EPARTMENT OF HEALTH AND HUMAN SERVICES	
ENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M				) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				ETED	
		155825	B. WI	B. WING		10/03/2024		
NAME OF PROVIDER OR SUPPLIER			2345 W	ADDRESS, CITY, STATE, ZIP COD				
ST AUGU	JSTINE HOME FOF	R THE AGED		INDIAN	APOLIS, IN 46260			
(X4) ID	SUMMARY S	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	
E 0000								
<b>5</b>								
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Dates: 10/03/24		E 0000					
	Facility Number: 00 Provider Number: 1							
	AIM Number: 1002							
	Augustine Home for compliance with En Requirements for M Participating Provid	Preparedness survey, St. r the Aged was found in nergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR						
	The facility has 23 c the survey, the censure.	pertified beds. At the time of us was 20.						
	Quality Review con	npleted on 10/07/24						
K 0000		•						
1. 0000								
Bldg. 01	A Life Safety Code	Recertification and State	K 0	000	This Plan of Correction constit	utes		
	Licensure Survey w	ras conducted by the Indiana th in accordance with 42 CFR	Ko	000	the written allegation of compliance for the deficiencies cited. However, the submission the Plan of Correction is not all	s n of		
	Survey Dates: 10/0	3/24			admission that a deficiency ex or that one is cited correctly. T			
	Facility Number: 0				Plan of Correction is submitted			
	Provider Number:				meet the requirements establis	shed		
	AIM Number: 1002				by state and federal law. St. Augustine Home for the Aged			
	At this Life Safety (	Code survey, St. Augustine			desires this Plan of Correction	to		

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

TITLE

(X6) DATE

Steven M Still Administrator 10/18/2024

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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10/25/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 10/03/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST ST AUGUSTINE HOME FOR THE AGED INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Home for the Aged was found not in compliance be considered the facility's with Requirements for Participation in allegation of compliance. Medicare/Medicaid, 42 CFR Subpart 483.90(a), Compliance is effective October Life Safety from Fire and the 2012 edition of the 23, 2024. National Fire Protection Association (NFPA) 101, We respectfully request a desk Life Safety Code (LSC), Chapter 19, Existing review of our Plan of Correction. Health Care Occupancies and 410 IAC 16.2. This facility, located on the 1st and 2nd of a three story building with a basement, was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident rooms. The facility has a capacity of 23 and had a census of 20 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/07/24 K 0232 **NFPA 101** SS=E Aisle, Corridor, or Ramp Width Bldg. 01 Based on observation and interview, the facility K 0232 What corrective action(s) will 10/23/2024 failed to meet the clear width requirement for 1 of be accomplished for those over 4 corridors or met an exception per residents found to have been 19.2.3.4(5). LSC 19.2.3.4(5) states where the affected by the deficient corridor width is at least 8 feet, projections into practice? the required width shall be permitted for fixed All furniture stored in the hallway furniture, provided that all of the following adjacent to the Beauty Salon and conditions are met: Chaplain's Office has been affixed (a) the fixed furniture is securely attached to the to the floor. This work was floor or to the wall. performed on October 16, 2024.

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(b) the fixed furniture does not reduce the clear

unobstructed corridor width to less than six feet,

except as permitted by 19.2.3.4(2).

Event ID:

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Furniture 1&2)

(See photos entitled K232 Affixed

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	COMPLETED		
	155825		B. WI	NG		10/03/2024	
		<u> </u>	<del>'                                    </del>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			/ 86TH ST		
ST AUG	USTINE HOME FOI	R THE AGED			IAPOLIS, IN 46260		
	1				, T	975	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
TAG	``	NCY MUST BE PRECEDED BY FULL	'	PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	COMPLETION	
IAG		R LSC IDENTIFYING INFORMATION are is located only on one side		TAG		DATE	
	of the corridor.	ire is located only on one side			How other residents having potential to be affected by the		
		are is grouped such that each			same deficient practice will be		
		exceed an area of 50 square			identified and what corrective		
	feet.	exceed an area of 50 square			action(s) will be taken.		
		are groupings addressed in			All residents using the Beauty	,	
		separated from each other by a			Shop have the potential to be		
	distance of at least	-			affected by this practice. All		
		are is located so as to not			furniture stored in the hallway		
	* /	ouilding service and fire			adjacent to the Beauty Shop a		
	protection equipme	_			Chaplain's Office has been af		
		ghout the smoke compartment			to the floor. (See photos entit		
	are protected by an electrically supervised				K232 Affixed Furniture 1&2)		
		etection system in accordance			Tiese / iiii/iiiai e Tiese/		
		fixed furniture spaces are			What measures will be put ir	nto	
		ed to allow direct supervision			place and what systemic		
		from a nurse's station or similar			changes will be made to		
	space.				ensure that the deficient		
	^	partment is protected			practice does not recur.		
		pproved, supervised automatic			Department Heads will be		
		accordance with 19.3.5.8			informed as to the requiremen	nt of	
	This deficient pract	tice could affect over 5			furniture permanently stored in		
	residents, staff and	visitors.			hallways to be affixed to the w		
					or floor. They will be asked to		
	Findings include:				report any permanently stored	d l	
					furniture that is not affixed to t	:he	
	Based on observation	ons with the Facilities			floor or wall to the Administrat	or	
	Operations Manage	er and the Assistant Facilities			for follow up action. This will b	ре	
		er during a tour of the facility			done at the staff meetings on		
	from 12:55 p.m. to	2:35 p.m. on 10/03/24, one wood			October 21 and 28. It will also	o be	
	table was stored in	the corridor outside the Salon			presented at the next monthly	,	
		The table was not affixed to the			QAPI Committee meeting on		
		and projected one foot into the			November 12, 2024.		
	eight foot wide corn	ridor. In addition, benches					
	were stored in the c	corridor outside the Chaplains			How the corrective action(s)		
	Office across from	the Salon on the first floor.			will be monitored to ensure t	the	
	The benches were r	not affixed to the floor or to the			deficient practice will not		
	wall and each bench	h extended 18 inches into the			recur, i.e. what quality		
	eight foot wide corn	ridor. Based on interview at			assurance program will be p	ut	
the time of the observations, the Facilities				into place.			

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155825	B. WING 10/03/2024			/2024	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
OT ALICI	IOTINE LIONE FOR	THE AGED			86TH ST		
ST AUGUSTINE HOME FOR THE AGED				INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	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
		r and the Assistant Facilities			The Activity Director will note	and	
		r stated comprehensive care			report any furniture permanen	tly	
		omary access to the Salon on			stored in the hallway adjacent	to	
	-	greed furniture was stored in			the Beauty Shop and Chaplair	า'ร	
	the corridor at the a	forementioned locations which			Office. Her office is located or	า	
	was not affixed to the	he floor or to the wall.			that same hallway. Facility		
					Operations Manager will moni	tor	
	These findings were				for compliance.		
		Facilities Operations Manager					
		acilities Operations Manager			By what date the systemic		
	during the exit conf	erence.			changes for each deficiency		
				will be complete.			
	3.1-19(b)				October 23, 2024		
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	1 - Tooling and					
2.49.01		view and interview, the facility	$ _{K0}$	345	What corrective action(s) wil	1	10/23/2024
		of 1 fire alarm systems in	IK 0	J <del>T</del> J	be accomplished for those	•	10/23/2024
		FPA 72, National Fire Alarm			residents found to have been	า	
		LSC Sections 19.3.4.5.1 and			affected by the deficient	-	
		tion 14.3.1 states that unless			practice?		
		by 14.3.2, visual inspections			A second Fire Alarm System		
	•	in accordance with the			Inspection is scheduled with o	ur	
	-	14.3.1, or more often if required			contractor, Koorsen, on Octob		
		ving jurisdiction. Table 14.3.1			22, 2024. Additionally, the fac		
	states that the follow	wing must be visually			has signed a new agreement	•	
	inspected semi-annu	ually:			our contractor to provide fire		
	a. Control unit troub	ble signals			system inspections and		
	b. Remote annuncia	itors			maintenance for 2025 to inclu	de	
	c. Initiating devices	(e.g. duct detectors, manual			two (2) semi-annual Fire Alarn	n	
	fire alarm boxes, he	eat detectors, smoke detectors,			System Inspections. (See K34	45	
	etc.)				Signed Koorsen Contract for 2	2025)	
	d. Notification appli	iances					
	e. Magnetic hold-op				How other residents having	the	
	This deficient practi	ice could affect all residents,			potential to be affected by th	e	
	staff and visitors.				same deficient practice will b	Эе	
					identified and what correctiv	е	
	Findings include:				action(s) will be taken?		
					All residents have the potentia	ıl to	

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10/25/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/03/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST INDIANAPOLIS, IN 46260 ST AUGUSTINE HOME FOR THE AGED (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 Based on review of the fire alarm system be affected by this practice. A inspection contractor's "Alarm System second Fire Alarm System Inspection" documentation dated 04/20/23 and Inspection is scheduled with our "Alarm System Inspection" documentation dated contractor, Koorsen, on October 04/11/24 with the Facilities Operations Manager 22, 2024. Additionally, the facility and the Assistant Facilities Operations Manager has signed a new agreement with during record review from 9:40 a.m. to 12:25 p.m. our contractor to provide fire on 10/03/24, visual semi-annual fire alarm system system inspections and inspection documentation six months after maintenance for 2025 to include 04/20/23 was not available for review. Based on two (2) semi-annual Fire Alarm interview at the time of record review, the System Inspections. (See K345 Facilities Operations Manager and the Assistant Signed Koorsen Contract for 2025) Facilities Operations Manager agreed visual semi-annual inspection documentation for the What measures will be put into facility's fire alarm system six months after place and what systemic 04/20/23 was not available for review. changes will be made to ensure that the deficient These findings were reviewed with the practice does not recur. Administrator, the Facilities Operations Manager A new agreement has been signed and the Assistant Facilities Operations Manager with our contractor to perform during the exit conference. semi-annual Fire Alarm System Inspections for 2025 and going 3.1-19(b) forward. (See new K345 Signed Koorsen Contract for 2025) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. The Assistant Facilities Operations Manager or designee is responsible for monitoring the performance and timeliness of the contracted services. The second Fire Alarm System Inspection will be presented to the next monthly

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meeting of the QAPI Committee for confirmation of performance.

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155825	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  10/03/2024		
NAME OF PROVIDER OR SUPPLIER ST AUGUSTINE HOME FOR THE AGED			STREET ADDRESS, CITY, STATE, ZIP COD 2345 W 86TH ST INDIANAPOLIS, IN 46260				
(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		
K 0754 SS=E Bldg, 01	NFPA 101 Soiled Linen and	Trash Containers		The Facilities Operations Man will monitor for compliance.  By what date the systemic changes for each deficiency will be complete.  October 23, 2024			
Bldg. 01	failed to ensure tras Biohazard storage r protected as a hazar Section 19.7.5.7. T affect over 10 resid vicinity of the Bioh Office on the secon Findings include:  Based on observation Operations Manage Operations Manage from 12:55 p.m. to unattended 55 gallo partially filled with room by Sister's Of lid for the container capacity receptacle. room was not self of Based on interview observations, the Fa and the Assistant Fa agreed the aforement	ons with the Facilities r and the Assistant Facilities r during a tour of the facility 2:35 p.m. on 10/03/24, one n capacity receptacle was trash in the Biohazard Storage fice on the second floor. The r stated it was a 55 gallon The corridor door to the losing or automatic closing. at the time of the acilities Operations Manager acilities Operations Manager ntioned receptacle was not comprotected as a hazardous	K 0754	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 55-gallon trash container removed from the bio-hazard storage room and replaced wi 32-gallon container on Octobe 2024. (See K754 New Bio-Hai Waste Can)  How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Other residents are unaffected to proximity to the bio-hazard storage room.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Facilities Operations Director designee will monitor the	was th a er 8, zard  the ee de d due		

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These findings were reviewed with the

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bio-hazard storage room, during

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155825	B. WING 10/03/2024			/2024	
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				/ 86TH ST		
ST AUGI	JSTINE HOME FOR	R THE AGED			APOLIS, IN 46260		
017.000	The state of the following the			IIVDI/IIV	7 (1 OLIO, IIV 40200		<b>I</b>
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG			DATE
		Facilities Operations Manager			morning rounds, to ensure the		
		acilities Operations Manager			32-gallon container remains a	nd is	
	during the exit conf	erence.			not replaced with an		
	2.1.10(1)				inappropriately sized containe	r.	
	3.1-19(b)				l., ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,		
					How the corrective action(s)		
					will be monitored to ensure t	ne	
					deficient practice will not		
					recur, i.e. what quality		
					assurance program will be p into place.	ut	
					The Facilities Operations Dire	ctor	
					will be responsible for	ClOi	
					compliance. He will present h	ie	
					findings to the QAPI Committee		
					for the next three (3) monthly	,0	
					meetings.		
					, meaninge.		
					By what date the systemic		
					changes for each deficiency		
					will be complete.		
					October 23, 2024		
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01							
		review, observation and	K 0	918	What corrective action(s) wil	I	10/23/2024
	interview; the facili	ty failed to document			be accomplished for those		
		or monthly load testing for 12			residents found to have beer	า	
		ecent 12 month period to meet			affected by the deficient		
	-	NFPA 110, Standard for			practice?		
		ndby Powers Systems, 2010			The Generator Log has been		
		4.2. Section 8.4.2 states diesel			updated to include columns to		
	-	be exercised at least once			record the Load Test and		
		mum of 30 minutes, using one			Cool-down times going forwar	d.	
	of the following me				This was completed and		
	- · ·	intains the minimum exhaust			implemented on October 10,		
		recommended by the			2024. The generator is tested		
	manufacturer	temperature conditions and at			weekly as indicated on the		
	L tza Under operating	Temperature conditions and at	1		i auached Generator Log (See	خ	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155825	B. WING 10/03/2024			2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			86TH ST		
ST AUGL	JSTINE HOME FOR	R THE AGED			APOLIS, IN 46260		
			1	ID	· 	1	(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAU		cent of the EPS (Emergency		IAU	K918 St Augustine Generator		DATE
	Power Supply) nam				Log)		
		es diesel-powered EPS			Log)		
		not meet the requirements of			How other residents having	tho	
		ised monthly with the available			potential to be affected by th		
		Power Supply System) load and			same deficient practice will be		
		nnually with supplemental			identified and what corrective		
		n 50 percent of the EPS			action(s) will be taken?		
		g for 30 continuous minutes			All residents have the potentia	al to	
	-	75 percent of the EPS			be affected by this practice. T		
		g for 1 continuous hour for a			Generator Log has been upda		
	*	f not less than 1.5 continuous			to include columns to record to		
	hours. This deficient practice could affect all				Load Test and Cool-down time		
	residents, staff and	-			going forward. This was		
	,				completed and implemented of	on I	
	Findings include:				October 10, 2024. The gener		
	J				is tested weekly as indicated of		
	Based on review of	"Generator Log"			the attached Generator Log.		
		the most recent twelve month			K918 St Augustine Generator	•	
	period with the Faci	ilities Operations Manager and			Log)		
	the Assistant Facilit	ties Operations Manager					
	during record review	w from 9:40 a.m. to 12:25 p.m.			What measures will be put ir	nto	
	on 10/03/24, month	ly load testing documentation			place and what systemic		
	for the facility's dies	sel fuel fired emergency			changes will be made to		
	generator for the mo	ost recent twelve month period			ensure that the deficient		
	did not document th	ne loading that maintained the			practice does not recur.		
	minimum exhaust g	-			The Generator Log has been		
		e manufacturer or that the load			updated to include columns to		
		under operating temperature			record the Load Test and		
		ot less than 30 percent of the			Cool-down times going forwar	d.	
	_	rating. Based on interview at			This was completed and		
		eview, the Facilities Operations			implemented on October 10,		
	-	ssistant Facilities Operations			2024. The generator is tested	l k	
		placement diesel fired			weekly, and performance is		
		or was installed at the facility			recorded on the attached		
		years ago, the facility runs the			Generator Log by the Assistar		
	_	d each week and agreed			Facilities Operations Manager	r.	
	_	ng documentation for the most			(See K918 St Augustine		
		h period did not include the			Generator Log)		
	load percent achieve	ed for the test. Based on				l	

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10/25/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/03/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST INDIANAPOLIS, IN 46260 ST AUGUSTINE HOME FOR THE AGED (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 observations with the Facilities Operations How the corrective action(s) Manager and the Assistant Facilities Operations will be monitored to ensure the Manager during a tour of the facility from 12:55 deficient practice will not p.m. to 2:35 p.m. on 10/03/24, the facility has one recur, i.e. what quality diesel fuel fired emergency generator located assurance program will be put outside the building on the west side of the into place. property. The manufacturer's nameplate indicated The Facilities Operations Manager the generator was manufactured July 2022 and it will present the results of the was rated at 100 kW. weekly generator tests to the QAPI Committee at its next three These findings were reviewed with the (3) monthly meetings. Facilities Administrator, the Facilities Operations Manager Operations Manager is and the Assistant Facilities Operations Manager responsible for compliance. during the exit conference. By what date the systemic 3.1-19(b) changes for each deficiency will be complete. 2. Based on record review, observation and October 23, 2024 interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for 12 of 12 months. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.4 which requires emergency generators providing power to emergency lighting systems to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. NFPA 110, Section 6.2.10 Time Delay on Engine Shutdown requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown to allow for engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. NFPA 110, Section 8.3.4 states a permanent record of the Emergency Power Supply Systems (EPSS) inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors.

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

Event ID:

L6PB21

Facility ID: 000389

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

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155825	B. W	ING		10/03/2024	
NAME OF PROVIDER OR SUPPLIER			2345 W	ADDRESS, CITY, STATE, ZIP COD			
ST AUGU	ST AUGUSTINE HOME FOR THE AGED			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	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
	Findings include:						
	Based on review of	"Generator Log"					
	documentation for t	he most recent twelve month					
	period with the Faci	ilities Operations Manager and					
		ies Operations Manager					
	-	w from 9:40 a.m. to 12:25 p.m.					
		ly load testing documentation					
		twelve month did not include					
		ased on interview at the time of					
		facilities Operations Manager acilities Operations Manager					
		t diesel fired emergency					
	generator was instal						
	_	years ago, the facility runs the					
		d each week and agreed cool					
	_	recorded in load testing					
		he most recent twelve month					
	period. Based on ol	bservations with the Facilities					
	Operations Manage	r and the Assistant Facilities					
	Operations Manage	r during a tour of the facility					
	_	2:35 p.m. on 10/03/24, the facility					
		fired emergency generator					
		building on the west side of					
		nanufacturer's nameplate					
		ator was manufactured July					
	2022 and it was rate	ed at 100 kW.					
	These findings were	e reviewed with the					
	_	Facilities Operations Manager					
		acilities Operations Manager					
	during the exit conf	-					
	-						
	3.1-19(b)						

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