STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING **01** B. WING _____	R **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN VILLAGE	**2026 EAST 54TH ST** **INDIANAPOLIS, IN 46220**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/11/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/12/25 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 At this PSR survey, American Village was found 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. American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered. The east wing of the second floor of Washington Manor houses the Moving Forward rehabilitation wing. 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 battery operated smoke detectors in 59 of 82 resident sleeping rooms. The facility has smoke detectors hard wired to the facility's electrical system in 23 of 82 resident sleeping rooms. The facility has a capacity of 150 and had a census of 122 at the time of this survey. All areas where residents have customary access	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 were sprinklered. All areas providing facility services were sprinklered except for a detached storage and repair shed. Quality Review completed on 06/16/25	{K 000}		