMPLETED  08/01/2024			
NAME OF I	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					monthly site visits.		
					V. Plan of Correction completion date.		
					Plan of Completion date is Au 20th, 2024	gust	
K 0353	NFPA 101						
SS=F	-	- Maintenance and Testing					
Bldg. 01							
		review, observation and	K 035	53	K 353		08/20/2024
		ty failed to maintain automatic accordance with NFPA 25.			I. The corrective actions to I		
		all sprinkler systems shall be			accomplished for those	Je	
	_	nd maintained in accordance			residents found to have been	n	
	_	ndard for the Inspection,			affected by the deficient	· <del>-</del>	
		enance of Water-Based Fire			practice.		
		NFPA 25, 2011 Edition,					
		es the property owner or			Observation – 1 – The Comm	-	
		tative shall correct or repair			failed to ensure that the fire po	•	
	_	airments that are found during			was functioning correctly. The	9	
	_	and maintenance required by ections and repairs shall be			Maintenance Supervisor has contracted with Safecare to re	nair	
		fied maintenance personnel or			the fire pump. The fire pump h	•	
		or. NFPA 25, Section 4.3.1			not been repaired but see	ido	
	_	all be made for all inspections,			attached document labeled		
		nce of the system components			"Safecare Fire Pump Repair"	to	
		vailable to the authority			show that it has been contract	ted.	
		upon request. This deficient					
	_	t all residents, staff, and					
	visitors in the facility	ty.			Observation – 2 – The Comm	-	
	Findings include:				failed to ensure that the fire ris		
	i manigo metade.				install date. The Maintenance		
	Based on review of	the sprinkler system			Supervisor has had Safecare	•	
		or's letter dated 04/23/23, the			replace the gauges on 8/18 to	)	
	_	cility's sprinkler systems is			ensure all gauges on the fire		
		d of repair. The 04/23/23			system are within 5 years.		
	documentation state	ed "our technician noted the			_		

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Event ID:

CNLW21 Facility ID: 000103

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155196	B. W	ING		08/01/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
/ \L   L   \	vi 11L/\L111 \ L1V			INDIAN	, OLIO, IIV 70201		
(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
	_	s not operational and needs to					
		land hardware is seized			II. The facility will identify		
	preventing any further adjustment to the packing.				other residents that may		
		dation that the pump receive a			potentially be affected by the	•	
		with new gland hardware". In			deficient practice.		
		the sprinkler system inspection			Chaff and Davidsonts have the		
		Order" documentation dated	Staff and Residents have the				
	07/30/24 indicated "found that the gland packing on both sides leaked, could not tighten due to a				potential to be affected by this	•	
	seized bolt. Found that the 6" Wall PIV did not				deficient practice.		
		er leaking from the test headers			III. The facility will put into		
	_	ork Required: Mike			place the following systemat	tic	
		nd rebuild, a casing			changes to ensure that the		
	(circulation) relief valve replacement, a transducer				deficient practice does not		
	replacement, and the wall PIV replacement".				recur.		
	1 -	at the time of record review,			l roodi.		
		enance Director stated fire			There is a new Monthly TELS	,	
	_	entation on or after 04/23/23			tasks that was created to insp		
		or review and the facility is			and run the fire pump to ensu		
		the 07/30/24 items to be			is operating correctly. See		
	repaired. Based on	observations with the			attached TELS Task labeled		
	Regional Maintena	nce Director and the			"Altenheim Fire Pump TELS T	ask"	
	Maintenance Direct	tor during a tour of the facility			·		
	from 1:10 p.m. to 3	:40 p.m. on 08/01/24, the facility			IV The facility will monitor		
	has three supervised	d wet sprinkler system riser			the corrective action by		
		ich is equipped with a fire			implementing the following		
		inkler system riser location			measures.		
	with the fire pump i	is in the basement mechanical					
	room.				CarDon Corporate Facilities w		
					audit all fire life safety inspect		
		e reviewed with the Executive			to ensure and recommendation	ns	
		nal Maintenance Director, the			or repairs are completed.		
		tor and the Assistant					
	Maintenance Direct	tor during the exit conference.			V. Plan of Correction		
	2.1.10(1)				completion date.		
	3.1-19(b)				Dian of Completion data is Ass	au ot	
	2 Dagad an aba	vation and interview the			Plan of Completion date is Au	gusi	
		ration and interview, the			20th, 2024		
		sure 5 of 5 sprinkler system inkler riser locations were					
1	i gauges at 1 OL J SPI	mikici iisci iocanons weie	1		I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/01/2024	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	replaced every 5 ye every 5 years by corgauge. NFPA 25, S Testing, and Mainted Protection Systems, states gauges shall be tested every 5 years calibrated gauge. Opercent of the full streplaced. This deficient deficient that the state of the full streplaced. This deficient def	ars or documented as tested imparison with a calibrated standard for the Inspection, chance of Water-Based Fire (2011 Edition, Section 5.3.2.1 per replaced every 5 years or a by comparison with a gauges not accurate to within 3 cale shall be recalibrated or client practice could affect all visitors in the facility.  Ons with the Regional cor and the Maintenance pur of the facility from 1:10 p.m. 201/24, the facility has three in the steel of the face of each in the steel on the sprinkler system interview at the time of the facility and been the most recent five year occumentation of sprinkler in the steel of each of the five in the steel of the five in the Assistant in the steel of the Assistant in the steel			
	Maintenance Direct	or during the exit conference.			

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Event ID:

 $\begin{array}{ccc} CNLW21 & {\it Facility ID:} & 000103 \end{array}$ 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPL A. BUILDING B. WING	e construction g <u>01</u>	(X3) DATE SURVEY COMPLETED 08/01/2024	
	PROVIDER OR SUPPLIER		352	EET ADDRESS, CITY, STATE, ZIP CO 5 E HANNA AVE IANAPOLIS, IN 46237	DD .
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE AP	OULD BE COMPLETION
K 0361 SS=D Bldg. 01	3.1-19(b)  NFPA 101 Corridors - Areas  Based on observation failed to ensure 1 of basement was separ partition capable of smoke as required if an Exception per 19 that spaces other that treatment rooms, and open to the corridor provided: (a) The space opens onto in are protected by an automatic smoke dewith 19.3.4, and (b) automatic sprinklers to obstruct access to practice could affect the basement.  Findings include:  Based on observation Maintenance Direct during a toto 3:40 p.m. on 08/0 doors to the Employ were not equipped were not equipped were not equipped were not equipped were corridor side of the	Open to Corridor  on and interview, the facility for Employee Lounges in the sated from the corridor by a resisting the passage of a sprinklered building, or met 0.3.6.1(7). LSC 19.3.6.1(7) states an patient sleeping rooms, and hazardous areas shall be and unlimited in area, bace and corridors which the the same smoke compartment electrically supervised attection system in accordance. Each space is protected by an ansate and corridors, and (c) The space does not be required exits. This deficient at over two staff and visitors in one with the Regional corridor and the Maintenance are of the facility from 1:10 p.m. 101/24, both of the two corridor are Lounge in the basement with a positive latching device. It is predicted as the proof of the two corridors are the same and the	K 0361	I. The corrective action accomplished for thos residents found to hav affected by the deficient practice.  Observation – The comma failed to ensure that the room in the basement had the latched since this a contain a smoke detected Maintenance Supervisor SafeCare come and insomoke detector in this at this change no latching on the door is needed.  II. The facility will ide other residents that may potentially be affected deficient practice.  Staff and Residents that basement have the potential staffected by this deficient practice.	ns to be e re been int  munity break had doors had hall a harea. With hardware  entify ay by the  t use the ential to be it practice.
	electrically supervis	om was not protected by an sed automatic smoke detection interview at the time of the egional Maintenance Director		III. The facility will put place the following sys changes to ensure that deficient practice does	stematic t the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155196	B. W	ING		08/01/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and the Maintenanc	e Director agreed the			recur.		
	Employee Lounge v	was open to the corridor and					
	was not protected by	y an electrically supervised			This is a permanent fix and no	)	
	automatic smoke de	etection system.			further follow up is required.		
	These findings were	e reviewed with the Executive			IV The facility will monitor		
	_	nal Maintenance Director, the			the corrective action by		
Maintenance Director and the Assistant  Maintenance Director during the exit conference.				implementing the following			
				measures.			
	3.1-19(b)				This is a permanent fix and no	)	
				further follow up is required.			
					V. Plan of Correction		
					completion date.		
					completion date.		
					Plan of Completion date is Au	gust	
					20th, 2024		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01							
		on and interview, the facility	K 0	363	K 363		08/20/2024
		f over 30 corridor doors had no					
	-	ing and latching into the door			I. The corrective actions to b	Эе	
		sist the passage of smoke.			accomplished for those		
	-	ice could affect over 20			residents found to have been	า	
		visitors in the vicinity of the			affected by the deficient		
	A/B Wing Unit Ma	nager's Office.			practice.		
	Findings include:				Observation 1– The communi	tv	
					failed to ensure that the A/B U	-	
	Based on observation	ons with the Regional			Managers Door shut and close		
		for, the Maintenance Director			so there was not a gap around		
		laintenance Director during a			The Maintenance Supervisor I		
		from 1:10 p.m. to 3:40 p.m. on			installed a latching plate on th		
		ng plate on the door frame for			door.	-	
		the A/B Wing Unit Manager's					
		which caused the door to have					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY  COMPLETED
		155196	B. Wl	ING		08/01/2024
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
ing	a one inch gap in be and the door stop or door was in the full Based on interview observations, the Ro	etween the face of the door in the door frame when the y closed and latched position.		TAG	II. The facility will identify other residents that may potentially be affected by the deficient practice.	
		ridor door had an impediment door frame and would not f smoke.			Staff and residents have the potential to be affected by this deficient practice.	;
	Director, the Region Maintenance Direct	e reviewed with the Executive nal Maintenance Director, the or and the Assistant for during the exit conference.			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  There is a current TELS task to inspect all fire doors to ensure they latch properly. See attact	to 3
					TELS task Labeled "Altenheim Corridor Door Inspection TELS Task"  IV The facility will monitor	
					the corrective action by implementing the following measures.  CarDon Corporate Facilities w	ill
					inspect all doors during their s visits to ensure they shot and latch properly.	<b>I</b>
					V. Plan of Correction completion date.	
					Plan of Completion date is Au	gust

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/01/2024	
	PROVIDER OR SUPPLIER		3	3525 E I	DDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	REGULATORY OR  NFPA 101  Utilities - Gas and  Based on observation failed to ensure 1 of locations were provinterrupter (GFCI) personal failed to ensure 1 of locations were provinterrupter (GFCI) personal failed to ensure 1 of locations were provinterrupter (GFCI) personal failed for 9.1. LSC 9 and equipment to confide the for Personnel, states circuit-interruption provided as required ground-fault circuitare a readily accessible (B) Other Than Dwingle-phase, 15- and installed in the location through (8) shall has circuit-interrupter personal failed in the location fa	Electric  on and interview, the facility Electric and a substitute of the substitute of		'AG	K 511  I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation – The community failed to ensure that the beauty shop receptacles closest to the hair washing station was GFI protected. The Maintenance Supervisor has installed a GF See attached picture labeled "Altenheim- Salon Receptacles".  II. The facility will identify other residents that may potentially be affected by the deficient practice.  Staff and residents that use the beauty shop have the potential be affected by this deficient practice.  III. The facility will put into	be n / ty ie i. e	
	only, where the con supervision ensure t are involved, an ass conductor program shall be permitted to outlets used to supp	(4): In industrial establishments ditions of maintenance and that only qualified personnel ured equipment grounding as specified in 590.6(B)(2) or only those receptacle ly equipment that would ard if power is interrupted or			place the following systema changes to ensure that the deficient practice does not recur.  This is a permanent fix so no further follow up is needed.	tic	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURV	/EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETEI	
		155196	B. W	ING		08/01/202	4
NAME OF I	PROVIDER OR SUPPLIEI	· ?	-		ADDRESS, CITY, STATE, ZIP COD	_	
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(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 DEFICIENCY)	CO CO	MPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	protection.	t is not compatible with GFCI			IV The facility will monitor the corrective action by		
	*	eceptacles are installed within			implementing the following		
	1 1	outside edge of the sink.			measures.		
		(5): In industrial laboratories,			measures.		
	_	supply equipment where			CarDon Corporate Facilities v	<sub>/ill</sub>	
	removal of power would introduce a greater				monitor the community during		
	hazard shall be permitted to be installed without				their site visits looking for other		
	GFCI protection.				areas that might need GFI		
	Exception No. 2 to (5): For receptacles located in				outlets.		
	patient bed locations of general care or critical						
		care facilities other than those			V. Plan of Correction		
	covered under 210.8(B)(1), GFCI protection shall				completion date.		
	not be required.						
	(6) Indoor wet loca				Plan of Completion date is Au	gust	
	1 1	vith associated showering			20th, 2024		
	facilities						
		e bays, and similar areas where					
	_	c equipment, electrical hand					
	used.	ghting equipment are to be					
	used.						
	NFPA 70, 517-20 V	Wet Locations, requires all					
	receptacles and fixe	ed equipment within the area of					
		have ground-fault circuit					
		protection. Note: Moisture can					
		resistance of the body, and					
		is more subject to failure.					
	•	ice could affect one resident in					
	the Beauty Shop.						
	Findings include:						
	- mamga meraac.						
		ons with the Regional					
		tor, the Maintenance Director					
	and the Assistant Maintenance Director during a						
	tour of the facility from 1:10 p.m. to 3:40 p.m. on						
	08/01/24, the electrical receptacles in the wall						
		installed within three feet of					
	the sink in the Beau	ity Shop were not provided					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/01/2024	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	circuit breaker for the located to determine protected. The recent tested with an Ideal device. Based on in observations, the Reand the Maintenance breaker for the recent and agreed the recent aground fault circuit. These findings were Director, the Region Maintenance Direct Mai	recuit interrupters (GFCI). The he outlet box could not be e if the circuit was GFCI ptacles did not trip when Industries circuit testing herview at the time of the egional Maintenance Director e Director agreed the circuit ptacles could not be located ptacles were not provided with interrupters (GFCI).  The reviewed with the Executive hal Maintenance Director, the for and the Assistant for during the exit conference.  The reviewed with the Executive hal Maintenance Director, the for and the Assistant for during the exit conference.  The reviewed with the Executive hal Maintenance Director, the for and the Assistant for during the exit conference.  The reviewed with the Executive half maintenance Director, the for and the Assistant for during the exit conference.  The reviewed with the Executive half maintenance Director, the for an interview, the facility for an exit conference.  The reviewed with the Executive half maintenance Director, the for an interview, the facility for an exit conference.  The reviewed with the Executive half half half half with the Executive half half half half half half half half	K 0918	K 918  I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation 1: The communit failed to ensure that the emergency lights located in the main electrical room which had the generator illuminated whe tested. The Maintenance Supervisor has replaced the lithat did not function correctly. See picture labeled "Altenheir Gen- Room Emergency Lights"	n ity ne ouses en ights

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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	A. BUILDING <u>01</u>			COMPLETED	
155196		B. W	B. WING 08/01/2024			2024		
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE			
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237			
	1							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY 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		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE	
	· ·	leficient practice could affect all						
	residents, staff and	VISITORS.			Observation 2: The community	/		
	Pindings in ded.				failed to ensure that the			
	Findings include:				emergency generator had a			
	Rosed on observative	ons with the Regional			manual shut off switch outside the main electrical room. Durin			
		tor and the Maintenance				_		
		our of the facility from 1:10 p.m.			the inspection the surveyor an Maintenance Supervisor went			
	_	01/24, two of the three wall			and out of another door to ent			
		ck up lights installed in the			this location. There is an exis			
		n in the basement which			shut off switch outside of the o			
		ncy generator room for the			entrance. See picture labeled			
	_	iminate when tested. Based on			"Altenheim- Generator Emerge			
		e of the observations, the			Shut off."	,		
	Maintenance Direct	tor stated the lights are old and						
	don't work and agre	eed two of the three battery						
	back up lights insta	lled in the room failed to			II. The facility will identify			
	illuminate.				other residents that may			
					potentially be affected by the	,		
	_	e reviewed with the Executive			deficient practice.			
		nal Maintenance Director, the						
		tor and the Assistant			Staff and residents in the			
	Maintenance Direct	tor during the exit conference.			community have the potential	to		
					be affected by this deficient			
	3.1-19(b)				practice.			
	2 Daged1	ation and intermiors the feetile						
		ation and interview, the facility			III. The feetite will not inte			
		f 1 remote manual stops for the or for the facility was located			III. The facility will put into	.		
		or room housing the			place the following systemat	IC		
		or in accordance with NFPA			changes to ensure that the deficient practice does not			
		Ith Care Facilities Code, 2012			•			
		.5.1.3 states emergency			recur.			
		dby power system, where			Observation 1: There is a curr	<sub>ent</sub>		
	-	ance with this code, shall be			monthly TELS task for the			
		d maintained in accordance			Maintenance Supervisor to ins	spect		
		andard for Emergency and			the Emergency lights in the			
		tems. NFPA 110, 2010 edition,			electrical room. See TELS ta	<sub>sk</sub>		
	, ,	stallations shall have a remote			labeled "Altenheim Emergency			
		of a type to prevent			Light Inspection TELS Task".	<b>'</b>		

CLI.ILIOIOI	THE CONTENTS	in our roug			012 1.0.000 000	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155196	B. WING		08/01/2024	
		<u> </u>		ADDRESS STEW OF THE STEET		
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
A1 TEX		VINIC COMMANDENTLY		HANNA AVE		
ALIENHI	EIM HEALTH & LIV	TING COMMUNITY	INDIAN	NAPOLIS, IN 46237		
(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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	inadvertent or unint	tentional operation located				
	outside the room ho	ousing the prime mover, where		Observation 2: This is a		
		where on the premises where		permanent fix so no further fo	llow	
		located outside the building.		up is needed.		
	-	stop station shall be labeled.				
		ice could affect all residents,		IV The facility will monitor		
	staff and visitors.	,		the corrective action by		
				implementing the following		
	Findings include:			measures.		
				measures.		
	Based on observation	ons with the Regional		CarDon Corporate Facilities a	udit	
		tor and the Maintenance		the documents for the emerge		
	Director during a to	our of the facility from 1:10 p.m.		light testing during their annua	-	
		01/24, the facility has one diesel		CQR.		
	•	by generator for the facility		ogr.		
	_	nain electrical room in the		V. Plan of Correction		
		ergency generator had an		completion date.		
		ndicating the generator was		completion date.		
	_	d was delivered to the facility		Plan of Completion date is Au	ialiet	
		only remote emergency stop		20th, 2024.	igust	
		e facility was in the room		2001, 2024.		
		for. Based on interview at the				
	time of the observa					
		tor and the Maintenance				
		remote manual stop station for				
		erator was installed in the room				
	housing the generat					
	and general					
	These findings were	e reviewed with the Executive				
		nal Maintenance Director, the				
		tor and the Assistant				
		tor during the exit conference.				
	3.1-19(b)					
K 0920	NFPA 101					
SS=E	Electrical Equipme	ent - Power Cords and				
Bldg. 01	Extens					
	Based on observation	on and interview, the facility	K 0920	K 920	08/20/2024	
	failed to ensure 2 or	f 2 extension cords including				

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 08/01/2024 155196 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (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 power strips were not used as a substitute for I. The corrective actions to be fixed wiring. LSC 19.5.1 requires utilities to accomplished for those comply with Section 9.1. LSC 9.1.2 requires residents found to have been electrical wiring and equipment to comply with affected by the deficient NFPA 70, National Electrical Code, 2011 Edition. practice. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables Observation 1– The community shall not be used as a substitute for fixed wiring of failed to ensure that there were no a structure. LSC Section 4.5.7 states any building non approved power strip being service equipment or safeguard provided for life used within the Community. The safety shall be designed, installed and approved power strip near the resident room in accordance with all applicable NFPA standards. #1116 and in the Cube X room This deficient practice could affect over 20 was removed and a quad electrical residents, staff and visitors. outlet install. See attached picture labeled "Altenheim Cube X Findings include: Room Receptacle." Based on observations with the Regional Observation 2– The community Maintenance Director, the Maintenance Director failed to ensure that there were no and the Assistant Maintenance Director during a non approved power strip being tour of the facility from 1:10 p.m. to 3:40 p.m. on used within the Community. The 08/01/24, the following was noted: power strip in the Davita Dialysis a. a temperature monitor, a refrigerator and a storage room was removed and a dehumidifier were plugged into a power strip in quad electrical outlet install. See the storage room by Room 1116. attached picture labeled b. a microwave oven, a refrigerator, a toaster and a "Altenheim Cube X Room coffee pot were plugged into a power strip in the Receptacle." dialysis storage room. Based on interview at the time of the observations, the Regional Maintenance Director II. The facility will identify other residents that may and the Maintenance Director agreed power strips cords were being used as a substitute for fixed potentially be affected by the wiring at the aforementioned two locations. deficient practice. These findings were reviewed with the Executive Staff and residents in the Director, the Regional Maintenance Director, the community have the potential to Maintenance Director and the Assistant be affected by this deficient Maintenance Director during the exit conference. practice. 3.1-19(b)

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/01/2024
	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.	tic
				The Maintenance Department been reeducated on the powe strip policy and what are appr type and uses.	er
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities we inspect offices and resident roas part of their CQR to ensure there are no non approved postrips or uses within the community.	ooms e
				V. Plan of Correction completion date.	
				Plan of Completion date is Au 20th, 2024	gust
K 0000					
Bldg. 02		Survey was conducted by the t of Health in accordance with	K 0000	Aug 20th, 2024	
	Survey Date: 08/01 Facility Number: 0			Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health	

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Event ID:

CNLW21 Facility ID: 000103

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		` ′	X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>02</u> COMPLE			
		155196	B. WI	NG		08/01/	/2024
	PROVIDER OR SUPPLIER		•	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237		
(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
	Provider Number:	155196			2 North Meridian Street		
	AIM Number: 100	290000			Indianapolis, IN 46204		
	& Living Communiwith Requirements Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupa This facility consist 02. Building 02 cor Rehabilitation Wing determined to be of was fully sprinklere has a fire alarm syst the corridors, in all has smoke detectors system in resident s has a capacity of 87 time of this survey.  All areas where resi were sprinklered an services were sprinklered an	s, 42 CFR Subpart 483.90(a), re and the 2012 Edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.  Is of Building 01 and Building ansists of the one story gronstructed in 2014 and was Type V (111) construction and and. The Rehabilitation Wing tem with smoke detection in areas open to the corridor and as hard wired to the fire alarm leeping rooms. The facility and had a census of 84 at the didents have customary access did all areas providing facility			Re: Allegation of Complian Event ID Number: CNLW21 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licens Survey conducted on August 2024. This letter is to inform y that the plan of correction attached is to serve as Altenh-Health & Living Community credible allegation of complian We allege substantial complian on August 20, 2024. We are requesting a desk review for the plan of correction.  If you have any further question please do not hesitate to contame at 317-788-4261.  Sincerely,	of sure 1st, you eim nce. nce	
	Quality Review col.				Deborah Baah, HFA Administrator		
					Altenheim Health and Living		
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors						
J		on and interview, the facility	K 02	222	K 222		08/20/2024
		means of egress through 3 of					
		cks were readily accessible for nd visitors. LSC 7.2.1.6.1,			I. The corrective actions to be accomplished for those	oe	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		r í	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUI         A. BUILDING       02       COMPLETI         B. WING       08/01/20		
	PROVIDER OR SUPPLIER		352	EET ADDRESS, CITY, STATE, ZIP COD 25 E HANNA AVE DIANAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TION (X5) LD BE COMPLETION ROPRIATE DATE
me	Delayed Egress Lock delayed egress lock installed on doors so hazard contents in bethroughout by an apfire detection system Section 9.6, or an apprinkler system ins Section 9.7, and whethrough 42, provide (a) The doors unlock	eks allows approved, listed, as shall be permitted to be serving low and ordinary buildings protected approved, supervised automatic in installed in accordance with approved, supervised automatic talled in accordance with ere permitted in Chapters 12 d:  k upon actuation of an		residents found to have affected by the deficient practice.  Observation 1– The commodified to ensure that the Finding Room exterior gladdoor opened properly by keypad or delayed egress Maintenance Supervisor Automatic Door out to rep	munity Rehab ss exit the s. The had Your
	installed in accordant the actuation of any than two smoke detesupervised automati installed in accordance (b) The doors unloc controlling the lock (c) An irreversible pwithin 15 seconds unthe release device renot be required to excontinuously applie	d automatic sprinkler system hee with Section 9.7, or upon heat detector or not more ectors of an approved, for fire detection system hee with Section 9.6. k upon loss of power for locking mechanism. forcess shall release the lock pon application of a force to equired in 7.2.1.5.4 that shall forced 15 lbf nor required to be d for more than 3 seconds. Frelease process shall activate		door.  Observation 2– The commodified to ensure that the Tallian Room exterior glass exists opened properly by the kindle delayed egress. The Maintenance Supervisor Automatic Door out to register.  II. The facility will iden	Therapy door eypad or had Your pair the
	an audible signal in the door lock has be of force to the relea by manual means of Exception: Where a having jurisdiction, seconds shall be per (d) On the door adjathere shall be a read letters not less than inch in stroke width that reads: "PUSH UNTIL AL. DOOR CAN BE O	the vicinity of the door. Once the released by the application using device, relocking shall be ally.  pproved by the authority a delay not exceeding 30 mitted.  Independent of the release device, ally visible, durable sign in 1 inch high and at least 1/8 on a contrasting background		other residents that may potentially be affected be deficient practice.  All Staff and residents or south side of the communithe potential to be affected.  III. The facility will put in place the following system changes to ensure that deficient practice does not recur.	by the  In the nity have ed.  Into ematic the not

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u> COMPLET			ETED
		155196	B. W	B. WING 08/01/2024			2024
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
					HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CLUDERIS N. 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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
		visitors if needing to exit the			task to inspect all exit doors to	,	
	facility.	5			ensure the keypads and delay		
	J				egress functions are working	-	
	Findings include:				properly. See attached TELS	task	
	i mamgs meraac.				Labeled "Altenheim Delayed	lask	
	Based on observation	ons with the Regional			Egress Door Inspection TELS		
		tor, the Maintenance Director			Task"		
		Iaintenance Director during a			I GOR		
		From 1:10 p.m. to 3:40 p.m. on			IV The facility will monitor		
		oor set to the outside of the			the corrective action by		
		pilitation Wing Dining Room			implementing the following		
		cility exit with an exit sign. The			measures.		
		pened by entering the posted			illeasures.		
	-	at the exit door set. However,			CarDon Corporate Facilities		
		t locked from the inside and			inspects the exit doors during	thoir	
		e opened from the inside			_	uieii	
		code was entered to release the			monthly site visits.		
		he exit door set was also			V Diam of Commontion		
	-	d egress signage, but it			V. Plan of Correction		
	_	et was not equipped with any			completion date.		
		vices and could be opened			Dian of Completion data is Au	quot	
	-	e door set with no delay. The			Plan of Completion date is Au	gust	
		om exit door to the outside of			20th, 2024		
		marked as a facility exit with					
		same scenario was noted for					
	•	vas for the Dining Room door					
		Rehab Center exit door to the					
		ty was marked as a facility exit					
		The door was a delayed egress					
	_	o open when pushed for 15					
		or was not equipped with the					
		egress door signage. The door					
		0 0					
		entering the posted code at					
		tit door. Based on interview at					
		rvations, the Regional					
		tor agreed the Dining Room					
		chab Therapy Room exit door					
		facility gave the appearance					
		egress doors when they were					
	not and the Rehab (	Center exit door to the outside					

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Event ID:

CNLW21 Facility ID: 000103

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>		
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
K 0281 SS=E Bldg. 02	of the facility was a not equipped with t door signage.  These findings were Director, the Regio Maintenance Director Maintenance Office Maintenance Office Maintenance Office Maintenance Office Maintenance Director Main	on and interview, the facility ess lighting for 2 of 5 exit s arranged so the failure of fixture (bulb) would not leave s. LSC 7.8.1.4 requires e arranged so that that the e lighting unit does not result evel of less than 0.2 foot-candle rea. This deficient practice 0 residents, staff and visitors if facility.  ons with the Regional tor, the Maintenance Director laintenance Director during a from 1:10 p.m. to 3:40 p.m. on ischarge for the Rehabilitation in was equipped with two cutures each with one light bulb re's light bulb was burnt out. discharge for the Rehab also equipped with two	K 0281	K 281  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that the exit do lights by the Rehab exit were working properly. The Maintenance Supervisor changall bulbs to ensure they are illuminating correctly.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  Staff and residents in the community that use this exit page.	08/20/2024  ne n  por ged
		ctures each with one light bulb re's light bulb was also burnt		have the potential to be affected by this deficient practice.	ed

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Event ID:

 $CNLW21 \quad \ \ {\rm Facility\ ID:} \quad \ 000103$ 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ì í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  02			(X3) DATE SURVEY COMPLETED	
		155196	B. WING 08/01/2		/2024		
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observations, the Re the Maintenance Di each of the aforeme	view at the time of the egional Maintenance Director, rector agreed the discharge for entioned exits was not arranged number of operable lighting			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.	ic	
	Director, the Region Maintenance Direct	e reviewed with the Executive nal Maintenance Director, the for and the Assistant or during the exit conference.			There is a new monthly TELS for the Maintenance Supervisor walk the exterior to ensure that exit lights are illuminated. See attached TELS Task labeled "Altenheim Exterior Lights TELT Task"	or to t all	
					IV The facility will monitor the corrective action by implementing the following measures.		
					CarDon Corporate Facilities inspect all exterior exit lighting during their monthly site visits.		
					V. Plan of Correction completion date.		
					Plan of Completion date is Aug 20th, 2024	gust	
K 0374 SS=E Bldg. 02	Barrie	lding Spaces - Smoke					
	failed to ensure 1 of would restrict the m 20 minutes. LSC 19 barriers shall compl 8.5.4.1 requires doo	on and interview, the facility of 2 sets of smoke barrier doors novement of smoke for at least 9.3.7.8 requires doors in smoke by with LSC Section 8.5.4. LSC ors in smoke barrier shall close only the minimum clearance	K 03	374	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		08/20/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	A. BUILDING 02 COMPLETED  B. WING 08/01/2024			
		155196	B. WIN	IG		08/01/2	2024
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					HANNA AVE		
ALTENHI	EIM HEALTH & LIV	TING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		er operation. This deficient et 20 residents, staff and			Observation. The community		
	_	ity of the smoke barrier door			Observation – The community failed to ensure that corridor d		
	set by Room 1137.	-			by resident room 1137 shut ar		
					latched properly. The		
	Findings include:				Maintenance Supervisor has		
	_				adjusted the doors so they will		
		ons with the Regional			latch properly.		
		tor, the Maintenance Director					
		faintenance Director during a			II. The facility will identify		
	-	From 1:10 p.m. to 3:40 p.m. on			other residents that may		
	·	door in the corridor door set			potentially be affected by the	•	
	-	ed to fully self-close which left a ween the meeting edges of the			deficient practice.		
		d to close multiple times. Each			Staff and Residents in the		
		door set was equipped with a			community have the potential	to	
		and was held in the fully open			be affected by this deficient		
	_	I mounted magnetic hold open			practice.		
	_	e with fire alarm system			process.		
	activation. Based o	on interview at the time of the					
	observations, the Ro	egional Maintenance Director			III. The facility will put into		
		ee Director agreed the south			place the following systemat	ic	
		entioned corridor door set failed			changes to ensure that the		
		eaving a one inch gap in			deficient practice does not		
	between the meetin	g edges of the door set.			recur.		
	These findings were	e reviewed with the Executive			There is a current TELS task t		
	_	nal Maintenance Director, the			inspect all fire doors to ensure		
		tor and the Assistant			they latch properly. See attack		
		tor during the exit conference.			TELS task Labeled "Altenheim		
		-			Corridor Door Inspection TELS		
	3.1-19(b)				Task"		
					N/ The feetile		
					IV The facility will monitor the corrective action by		
					implementing the following		
					measures.		
					CarDon Corporate Facilities w	ill	

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

PRINTED: 09/18/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	X2) MULTIPLE CONSTRUCTION X A. BUILDING <u>02</u> B. WING			(X3) DATE COMPL <b>08/01</b> /	ETED
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					inspect this door during their monthly site visits.		
					V. Plan of Correction completion date.		
					Plan of Completion date is Aug 20th, 2024	gust	

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