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

PRINTED: 09/30/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG <b>01, 02</b>		(X3) DATE SURVEY COMPLETED	
		155196	B. WING _				R <b>26/2024</b>
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY				3525 E HANN	RESS, CITY, STATE, ZIP CODE NA AVE DLIS, IN 46237	1 03/	20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	;	{K 0	00}			
	Code Recertification conducted on 08/01/2	it (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the of Health in accordance with					
	Facility Number: 000 Provider Number: 15 AIM Number: 10029	55196					
	Community was foun Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire National Fire Protecti Life Safety Code (LS						
	02. Building 01 cons of the first floor of a the basement and was d (222) construction and facility has a fire alarm detection on all levels areas open to the consmoke detectors have electrical system in the	s in the corridors and in all ridor. The facility has d wired to the building ne A, B and C wings. The of 87 and had a census of					
		ents have customary access areas providing facility ered.					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 02</b>		(X3) DATE SURVEY COMPLETED		
		155196	B. WING			R 09/26/2024	
NAME OF PE	ROVIDER OR SUPPLIER	100.00		-	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	26/2024
TVAINE OF T	TOVIDER OR OUT FEEL				1525 E HANNA AVE		
ALTENHE	IM HEALTH & LIVING CO	OMMUNITY			NDIANAPOLIS, IN 46237		
0/10 ID	CLIMMADY CT.	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page	s 1	{K 0	ሰበነ			
(11000)			\\(\)	ooy			
		Quality Review completed on 09/26/24 INITIAL COMMENTS					
{K 000}	INITIAL COMMENTS			00}			
	Code Recertification a conducted on 08/01/2	t (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the of Health in accordance with					
	42 CFR 483.90(a).	Trioditi iii dooraanoo war					
	Survey Date: 09/26/2	4					
	Facility Number: 000 Provider Number: 15 AIM Number: 100290	5196					
	and Living Community with Requirements for Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protection Life Safety Code (LSC)	de Survey, Altenheim Health y was found in compliance r Participation in 2 CFR Subpart 483.90(a), and the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19, Existing acies and 410 IAC 16.2.					
	02. Building 02 consi Rehabilitation Wing of determined to be of T was fully sprinklered. has a fire alarm syste the corridors, in all are has smoke detectors system in resident sle has a capacity of 87 at the time of this survey	onstructed in 2014 and was type V (111) construction and The Rehabilitation Wing m with smoke detection in eas open to the corridor and hard wired to the fire alarm seping rooms. The facility and had a census of 78 at					
	All areas where reside	ents have customary access					

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		155196	B. WING			R 09/26/2024	
NAME OF PR	ROVIDER OR SUPPLIER	100.00		STREET ADDRESS, CITY, STATE, ZIP CODE		09/20/2024	
ALTENHEIM HEALTH & LIVING COMMUNITY				3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
{K 000}	Continued From page were sprinklered and services were sprinkle Quality Review comp	all areas providing facility ered.	{K 0				