STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(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. Survey Date: 08/01/24 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 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	E 0000	Aug 20th, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID Number: CNLW21 Dear Mrs. Buroker: 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, Deborah Baah, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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.

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/01/24 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The facility has a capacity of 87 and had a census of 84 at the time of this survey. All areas where residents have customary access	K 0000	Administrator Altenheim Health and Living Aug 20th, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID Number: CNLW21 Dear Mrs. Buroker: 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,	

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	were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/06/24		Deborah Baah, HFA Administrator Altenheim Health and Living	
K 0100 SS=D Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 3 doors to the kitchen had no impediment to closing and latching into the door frame. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 2 staff and visitors. Findings include: Based on observations with the Regional Maintenance Director, 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, one of three doors to the kitchen failed to fully self-close and latch into the door frame when tested to close multiple times. The door was located just inside the entrance to the service 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 the observations, the Regional Maintenance Director and the Maintenance Director agreed the aforementioned kitchen door failed to fully self-close and latch into the door frame when tested to close multiple times.	K 0100	Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. **K 100** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	08/20/2024

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	These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		Observation – The community failed to ensure that the kitchen corridor door leading to the outside shut and latched properly. The Maintenance Supervisor has adjusted the door so it will latch properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and Residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic 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 attached 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 will inspect this door during their	

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			monthly site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's letter dated 04/23/23, the fire pump for the facility's sprinkler systems is operable but in need of repair. The 04/23/23 documentation stated "our technician noted the	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – 1 – The Community failed to ensure that the fire pump was functioning correctly. The Maintenance Supervisor has contracted with Safecare to repair the fire pump. The fire pump has not been repaired but see attached document labeled “Safecare Fire Pump Repair” to show that it has been contracted. Observation – 2 – The Community failed to ensure that the fire riser gauges we within 5 years on the install date. The Maintenance Supervisor has had Safecare replace the gauges on 8/18 to ensure all gauges on the fire system are within 5 years.	08/20/2024

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	casing relief valve is not operational and needs to be replaced. The gland hardware is seized preventing any further adjustment to the packing. It is our recommendation that the pump receive a full top off repack with new gland hardware". In addition, review of the sprinkler system inspection contractor's "Work Order" documentation dated 07/30/24 indicated "found that the gland packing on both sides leaked, could not tighten due to a seized bolt. Found that the 6" Wall PIV did not seal and slight water leaking from the test headers outside. Further Work Required: Mike recommended a gland rebuild, a casing (circulation) relief valve replacement, a transducer replacement, and the wall PIV replacement". Based on interview at the time of record review, the Regional Maintenance Director stated fire pump repair documentation on or after 04/23/23 was not available for review and the facility is seeking a quote for the 07/30/24 items to be repaired. Based on observations with the Regional Maintenance Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on 08/01/24, the facility has three supervised wet sprinkler system riser locations one of which is equipped with a fire pump. The wet sprinkler system riser location with the fire pump is in the basement mechanical room. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 5 of 5 sprinkler system gauges at 1 of 3 sprinkler riser locations were		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and Residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new Monthly TELS tasks that was created to inspect and run the fire pump to ensure it is operating correctly. See attached TELS Task labeled “Altenheim Fire Pump TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all fire life safety inspections to ensure and recommendations or repairs are completed. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	

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	replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Regional Maintenance Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on 08/01/24, the facility has three supervised wet sprinkler system riser locations one of which is equipped with a fire pump. The wet sprinkler system riser location with the fire pump in the basement mechanical room had a total of five water pressure gauges. The manufacture date of 2015 was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observations, the Maintenance Director stated he did not know if sprinkler system gauges had been recalibrated within the most recent five year period and agreed documentation of sprinkler system gauge replacement or recalibration was not available for review for each of the five sprinkler system gauges which were more than five years old. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference.			

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K 0361 SS=D Bldg. 01	3.1-19(b) NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 Employee Lounges in the basement was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over two staff and visitors in the basement. Findings include: Based on observations with the Regional Maintenance Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on 08/01/24, both of the two corridor doors to the Employee Lounge in the basement were not equipped with a positive latching device. Each door was equipped with a thumb twist deadbolt which required a key to unlock from the corridor side of the room. LSC 19.3.6.1(7) was not met because the room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of the observations, the Regional Maintenance Director	K 0361	**K 361** **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 break room in the basement had doors that latched since this area did not contain a smoke detector. The Maintenance Supervisor had SafeCare come and install a smoke detector in this area. With this change no latching hardware on the door is needed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and Residents that use the basement have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not**	08/20/2024

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	and the Maintenance Director agreed the Employee Lounge was open to the corridor and was not protected by an electrically supervised automatic smoke detection system. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		**recur.** This is a permanent fix and no further follow up is required. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix and no further follow up is required. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the A/B Wing Unit Manager's Office. Findings include: Based on observations with the Regional Maintenance Director, 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 latching plate on the door frame for the corridor door to the A/B Wing Unit Manager's Office was missing which caused the door to have	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The community failed to ensure that the A/B Unit Managers Door shut and closed so there was not a gap around it. The Maintenance Supervisor has installed a latching plate on the door. .	08/20/2024

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	a one inch gap in between the face of the door and the door stop on the door frame when the door was in the fully closed and latched position. Based on interview at the time of the observations, the Regional Maintenance Director and the Maintenance Director agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic 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 attached 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 will inspect all doors during their site visits to ensure they shot and latch properly. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 Beauty Shops with wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or	K 0511	**K 511** **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 beauty shop receptacles closest to the hair washing station was GFI protected. The Maintenance Supervisor has installed a GFI. See attached picture labeled "Altenheim- Salon Receptacle." **II. The facility will identify other residents that may potentially be affected by the deficient practice.** ~~S~~taff and residents that use the beauty shop have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix so no further follow up is needed.	08/20/2024

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	having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one resident in the Beauty Shop. Findings include: Based on observations with the Regional Maintenance Director, 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 mounted outlet box installed within three feet of the sink in the Beauty Shop were not provided		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the community during their site visits looking for other areas that might need GFI outlets. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	

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	155196	A. BUILDING 01 B. WING	08/01/2024

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ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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	with ground fault circuit interrupters (GFCI). The circuit breaker for the outlet box could not be located to determine if the circuit was GFCI protected. The receptacles did not trip when tested with an Ideal Industries circuit testing device. Based on interview at the time of the observations, the Regional Maintenance Director and the Maintenance Director agreed the circuit breaker for the receptacles could not be located and agreed the receptacles were not provided with ground fault circuit interrupters (GFCI). These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on observation and interview, the facility failed to ensure 2 of 3 emergency task generator battery backup lights was maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0918	**K 918** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1: The community failed to ensure that the emergency lights located in the main electrical room which houses the generator illuminated when tested. The Maintenance Supervisor has replaced the lights that did not function correctly. See picture labeled “Altenheim Gen- Room Emergency Lights.”	08/20/2024

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	jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Regional Maintenance Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on 08/01/24, two of the three wall mounted battery back up lights installed in the main electrical room in the basement which houses the emergency generator room for the facility failed to illuminate when tested. Based on interview at the time of the observations, the Maintenance Director stated the lights are old and don't work and agreed two of the three battery back up lights installed in the room failed to illuminate. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 remote manual stops for the emergency generator for the facility was located outside of the indoor room housing the emergency generator in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.5.1.3 states emergency generators and standby power system, where required for compliance with this code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 edition, 5.6.5.6 states all installations shall have a remote manual stop station of a type to prevent		Observation 2: The community failed to ensure that the emergency generator had a manual shut off switch outside of the main electrical room. During the inspection the surveyor and Maintenance Supervisor went in and out of another door to enter this location. There is an existing shut off switch outside of the other entrance. See picture labeled "Altenheim- Generator Emergency Shut off." **II. The facility will identify other residents that may potentially be affected by the deficient practice.** ~~S~~taff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1: There is a current monthly TELS task for the Maintenance Supervisor to inspect the Emergency lights in the electrical room. See TELS task labeled "Altenheim Emergency Light Inspection TELS Task".	

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	inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. The remote manual stop station shall be labeled. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Regional Maintenance Director and the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:40 p.m. on 08/01/24, the facility has one diesel fuel fired emergency generator for the facility located inside the main electrical room in the basement. The emergency generator had an affixed nameplate indicating the generator was rated at 285 kW and was delivered to the facility on 02/28/74. The only remote emergency stop button located in the facility was in the room housing the generator. Based on interview at the time of the observations, the Regional Maintenance Director and the Maintenance Director agreed the remote manual stop station for the emergency generator was installed in the room housing the generator. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		Observation 2: This is a permanent fix so no further follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities audit the documents for the emergency light testing during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including	K 0920	**K 920**	08/20/2024

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

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			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The Maintenance Department has been reeducated on the power strip policy and what are approved type and uses. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect offices and resident rooms as part of their CQR to ensure there are no non approved power strips or uses within the community. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/01/24 Facility Number: 000103	K 0000	Aug 20th, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health	

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	Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code Survey, Altenheim Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 84 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/06/24		2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID Number: CNLW21 Dear Mrs. Buroker: 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, Deborah Baah, HFA Administrator Altenheim Health and Living	
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1,	K 0222	**K 222** **I. The corrective actions to be accomplished for those**	08/20/2024

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	Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 20		**residents found to have been affected by the deficient practice.** Observation 1– The community failed to ensure that the Rehab Dining Room exterior glass exit door opened properly by the keypad or delayed egress. The Maintenance Supervisor had Your Automatic Door out to repair the door. Observation 2– The community failed to ensure that the Therapy Room exterior glass exit door opened properly by the keypad or delayed egress. The Maintenance Supervisor had Your Automatic Door out to repair the door. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Staff and residents on the south side of the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current weekly TELS	

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	residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Regional Maintenance Director, 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 exit door set to the outside of the facility in the Rehabilitation Wing Dining Room was marked as a facility exit with an exit sign. The door set could be opened by entering the posted code at the keypad at the exit door set. However, the door set was not locked from the inside and the door set could be opened from the inside whether or not the code was entered to release the door set to open. The exit door set was also marked with delayed egress signage, but it appeared the door set was not equipped with any magnetic release devices and could be opened when pushing on the door set with no delay. The Rehab Therapy Room exit door to the outside of the facility was also marked as a facility exit with an exit sign, but the same scenario was noted for this exit door as it was for the Dining Room door set. In addition, the Rehab Center exit door to the outside of the facility was marked as a facility exit with an exit sign. The door was a delayed egress door and released to open when pushed for 15 seconds but the door was not equipped with the necessary delayed egress door signage. The door could be opened by entering the posted code at the keypad at the exit door. Based on interview at the time of the observations, the Regional Maintenance Director agreed the Dining Room door set, and the Rehab Therapy Room exit door to the outside of the facility gave the appearance they were delayed egress doors when they were not and the Rehab Center exit door to the outside		task to inspect all exit doors to ensure the keypads and delayed egress functions are working properly. See attached TELS task Labeled “Altenheim Delayed Egress Door Inspection TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects the exit doors during their monthly site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	

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	of the facility was a delayed egress door but was not equipped with the necessary delayed egress door signage. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)			
K 0281 SS=E Bldg. 02	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure egress lighting for 2 of 5 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Regional Maintenance Director, 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 exit discharge for the Rehabilitation Wing Dining Room was equipped with two separate lighting fixtures each with one light bulb but one of the fixture's light bulb was burnt out. In addition, the exit discharge for the Rehab Therapy Room was also equipped with two separate lighting fixtures each with one light bulb but one of the fixture's light bulb was also burnt	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 door lights by the Rehab exit were working properly. The Maintenance Supervisor changed all bulbs to ensure they are illuminating correctly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** ~~S~~taff and residents in the community that use this exit path have the potential to be affected by this deficient practice.	08/20/2024

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	out. Based on interview at the time of the observations, the Regional Maintenance Director, the Maintenance Director agreed the discharge for each of the aforementioned exits was not arranged with the minimum number of operable lighting fixtures. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new monthly TELS task for the Maintenance Supervisor to walk the exterior to ensure that all exit lights are illuminated. See attached TELS Task labeled "Altenheim Exterior Lights TELS Task" **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 August 20th, 2024	
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance	K 0374	**K 374** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	08/20/2024

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	necessary for proper operation. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the smoke barrier door set by Room 1137. Findings include: Based on observations with the Regional Maintenance Director, 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 south door in the corridor door set by Room 1137 failed to fully self-close which left a one inch gap in between the meeting edges of the door set when tested to close multiple times. Each door in the corridor door set was equipped with a self-closing device and was held in the fully open position with a wall mounted magnetic hold open device set to release with fire alarm system activation. Based on interview at the time of the observations, the Regional Maintenance Director and the Maintenance Director agreed the south door in the aforementioned corridor door set failed to fully self-close leaving a one inch gap in between the meeting edges of the door set. These findings were reviewed with the Executive Director, the Regional Maintenance Director, the Maintenance Director and the Assistant Maintenance Director during the exit conference. 3.1-19(b)		Observation – The community failed to ensure that corridor door by resident room 1137 shut and latched properly. The Maintenance Supervisor has adjusted the doors so they will latch properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and Residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic 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 attached 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 will	

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			inspect this door during their monthly site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 20th, 2024	