	Γ OF HEALTH AND HUI R MEDICARE & MEDIC					FO	TTED: 07/25/2023 RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155196	A. BU B. WI	JILDING ING	<del></del>	COMPLETED 06/22/2023	
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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
E 0000	conducted by the In accordance with 42  Survey Date: 06/22  Facility Number: 0  Provider Number: 100  At this Emergency Altenheim Health a found not in compli	/23 000103 155196	E 00	000	July 10th, 2023  Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204  Re: Allegation of Complian Dear Mrs. Buroker:		

Correction for the State Licensure Survey NYOL21 conducted on June 22nd, 2023. 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 July 10th, 2023. We are requesting paper compliance for this plan of correction.

Please find enclosed the Plan of

If you have any further questions, please do not hesitate to contact me at 317-919-1500.

Sincerely,

Chirag Patel, HFA

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

The facility has 87 certified beds. At the time of

the survey, the census was 85.

Quality Review completed on 06/28/23

CFR 483.73.

TITLE

(X6) DATE

 Chirag
 Patel
 07/21/2023

Any defiency statement 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 disclodays 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: NY0L21 Facility ID: 000103 If continuation sheet Page 1 of 39

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

PRINTED: 07/25/2023 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	(X3) DATE SUR COMPLETE 06/22/202	ED
	ROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CO E HANNA AVE NAPOLIS, IN 46237	D	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	OCTION ULD BE PROPRIATE CO	(X5) OMPLETION DATE
				Administrator Altenheim Health and Li Submission of this plan correction in no way cor an admission by Altenhe and Living or its manage company that the allega contained in the survey true and accurate portra provision of nursing care services provided in this The Plan of Correction is and executed solely becrequired by Federal and Law.	of estitutes eim Health ement tions report is a yal of the e or other facility. s prepared eause it is State	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485. (e) Emergency an The [LTC facility a implement emerge	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. nd the CAH] must ency and standby power the emergency plan set		This statement of deficie plan of correction will be at the Monthly Quality Assurance/Assessment Committee meeting.		

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 2 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/22/2023	
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	3525 E	CADDRESS, CITY, STATE, ZIP CO E HANNA AVE NAPOLIS, IN 46237	D
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	Emergency gene generator must be the location requirements and LTC facilities Code.  482.15(e)(2), §48 Emergency gene The [hospital, CA implement the endinspection, testing requirements fou Facilities Code, National Code.  482.15(e)(3), §48 Emergency gene The [hospital, CA implement the endinspection, testing requirements fou Facilities Code, National Code.  482.15(e)(3), §48 Emergency gene and LTC facilities source to power and LTC facilities source to power of have a plan for his power systems of emergency, unless that section are a reference by the Federal Register 552(a) and 1 CFF the material from	33.73(e)(2), §485.625(e)(2) rator inspection and testing. All and LTC facility] must mergency power system g, and [maintenance] and in the Health Care MFPA 110, and Life Safety  33.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs of that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the			

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 3 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/22/2023		
		ROVIDER OR SUPPLIER	ING COMMUNITY		3525 E	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		Boulevard, Baltiman Archives and Reconstruction (NARA). For information this material at NA go to:  http://www.archive_of_federal_regulation from the character of the comment of the character o	rnges. Protection Association, 1 k, D, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, FPA 99, issued March 3, FPA 99, issued March 3,					

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 4 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155196	B. W	ING		06/22/	/2023
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(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
	including TIAs to chapter 7, issued August 6,						
	2009		F 04	241	. The comment of the control of the		07/10/2022
		on and interview, the facility	E 00	J <b>4</b> I	I. The corrective actions to b	oe Oe	07/10/2023
	_	the emergency power system in the Health Care Facilities			accomplished for those	_	
	-	and Life Safety Code in			residents found to have been	1	
		CFR 483.73(e)(2). This			affected by the deficient		
		ould affect all occupants.			practice.		
	astroioni praenee et	cara arroot air occupants.			Observation – The facility faile	ed to	
	Findings include:				implement the emergency pov		
	8				system requirements found in		
	Based on records re	eview and interview with the			health care facility code NFPA		
	Maintenance Director and the Corporate Support				110. The facility failed to provi		
	Representative on 06/22/23 between 9:45 a.m. and				documentation of an annual lo		
	12:45 p.m., no docu	mentation of an annual load			bank test for the diesel-power	ed	
	bank test for the die	esel powered generator was			generator. The annual load ba		
	available. Documer	ntation of an in house 4 hour			test for the diesel-powered		
	test was provided b	ut it did not meet the			generator was performed on		
	-	nts to include for the annual			04/26/2023 and the document	ation	
	load bank test. The				was placed in the Life Safety		
	-	ed that there was some			Book. See attached Load bar	nk	
		requirements and the			test results.		
		n fuel source expectations.			See attached load bank test t	hat	
		Pirector acknowledged a load			was completed on 4/26/2023.		
		nerator had not occurred			The annual test was complete		
	within the past year	•			time but not available for revie		
	TEL: C 1:	1 1 1 11 4			the time of inspection. To ensi	ure	
	This finding was ac				future load bank test		
		tor and the Corporate Support			documentation will be available		
	*	ne time of observation and			review we will change the PO		
	_	nference with the Maintenance			read CarDon Corporate Facilit	-	
		Support Representative, Staff dinator, Corporate Infection			audit the Life Safety Binder to		
	-	cal Specialist and Assistant			ensure the proper generator	14/	
	Administrator all pr	-			paperwork is in there for revie	vv.	
	A Summisuator all pr	Coont.			II. The facility will identify		
					other residents that may		
					potentially be affected by the	<u> </u>	
					deficient practice.	•	
					dendent practice.		

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

Event ID: NY0L21

Facility ID: 000103

If continuation sheet

Page 5 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	NUMBER A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/22/2023	
	ROVIDER OR SUPPLIE	R /ING COMMUNITY	3525	r address, city, state, zip cod E HANNA AVE NAPOLIS, IN 46237	IP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE OF T	(X5) COMPLETION DATE	
				-Staff and residents in the community have the potential be affected by this deficient practice.	to	
				III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.	ic	
				The Administrator and Maintenance Supervisor will remaintenance contracts to ensuthey are correct, and documentation was provided during the Emergency Preparedness Program annual review.	ure	
				IV The facility will monitor the corrective action by implementing the following measures.		
				CarDon Corporate facilities wil also review this information du their annual Corporate Quality Review.	ring	
				V. Plan of Correction completion date.		
				Plan of Completion date is July 10th, 2023	у	
K 0000						
Bldg. 01						

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

Event ID:

NY0L21

Facility ID: 000103

Page 6 of 39 If continuation sheet

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
		155196	B. WI	NG		06/22/	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			HANNA AVE		
ALTENH	EIM HEALTH & LI\	/ING COMMUNITY			IAPOLIS, IN 46237		
	ı				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	17.0	TAG			DATE
		Recertification and State	K 0	000	July 10th, 2023		
	-	vas conducted by the Indiana					
	-	lth in accordance with 42 CFR			Boards Browless Biosetes		
	483.90(a).				Brenda Buroker, Director		
	Survey Date: 06/22	2/23			Long-Term Care Division		
	Survey Date. 00/22	1/23			Indiana State Department of Health		
	Facility Number: 000103				2 North Meridian Street		
	Provider Number:				Indianapolis, IN 46204		
	AIM Number: 100				Indianapolis, IN 40204		
	7 mivi i valiloci. 100	2270000			Re: Allegation of Complia	nce	
	At this Life Safety	Code survey, Altenheim Health			The Thiogation of Compile	1100	
	-	unity was found not in					
	compliance with Requirements for Participation in				Dear Mrs. Buroker:		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),						
		ire and the 2012 Edition of the			Please find enclosed the Plar	າ of	
	National Fire Prote	ection Association (NFPA) 101,			Correction for the State Licen		
	Life Safety Code (1	LSC), Chapter 19, Existing			Survey NYOL21 conducted on		
	Health Care Occup	ancies and 410 IAC 16.2.			June 22nd, 2023. This letter	is to	
					inform you that the plan of		
	This facility consis	ts of Building 01 and Building			correction attached is to serve	e as	
	_	nsists of the A, B and C wings			Altenheim Health & Living		
	of the first floor of	a three story building with a			Community credible allegation	n of	
		determined to be of Type II			compliance. We allege		
		and was fully sprinklered. The			substantial compliance on Jul	-	
		arm system with smoke			10th, 2023. We are requestir	-	
		els in the corridors and in all			paper compliance for this plai	n of	
	-	orridor. The facility has smoke			correction.		
		d to the building electrical					
	-	and C wings. The two			If you have any further questi		
		f the first floor were also			please do not hesitate to conf	act	
	-	ek of 2 hour separation.			me at 317-919-1500.		
	Building 02 consist	<u>-</u>			Cim a small s		
		g constructed in 2014 and was			Sincerely,		
	determined to be of Type V (111) construction and						
		ed. The Rehabilitation Wing			China y Datal 1154		
	-	stem with smoke detection in			Chirag Patel, HFA		
		areas open to the corridor and			Administrator		
		s hard wired to the fire alarm			Altenheim Health and Living		
	system in resident	sleeping rooms. The facility			1		

CENTERIO I OI	times to mes a messio	III SERVICES			3.112 1.131 0,00 00;	
STATEMEN	T 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		06/22/2023	
					<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
A 1 TEAU 1	EINALIE AL TULO UNI	(INIC COMMANDATIVE		HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING 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	
	has a capacity of 87	7 and had a census of 85 at the		Submission of this plan of		
	time of this survey.			correction in no way constitute	es	
				an admission by Altenheim He	ealth	
	All areas where res	idents have customary access		and Living or its management		
	were sprinklered. A	All areas providing facility		company that the allegations		
	services were sprin	klered.		contained in the survey report	: is a	
				true and accurate portrayal of		
	Quality Review cor	mpleted on 06/28/23		provision of nursing care or of		
				services provided in this facilit		
				The Plan of Correction is prep	-	
				and executed solely because	it is	
				required by Federal and State	<b>:</b>	
			Law.			
				This statement of deficiencies	and	
				plan of correction will be revie	wed	
				at the Monthly Quality		
				Assurance/Assessment		
				Committee meeting.		
K 0211	NFPA 101					
SS=E	Means of Egress					
Bldg. 01	Means of Egress					
		ays, corridors, exit				
	discharges, exit lo	ocations, and accesses are				
		h Chapter 7, and the means				
	of egress is contir	nuously maintained free of				
		full use in case of				
	emergency, unles	s modified by 18/19.2.2				
	through 18/19.2.1					
	18.2.1, 19.2.1, 7.1					
	l '	ation and interview, the facility	K 0211	I. The corrective actions to	be 07/10/2023	
		f over 8 corridors were		accomplished for those		
	1	ained free of obstructions. LSC		residents found to have bee	n	
		projections into the required		affected by the deficient		
	_	nitted for wheeled equipment,		practice.		
	provided that all of	the following conditions are				
	met:			Observation 1– The motorized		
		uipment does not reduce the		wheelchair was being stored i	n	
	clear unobstructed	corridor width to less than 60		front of and obstructing the		

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 8 of 39

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE ( A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  06/22/2023	
	PROVIDER OR SUPPLIER		3525	r 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	inches.  (b) The health care training program ad wheeled equipment emergency.  (c) The wheeled equipment in use ii. Medical emergeriii. Patient lift and to This deficient pract facility.  Findings include:  Based on observation tour of the facility wand the Corporate Stock 1606/22/23 between 1 following was observation of and obstruct the rehab hallway in Maintenance Direct during the survey as stored it or why the being stored in from (3) In the corridor and near Resident in Protective Equipment of equipped with with move out of the hall Maintenance Direct to the protective Equipment of the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the hall Maintenance Direct to the protective Equipment of the protecti	occupancy fire safety plan and dress the relocation of the during a fire or similar ipment is limited to the and carts in use acy equipment not in use cansport equipment are affects all residents in the ons and interview during a with the Maintenance Director upport Representative on 2:45 p.m. and 3:45 p.m., the rved; theelchair was being stored in ting the stairwell exit door in	TAG	stairwell exit door in the rehal hallway near #1129. The motorized wheelchair was immediately removed from the area.  Observation 2– In the corridor near resident rooms #1208, #PPE carts were used without wheels – all PPE carts used it corridors near resident rooms #1208, and #1305 was replace with PPE carts equipped with wheels.  Observation 3– The facility factor to ensure 1 of over 8 exitic discharges was in accordance with Chapter 7 states the wide any means of egress shall be less than 36 inches where an part of this chapter do not specific minimum width. – A new side was installed to meet the accordance with Chapter 7 at Chapter11 near A-B nurses station. See attached picture sidewalk.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  At least 25 residents in the community have the potential be affected by this deficient	e  rs #1305  n the s ced  iiled  e th of e not nother ecify ewalk  nd  of
	_	acknowledged by the or and the Corporate Support		practice.  III. The facility will put into	

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 9 of 39

STATEMEN	NT 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	LETED
		155196	B. W	ING		06/22	/2023
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
A1 TEN111	EIM HEALTH & LIV	(INIC COMMALINITY			HANNA AVE IAPOLIS, IN 46237		
ALIENT	EIN DEALID & LIV	TING COMMONT Y		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	Representative at the	ne time of observation and			place the following systemat	tic	
	again at the exit con	nference with the Maintenance			changes to ensure that the		
	Director, Corporate	e Support Representative, Staff			deficient practice does not		
	Development Coor	dinator, Corporate Infection			recur.		
	Preventionist, Clin	ical Specialist and Assistant					
	Administrator all p	resent.			There is an existing weekly Ti	ELS	
					task to audit hallways/ path of	:	
					egress/ exits. See attached T	ELS	
	2) Based on observ	ation and interview, the facility			task labeled "Altenheim Pathv		
	failed to ensure 1 o	f over 8 exit discharges was in			TELS Task"		
	accordance with Cl	napter 7. LSC 7.3.4.1(2) states					
	the width of any me	eans of egress shall be not less			IV The facility will monitor		
	than 36 inches where another part of this chapter				the corrective action by		
	and Chapters 11 through 43 do not specify a				implementing the following		
	minimum width. This deficient practice affects at				measures.		
	least 25 residents in	n the facility.					
					CarDon Corporate Facilities w	/ill	
	Findings include:				audit all existing sidewalks an	d	
					paths of egress during their a	nnual	
	The exit discharge	near the A-B Nursing Station,			CQR process.		
	was marked "Emer	gency Exit" with a 46-inch exit					
	door. The exit discl	harge sidewalk was obstructed			V. Plan of Correction		
	_	wall constructed partially in the			completion date.		
	_	ge which restricted the width					
		e to 31 inches, as measured by			Plan of Completion date is Jul	ly	
	the Maintenance D	irector.			10th, 2023.		
		cknowledged by the					
		tor and the Corporate Support					
	•	ne time of observation and					
		nference with the Maintenance					
	_	Support Representative, Staff					
	•	dinator, Corporate Infection					
		ical Specialist and Assistant					
	Administrator all p	resent.					
	3.1-19(b)						
K 0271	NFPA 101						
SS=F	Discharge from F	yits.					

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	LETED
		155196	B. W	ING _		06/22	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t.			HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(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 APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
Bldg. 01	Discharge from Ex						
		arranged in accordance with					
		vel walking surface meeting 7.1.7 with respect to					
	-	ion and shall be maintained					
	_	s. Additionally, the exit					
		e a hard packed all-weather					
	travel surface.	a hara packed all weather					
	18.2.7, 19.2.7						
	·	on and interview, the facility	K 0	271	I. The corrective actions to b	ре	07/10/2023
	failed to ensure 1 of over 8 exit discharges had a				accomplished for those		
	level walking surface	ce, were free of obstructions,			residents found to have been	n	
	and constructed of h	nard packed all-weather travel			affected by the deficient		
		ce with CMS Survey and			practice.		
		05-38. This deficient practice					
	could affect 25 resid	dents and staff.			Observation – The facility faile		
					ensure 1 of over 8 exit dischar	_	
	Findings include:				was in accordance with Chapt		
	Događ an absamietic	ons and interview during a			states the width of any means		
		with the Maintenance Director			egress shall be not less than 3 inches where another part of t		
	_	Support Representative on			chapter do not specify minimu		
	_	2:45 p.m. and 3:45 p.m., the exit			width. – A new sidewalk was		
		A-B Nursing Station, was			installed to meet the accordan	ice	
	•	y Exit" and the exit discharge			with Chapter 7 and Chapter11		
		at the kitchen service drive			A-B nurses station. See attach		
	with a step ledge of	approximately 4-5 inches			picture of new sidewalk.		
	leading down to the	service drive.					
					II. The facility will identify		
	This finding was ac				other residents that may		
		or and the Corporate Support			potentially be affected by the	•	
	•	te time of observation and			deficient practice.		1
		nference with the Maintenance					
		Support Representative, Staff			A415-5405-5511-1-1-1		
	_	dinator, Corporate Infection			At least 25 residents in the	4_	1
		cal Specialist and Assistant			community have the potential	ιO	
	Administrator all pr	CSCIII.			be affected by this deficient		
	3.1-19(b)				practice.		
	5.1 17(0)						

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet Page 11 of 39

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/25/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  06/22/2023	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				III. The facility will put into place the following systemati changes to ensure that the deficient practice does not recur.  This is a permanent fix to this issue so no follow up will be needed.	ic	
				IV The facility will monitor the corrective action by implementing the following measures.		
				CarDon Corporate Facilities wi audit all existing sidewalks and paths of egress during their and CQR process.	ı	
				V. Plan of Correction completion date.		
				Plan of Completion date is July 10th, 2023.	′	
K 0281 SS=F Bldg. 01	discharge, is arrar and shall be eithe	ans of Egress ans of egress, including exit nged in accordance with 7.8 r continuously in operation matic operation without				
	Based on interview determined that the exterior emergency	and observation, it was facility failed to provide lighting for all exits. LSC sires emergency lighting	K 0281	K 281  I. The corrective actions to be accomplished for those	07/10/2023 e	

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

Event ID:

facilities for means of egress shall be provided for

NY0L21

Facility ID: 000103

residents found to have been

If continuation sheet

Page 12 of 39

PRINTED: 07/25/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01 COMPLETED 155196 B. WING 06/22/2023 STREET ADDRESS, CITY, STATE, ZIP COD N

NAME OF PROVIDER OR SUPPLIER	,,,,,,
While of the Viber or soft bler	3525 E HANNA AVE
ALTENHEIM HEALTH & LIVING COMMUNITY	INDIANAPOLIS, IN 46237

ALTENHEIM HEALTH & LIVING COMMUNITY			INDIANAPOLIS, IN 46237		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	the exit access and exit discharge. This deficient		affected by the deficient		
	practice could affect all occupants in the facility		practice.		
	including staff, visitors and residents if the facility				
	were required to evacuate in an emergency.		Observation – The exit discharge		
	F' 1' ' 1 1		path leading to the public way		
	Findings include:		from the Southwest stairwell exit		
			was not luminated – New lights		
	Based on observations and interview during a		were immediately installed to		
	tour of the facility with the Maintenance Director		illuminate the path of exit		
	and the Corporate Support Representative on		discharge.		
	06/22/23 between 12:45 p.m. and 3:45 p.m., the exit		This is the Assessed		
	discharge path leading to the public way from the		This is the tag where we asked		
	Southwest Stairwell Exit was not illuminated. No		you for clarification of the area.		
	lights were visible which would illuminate the path		You responded back and copied		
	of exit discharge. The Corporate Support		the surveyor on it. He could not		
	Representative was unable to locate lighting for		remember what location. I have		
	the exit discharge path.		walked the community and do not		
	This finding was acknowledged by the		see any area that needs additional		
	Maintenance Director and the Corporate Support		lighting. The building sits at a		
	Representative at the time of observation and		weird angle and has many branch		
	again at the exit conference with the Maintenance		hallways so we are unsure where the south west exit is. See		
	Director, Corporate Support Representative, Staff		attached aerial view of the		
	Development Coordinator, Corporate Infection		campus. How do we resolve this		
	Preventionist, Clinical Specialist and Assistant		issue where no one remembers		
	Administrator all present.		this issue. Do we need to have		
	Traininguator an present.		the surveyor come back and meet		
	3.1-19(b)		me there to discuss? There was		
			some miss communication during		
			the writing of the POC and there		
			has been no action taken on this		
			tag. There should have been no		
			follow up audit tool listed until we		
			come to an agreement of where		
			this location is.		
			II The facility will identify		
			II. The facility will identify		
			other residents that may		
			potentially be affected by the		
			deficient practice.		

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

Event ID: NY0L21

Facility ID: 000103

If continuation sheet

Page 13 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/22/2023
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				Staff and residents in the community that use this sidew have the potential to be affected by this deficient practice.  III. The facility will put into	ed
				place the following systemat changes to ensure that the deficient practice does not recur.	ic
				There is a new monthly TELS for the Maintenance Supervisor walk the corridors to ensure the all exit signs are illuminated.	or to
				IV The facility will monitor the corrective action by implementing the following measures.	
				V. Plan of Correction completion date.	
				Plan of Completion date is July 10th, 2023	y
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire ext accordance with a approved automa option is used, the				

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 14 of 39

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			
		155196	B. WING		06/22/2023	
	PROVIDER OR SUPPLIEF	ING COMMUNITY	3525 I	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	·	ors in accordance with 8.4.				
	Doors shall be sel	_				
	-	and permitted to have				
		applied protective plates that				
	the door.	inches from the bottom of				
		and zone locations of				
		that are deficient in				
	REMARKS.					
	19.3.2.1, 19.3.5.9					
	·					
	Area	Automatic Sprinkler				
	Separation					
		-Fired Heater Rooms				
	, -	er than 100 square feet)				
	•	nance, and Paint Shops				
		ooms (exceeding 64				
	gallons)	- D				
	e. Trash Collectio					
	(exceeding 64 gal	orage Rooms/Spaces				
	(over 50 square fe	· ·				
	,	classified as Severe				
	Hazard - see K32					
		on and interview, the facility	K 0321	I. The corrective actions to	be 07/10/2023	
		f over 10 hazardous area doors,		accomplished for those	1,,10,2020	
	such as storage room	ms, were provided with		residents found to have bee	n	
	properly working so	elf-closing devices. This		affected by the deficient		
	deficient practice co	ould affect more than 6 staff.		practice.		
	Findings include:			Observation – 1 – The kitchel	n exit	
				door into the service hall, equ	ipped	
		ons and interview during a		with a self-closing device faile	ed to	
		with the Maintenance Director		self-close and latch into the d		
	_	Support Representative on		frame. The door was fixed by	/ the	
		2:45 p.m. and 3:45 p.m., the		Maintenance Supervisor.		
	following was note					
		t door into the service hall,		Observation – 2 – The clean	·	
		f-closing device, failed to		corridor door on the rehab ha		
	self-close and latch into the door frame. At		1	equipped with a self-closing of	levice	

07/25/2023 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 155196 B. WING 06/22/2023 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 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 appeared that the door was rubbing near the top failed to self-close and latch in the of the door. The Maintenance Director applied a door frame. The door was fixed by hammer to the metal door but was unable to the Maintenance Supervisor. remedy the aforementioned issue. The kitchen contained large trash receptacles. (2) the clean utility corridor door on the Rehab II. The facility will identify Hall equipped with a self-closing device, failed to other residents that may self-close and latch in the door frame. potentially be affected by the deficient practice. These findings were acknowledged by the Maintenance Director and the Corporate Support Staff and residents in the A wing Representative at the time of observation and have the potential to be affected again at the exit conference with the Maintenance by this deficient practice. Director, Corporate Support Representative, Staff Development Coordinator, Corporate Infection III. The facility will put into Preventionist, Clinical Specialist and Assistant place the following systematic Administrator all present. changes to ensure that the deficient practice does not 3.1-19(b) recur. There is a monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled "Interior Door Inspection". IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will audit the building during their site visits to ensure the door compliance. V. Plan of Correction

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

Event ID:

NY0L21

Facility ID: 000103

completion date.

If continuation sheet

Page 16 of 39

PRINTED: 07/25/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 06/22/2023
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations of the Decorations of the Decorations of the Decorations of the Decorations of Decorations of the Decorations, paintings and other walls, ceilings and	prations prations prations shall be prohibited following is met: ant or treated with approved ing that is listed and labeled meet NFPA 701. exhibit heat release less in accordance with NFPA such as photographs, er art are attached to the		Plan of Completion date is Ju 10th, 2023	
	o The decoration are in such limited fire development of 19.7.5.6  Based on observation failed to ensure 1 or maintained in according 19.7.5.6 prohibits of an exception was more could affect 50 resistant failed to ensure 1 or maintained in according 19.7.5.6 prohibits of an exception was more could affect 50 resistant include:  Based on observation of the facility	ons and interview during a with the Maintenance Director Support Representative on 2:45 p.m., the	K 0753	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation 1- The Commun failed to ensure that there we candles with wicks inside the community. The two wick but candles in the solarium area or removed and the Church leadership educated that candidate in the solarium area or removed and the Church leadership educated that candidate in the solarium area or removed and the Church leadership educated that candidate in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the Church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated that candidates in the solarium area or removed and the church leadership educated	ity re no rning were dles
		nined two wick burning rate Support Representative		with wicks are not permitted in the community.	nside

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

removed the candles and stated that candles are

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet Page 17 of 39

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  Occasionally found in this area and hard to		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 06/22/2023
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  Occasionally found in this area and hard to				3525 E	HANNA AVE	
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	COMPLETION
This finding was acknowledged by the Maintenance Director and the Corporate Support Representative at the time of observation and again at the exit conference with the Maintenance Director, Corporate Support Representative, Staff Development Coordinator, Corporate Infection Preventionist, Clinical Specialist and Assistant Administrator all present.  3.1-19(b)  III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.  The Nursing and activity staff have been in-serviced on the combustible decoration policy and educated there should not be any combustible decoration allowed in the facility.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate Environmental Services will inspect solarium and all other hallways and rooms during their annual COR to ensure they are free from any combustible decorations and wicked candles.	TAG	occasionally found eliminate completely This finding was act Maintenance Direct Representative at the again at the exit con Director, Corporate Development Coord Preventionist, Clini Administrator all processions of the control of	in this area and hard to ly.  knowledged by the for and the Corporate Support the time of observation and inference with the Maintenance Support Representative, Staff dinator, Corporate Infection cal Specialist and Assistant	TAG	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.  The Nursing and activity staff his been in-serviced on the combustible decoration policy and educated there should not be a combustible decoration allowed the facility.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate Facilities and Corporate Environmental Service will inspect solarium and all othe hallways and rooms during their annual CQR to ensure they are free from any combustible	c  ave and any d in

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

Event ID:

NY0L21

Facility ID: 000103

completion date.

If continuation sheet

Page 18 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155196		A. BUILDING B. WING	01	COM	TE SURVEY MPLETED 22/2023	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIF E HANNA AVE NAPOLIS, IN 46237	PCOD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
				Plan of Completion of 10th, 2023	late is July	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manual loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers are program for period components is est manufacturer requ of maintenance ar and readily availate and circuits are ma and separate from Minimizing the pos	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with a sintervals, and exercised inthe for 4 continuous hours. It der load conditions include ted cold start and heal transfer of all EES inducted by competent in ance and testing of stored roes (Type 3 EES) are in IFPA 111. Main and feeder the inspected annually, and a dically exercising the hablished according to hirements. Written records and testing are maintained be. EES electrical panels arked, readily identifiable, in normal power circuits. Saibility of damage of the source is a design				

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 19 of 39

STATEMEN	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	ING		06/22/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
		view and interview, the facility	K 0	918	I. The corrective actions to I	Эе	07/10/2023
		of 1 generators annually to			accomplished for those		
		nts of NFPA 110, 2010 Edition,			residents found to have been	n	
		nergency and Standby Powers			affected by the deficient		
		.4.2. Section 8.4.2 states diesel			practice.		
	_	rvice shall be exercised at least			Observation Ti 6 "" 6"		
	1	minimum of 30 minutes, using			Observation – The facility faile		
	one of the following	g methods: iintains the minimum exhaust			implement the emergency pov		
		recommended by the			system requirements found in		
	manufacturer	recommended by the			health care facility code NFPA 110. The facility failed to provi		
		temperature conditions and at			documentation of an annual lo		
		cent of the EPS (Emergency			bank test for the diesel-power		
	Power Supply) nam				generator. The annual load ba		
		es diesel-powered EPS			test for the diesel-powered	ai in	
		not meet the requirements of			generator was performed on		
		ised monthly with the available			04/26/2023 and the document	ation	
		Power Supply System) load and			was placed in the Life Safety	dion	
		nnually with supplemental			Book. See attached Load bar	nk	
		Test) at not less than 50 percent			test results.		
	· ·	ate kW rating for 30 continuous			See attached load bank test the	nat	
	_	ess than 75 percent of the EPS			was completed on 4/26/2023.		
		g for 1 continuous hour for a			The annual test was complete	d on	
	total test duration of	f not less than 1.5 continuous			time but not available for revie		
	hours. This deficien	nt practice could affect all			the time of inspection. To ensi		
	occupants.				future load bank test		
					documentation will be availab	le for	
	Findings include:				review we will change the PO	C to	
					read CarDon Corporate Facili	-	
		eview and interview with the			audit the Life Safety Binder to		
		for and the Corporate Support			ensure the proper generator		
	1 -	06/22/23 between 9:45 a.m. and			paperwork is in there for revie	W.	
		mentation of an annual load					
		esel powered generator was			II. The facility will identify		
		ntation of an in house 4 hour			other residents that may		
		ut it did not meet the			potentially be affected by the	•	
		nts to include for the annual			deficient practice.		
	load bank test. The	Corporate Support			1		

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

Event ID:

NY0L21 Facility ID: 000103

If continuation sheet Page 20 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155196  A. BUILDING  B. WING			01	COMPLETED 06/22/2023
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD 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
	confusion about the distinctions between The Maintenance D	d that there was some requirements and the fuel source expectations. irector acknowledged a load terator had not occurred		Staff and residents in the community have the potential be affected by this deficient practice.	to
	This finding was acl Maintenance Direct Representative at th again at the exit con Director, Corporate Development Coord	knowledged by the or and the Corporate Support e time of observation and ference with the Maintenance Support Representative, Staff linator, Corporate Infection cal Specialist and Assistant		III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  The Administrator and Maintenance Supervisor will remaintenance contracts to ensure they are correct and documentation was provided during the Emergency Preparedness Program annual review.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities will also review this information dutheir annual Corporate Quality Review.  V. Plan of Correction completion date.	eview ure al
				Plan of Completion date is Jul 10th, 2023 I. The corrective actions to I accomplished for those residents found to have been affected by the deficient	oe e

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 21 of 39

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196  A. BUILDING B. WING  Of 155196  Of 22/2023  STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY	X1) PROVIDER/SUPPLIER/CLIA	ENT OF DEFICIENCIES	STATEMEN
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  K 0920 NFPA 101  SS=E Electrical Equipment - Power Cords and		IDENTIFICATION NUMBER	N OF CORRECTION	AND PLAN
ALTENHEIM HEALTH & LIVING COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and  3525 E HANNA AVE INDIANAPOLIS, IN 46237  (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  Practice.	B. WING 06/22/2023	155196		
PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  K 0920  NFPA 101  SS=E  Electrical Equipment - Power Cords and	3525 E HANNA AVE			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (ACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE D	ID BROWINGERS BLANGE CORRECTION (C	STATEMENT OF DEFICIENCIE	SUMMARY S	(X4) ID
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  Practice.  K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and	THE PRESENT OF ACTION SHOULD BE COMPANY	ICY MUST BE PRECEDED BY FULL	(EACH DEFICIEN	PREFIX
K 0920 NFPA 101 SS=E Electrical Equipment - Power Cords and	ON TAG DEFICIENCY) DA	R LSC IDENTIFYING INFORMATION	REGULATORY OR	TAG
SS=E Electrical Equipment - Power Cords and	practice.			
Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363. or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), T1A 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring the promitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents.    NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents.	K 0920  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 proper power strips were being used withing the	ent - Power Cords and  patient care vicinity are only ents of movable ed electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips in the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are precautions. Extension d as a substitute for fixed fre. Extension cords used fromoved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility f 1 power strips were not used fixed wiring to provide power igh current draw. 0.8 state unless specifically flexible cords and cables shall as a substitute for fixed wiring.	Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care roother UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the pinstalled and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (Based on observation failed to ensure 1 of as a substitute for fine equipment with a hin NFPA-70/2011, 400 permitted in 400.7 finot be used for (1) a This deficient practice.	SS=E

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet Page 22 of 39

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 06/22/2023 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: resident room #1119 was being used to power a coffee machine Based on observations and interview during a was removed. tour of the facility with the Maintenance Director and the Corporate Support Representative on 06/22/23 between 12:45 p.m. and 3:45 p.m., in II. The facility will identify resident room 1119 a power strip was being used other residents that may to power a coffee machine (high power draw potentially be affected by the equipment). deficient practice. This finding was acknowledged by the Staff and residents in the Maintenance Director and the Corporate Support community have the potential to Representative at the time of observation and be affected by this deficient again at the exit conference with the Maintenance practice. Director, Corporate Support Representative, Staff Development Coordinator, Corporate Infection Preventionist, Clinical Specialist and Assistant III. The facility will put into Administrator all present. place the following systematic changes to ensure that the 3.1-19(b) 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

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 23 of 39

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				LETED
		155196	B. W	ING		06/22	/2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
ALTENHEIM HEALTH & LIVING COMMUNITY				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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					completion date.		
					Plan of Completion date is Jul 10th, 2023	у	
K 0927	NFPA 101						
SS=F		Transfilling Cylinders					
Bldg. 01		Transfilling Cylinders					
		gen from one cylinder to					
		rdance with CGA P-2.5,					
	Transfilling of High	n Pressure Gaseous					
	Oxygen Used for I	Respiration. Transfilling of					
		cylinder to another is					
		nt care rooms. Transfilling					
		ontainers or to portable					
		) psi comply with conditions					
		NFPA 99). Transfilling to					
		tainers or to portable					
	containers under						
	11.5.2.2 (NFPA 99	11.5.2.3.2 (NFPA 99).					
		ation and interview, the facility	K <sub>0</sub>	027	I. The corrective actions to I	<b>h</b> o	07/10/2023
		f 1 oxygen trans-filling rooms	KU	921	accomplished for those	Je	07/10/2023
		n other areas in the facility in a			residents found to have been	n	
	room that is protect				affected by the deficient	•	
		uction in accordance with 2012			practice.		
	NFPA 99 11.5.2.3.1	1(1). This deficient practice					
	could affect all resid	dents.			Observation – The surveyor a	sked	
					us to prove that the rehab oxy		
	Findings include:				room that was constructed in	2014	
					has a 1 hour fire rated ceiling.		
		ons and interview during a			See attached set of plans labe		
	1	with the Maintenance Director			Altenheim Rehab Plans. Pag		
	_	Support Representative on			A4.1 shows wall section S-1-A		
		2:45 p.m. and 3:45 p.m., the			has the wall section for this ro		
	1	room near the Rehab area had			These plan went through ISDI		
		ng which appeared to be 1			plan review, multiple life safet		
		The Maintenance Director and			state fire marshal surveys. W	е	
		ort Representative were			cut a hole in the ceiling and		
	unsure of the ceiling	g thickness in the oxygen			confirmed that there is metal h	nat	

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 24 of 39

STATEMENT 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		06/22	/2023
				CTDEET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
	EIM HE∆I TH & I N	/ING COMMUNITY			IAPOLIS, IN 46237		
	LIIVI I IEALI FI & LI\	AING COIVIIVIONITT	_	INDIAN	IAI OLIO, IIN 4023 <i>1</i>		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	-	e layers of drywall were present			channel running perpendicula		
	on the ceiling and would have to check further.				the ceiling joists with 1 layer of	of	
	TELL C. 1.	1 1 1 11 1			5/8" drywall on there. This		
		cknowledged by the			construction type meets a 1 h		
		tor and the Corporate Support			fire rating. Do I need to call o		
	-	he time of observation and			architect and get a more form	aı	
	_	nference with the Maintenance e Support Representative, Staff			response?		
		dinator, Corporate Infection			Observation The new signature	0.1400	
	-	ical Specialist and Assistant			Observation- The new signage placed to ensure 2 x 2 oxyget		
	Administrator all p	-			storage/transfer rooms was	1	
	<sup>2</sup> Administrator an p	1030110			provided with a sign indicating	r that	
	2 Based on observ	ation and interview, the facility			transferring is occurring.	y ii lat	
		of 2 oxygen storage/transfer			a districting is occurring.		
		d with a sign indicating that					
	-	arring. NFPA 99 11.5.2.3.1(3)			II. The facility will identify		
	-	osted with signs indicating			other residents that may		
	-	occurring and that smoking in			potentially be affected by th	е	
	_	is not permitted. This deficient			deficient practice.		
	practice could affe						
					Staff and residents in the		
	Findings include:				community have the potential	to	
					be affected by this deficient		
		ons and interview during a			practice.		
	,	with the Maintenance Director					
	-	Support Representative on					
		12:45 p.m. and 3:45 p.m., the			III. The facility will put into		
		nsfer room (1) on the A-B Hall			place the following systema	tic	
	1 1	ehab area did not have a posted			changes to ensure that the		
		r distinction between when			deficient practice does not		
		gen is occurring in this location			recur.		
		Based on interview at the time			A	_	
		Maintenance Director stated			A new monthly TELS task ha		
		n stating when trans-filling g and when it is not. The			been created to inspect all int		
		g and when it is not. The ed that transferring of oxygen			signage. See attached TELS		
	was always occurri				Labeled "Altenheim Signage Task.	IELO	
	was aiways occurr	mg.			I ask.		
	This finding was a	cknowledged by the			IV The facility will monitor		
	_	tor and the Corporate Support			the corrective action by		
							1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	î ´	ILDING	01	COMPL	
IND I LAN	o. coldinerion	155196	B. WI		<u> </u>	06/22/	
		100100	D. W1			00/22/	
NAME OF F	ROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP COD		
					HANNA AVE		
ALTENH	LIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, 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 APPROPRIATE		.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ne time of observation and			implementing the following		
	-	nference with the Maintenance			measures.		
	_	Support Representative, Staff					
	-	dinator, Corporate Infection			CarDon Corporate Facilities w		
		cal Specialist and Assistant			inspect the oxygen rooms dur	-	
	Administrator all p	resent.			their annual CQR to ensure th	ie	
	2.1.10/13				proper signage is in place.		
	3.1-19(b)						
					V. Plan of Correction		
					completion date.		
					Dian of Completion data is 150		
					Plan of Completion date is Jul	у	
					10th, 2023		
K 0000							
-							
Bldg. 02							
-	A Life Safety Code	Recertification and State	K 00	000	July 10th, 2023		
	Licensure Survey v	vas conducted by the Indiana					
	Department of Hea	lth in accordance with 42 CFR					
	483.90(a).				Brenda Buroker, Director		
					Long-Term Care Division		
	Survey Date: 06/22	/23			Indiana State Department of		
					Health		
	Facility Number: (				2 North Meridian Street		
	Provider Number:	155196			Indianapolis, IN 46204		
	AIM Number: 100	290000					
					Re: Allegation of Complian	nce	
		Code survey, Altenheim Health					
	_	unity was found not in			<u> </u>		
	-	equirements for Participation in			Dear Mrs. Buroker:		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),					_	
		re and the 2012 Edition of the			Please find enclosed the Plan		
		ction Association (NFPA) 101,			Correction for the State Licens		
	,	LSC), Chapter 19, Existing			Survey NYOL21 conducted or		
	Health Care Occup	ancies and 410 IAC 16.2.			June 22nd, 2023. This letter i	s to	
	This facility	to of Duilding O1 or 4 Deciliary			inform you that the plan of		
		ts of Building 01 and Building			correction attached is to serve	as	
	02. Building 01 coi	nsists of the A, B and C wings	I		Altenheim Health & Living		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 06/22/2023	
ALTENH	PROVIDER OR SUPPLIER	ING COMMUNITY	3525 E INDIAN	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY  (EACH DEFICIENT  REGULATORY OF DESIGNATION OF THE FIRST PROOF OF THE PROOF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  a three story building with a determined to be of Type II and was fully sprinklered. The arm system with smoke els in the corridors and in all bridor. The facility has smoke d to the building electrical and C wings. The two f the first floor were also k of 2 hour separation. So of the one story g constructed in 2014 and was a Type V (111) construction and bed. The Rehabilitation Wing tem with smoke detection in areas open to the corridor and shard wired to the fire alarm sleeping rooms. The facility and had a census of 85 at the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Community credible allegation compliance. We allege substantial compliance on Jul 10th, 2023. We are requestin paper compliance for this plar correction.  If you have any further questic please do not hesitate to contime at 317-919-1500.  Sincerely,  Chirag Patel, HFA Administrator Altenheim Health and Living  Submission of this plan of correction in no way constitute an admission by Altenheim He and Living or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or of services provided in this facilit The Plan of Correction is prepand executed solely because	es ealth t is a t the ther ty. bared
K 0222 SS=F	NFPA 101 Egress Doors			required by Federal and State Law.  This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	and
JU-1	Laices Dools		1		1

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

Event ID:

NY0L21 Facility ID: 000103

If continuation sheet Page 27 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		, ,	UILDING	nstruction  02	(X3) DATE COMPI 06/22			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION	
	`				CROSS-REFERENCED TO THE APP	ROPRIATE		
		CLSC IDENTIFTING INFORMATION		TAU			DATE	
Bldg. 02	Egress Doors Doors in a require be equipped with requires the use of egress side unless special locking ar CLINICAL NEEDS LOCKING Where special loc clinical security no used, only one loc permitted on each be made for the re by: remote control locks or keys carr other such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the the Clinical or Sec are being met. In electrical locks the release upon loss building is protect automatic sprinkle space is protected detection system at an attended loc space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2	sking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants. I of locks; keying of all ied by staff at all times; or emeans available to the a c.2.2.6, 19.2.2.2.5.1, I c.2.2.6, 19.2.2.2.5.1, I c.3. LOCKING Seking arrangements for the empatient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to a for power to the device; the eed by a supervised er system and the locked device to the sprinkler and detection and to unlock the doors 1.2.2.5.2, TIA 12-4		TAG	DEFICIENCY)		DATE	
	DELAYED-EGRE ARRANGEMENT Approved, listed of							
		in accordance with						

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet Page 28 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 06/22/2023			
	PROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  FACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	contents in buildin an approved, super detection system of automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted.  18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detect approved, supervisystem.  18.2.2.2.4, 19.2.2. Based on observation failed to ensure all deficient practice confacility.  Findings include:  Based on observation facility wand the Corporate Stocky of the facility wand the Corporate Stocky of the facility of the facility wand the Corporate Stocky of the facility of the facility wand the Corporate Stocky of the facility of the facili	g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised r system.  2.4  OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall  2.4  BY EXIT ACCESS IGEMENTS I access door locking in .2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an sed automatic sprinkler  2.4  On and interview, the facility exterior exit doors were readily to open on first try. This build affect all occupants in the exit with the Maintenance Director upport Representative on 2:45 p.m. and 3:45 p.m., the oor near the Elevator on the been when tried. After several	K 0222	The corrective actions to be accomplished for those residents found to have bee affected by the deficient practice.  Observation – The exterior gleexit door near the elevator on AL hall did not function correct your Automatic Door was call out to repair. Your Automatic Door repaired the glass door 7/13/2023. See attached wor order and invoice for the completed work.  II. The facility will identify	n  ass the stly. ed on		

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

Event ID:

NY0L21 Facility

Facility ID: 000103

If continuation sheet

Page 29 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	B. WING		
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  ALSO DEPOTE THE VINC DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	required excessive to fegress travel.  This finding was ac Maintenance Direct Representative at the again at the exit con Director, Corporate Development Coord	knowledged by the cor and the Corporate Support the time of observation and ofference with the Maintenance Support Representative, Staff dinator, Corporate Infection cal Specialist and Assistant	TAG	other residents that may potentially be affected by the deficient practice.  All Staff and residents on the south side of the community the potential to be affected.  III. The facility will put into place the following systemath changes to ensure that the deficient practice does not recur.  The Maintenance Supervisor audit all exit doors to ensure all doors are functioning proponthere is a monthly task in Test to check door functions month See attached TELS task labe "Altenheim Exterior Door Tell Task.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate Facilities inspects the exit doors during annual CQR.  V. Plan of Correction completion date is June 10th, 2023	DATE  DATE
K 0293 SS=E	NFPA 101 Exit Signage				

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 30 of 39

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	A. BUILDING <u>02</u> CO		COMPL	3) DATE SURVEY COMPLETED 06/22/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(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 APPROPRIATION OF THE APPROPRIATION	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 02	Exit Signage 2012 EXISTING Exit and directional accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with I where the line of each Based on observation failed to install exit accordance with LS other than main extended by an approfrom any direction of states horizontal conwithin an exit enclous approved exit or direction of the continuation of the facility wand the Corporate Subject of the Southwest Exit soptions to exit to the signage was evident follow the exit dischway. The Corporate	al signs are displayed in .10 with continuous erved by the emergency existing less than 30 occupants exit travel is obvious.) on and interview; the facility signage in 1 of 1 exits in C 7.10. LSC 7.10.1.2.1 exits, erior exit doors that obviously tifiable as exits, shall be ved sign that is readily visible of exit access. LSC 7.10.1.2.2 mponents of the egress path sure shall be marked by ectional exit signs where the egress path is not obvious. Ice could affect up to 15 exits and interview during a with the Maintenance Director upport Representative on 2:45 p.m. and 3:45 p.m., outside Stairwell there were multiple expublic way. No directional appointing which way to go to harge and arrive at the public Support Representative lid need to have directional	K 0:	293	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The exit discharpath leading to the public way from the Southwest exit door wonot posted – The new exterior directional exit sign was install See attached picture showing new exterior directional sign attached to the fence.  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 sidew have the potential to be affected by this deficient practice.  III. The facility will put into place the following systemat changes to ensure that the	rge vas ed. a	07/10/2023
	Maintenance Direct	or and the Corporate Support			deficient practice does not		

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

Event ID:

NY0L21 Facility ID: 000103

If continuation sheet Page 31 of 39

PRINTED: 07/25/2023

DEPARTMEN	Γ OF HEALTH AND HU!	MAN SERVICES				FOI	RM APPROVED
CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	02	COMPLETED	
		155196	B. W	ING		06/22	/2023
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne time of observation and			recur.		
	-	nference with the Maintenance					
	_	Support Representative, Staff			There is a new weekly TELS t		
	_	dinator, Corporate Infection			for the Maintenance Superviso		
		cal Specialist and Assistant			walk the corridors to ensure al	I	
	Administrator all pr	resent.			exit signage are posted. See		
	2.1.10(1-)				TELS task labeled "Altenheim		
	3.1-19(b)				Pathways TELS Task".		
				IV The facility will monitor			
					the corrective action by		
					implementing the following		
					measures.		
					CarDon Corporate Facilities w		
					audit all existing sidewalks and		
					paths of egress during their ar	ınuaı	
					CQR process.		
					V. Plan of Correction		
					V. Plan of Correction completion date.		
					Plan of Completion date is Jul 10th, 2023	y	
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 02	Corridor - Doors						
J	Doors protecting of	corridor openings in other					
		losures of vertical openings,					
		is areas resist the passage					
		made of 1 3/4 inch					
	solid-bonded core	wood or other material					

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

capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors

to rooms containing flammable or

combustible materials have positive latching

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 32 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  06/22/2023		
	PROVIDER OR SUPPLIER		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 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	
	hardware. Roller I CMS regulation. Tapply to auxiliary apply apply to auxiliary apply app	atches are prohibited by These requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	I. The corrective actions to I accomplished for those residents found to have been affected by the deficient practice.  Observation 1– The door stop the nursing service office on the stop to the stop that the stop the stop the stop that the	n at he	

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

Based on observations and interview during a

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

AL living area door was removed.

Page 33 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/22/2023 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 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 tour of the facility with the Maintenance Director Observation 3- The door stops at and the Corporate Support Representative on on the door of dialysis unit was 06/22/23 between 12:45 p.m. and 3:45 p.m., the removed. following corridor doors were propped open: Observation 4 - #1312, Resident A) The Nursing Services Office on the 1200 Hall room door was looked at by Your had a door stop. Automatic door. Your Automatic B) The AL living Area had a door stop. Door repaired the glass door on C) The Door into the Dialysis Unit had a door 7/13/2023. See attached work order and invoice for the stop. D) RR #1312 would not latch, the door plate completed work. appeared to be missing. II. The facility will identify This finding was acknowledged by the other residents that may Maintenance Director and the Corporate Support potentially be affected by the Representative at the time of observation and deficient practice. again at the exit conference with the Maintenance Director, Corporate Support Representative, Staff Development Coordinator, Corporate Infection Staff and residents have the Preventionist, Clinical Specialist and Assistant potential to be affected by this Administrator all present. deficient practice. 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 monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled "Interior Door Inspection". IV The facility will monitor the corrective action by implementing the following measures.

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 34 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDI	CAID SERVICES				
STATEMENT OF DEFICIENCIES	V1) DPOVIDED/CLIDDLIED/CLIA	(Y2) MIJI TIDI E C			

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER  155196	A. BUILDING 02  B. WING		COMPLETED 06/22/2023		
	PROVIDER OR SUPPLIER		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 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		
				CarDon Corporate Facilities w inspect all doors during their annual site visits.	ill		
				V. Plan of Correction completion date.			
				Plan of Completion date is July 10th, 2023	y		
K 0511 SS=E Bldg. 02	complies with NFF Code, electrical wi complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.					
	Based on observation, the facility failed to ensure 1 of 1 electrical connections in a stairwell were maintained in a safe operating condition. 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, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 15 residents.		K 0511	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.	07/10/2023		
				Observation – In the southwes exit stairwell from assisted livin there were some exposed wire where the cover was missing fa ventilation unit. The large ventilation cover was reinstalled and wires were covered. See attached picture.	ng es rom		
	tour of the facility wand the Corporate S	ons and interview during a with the Maintenance Director upport Representative on 2:45 p.m. and 3:45 p.m., in the		II. The facility will identify other residents that may potentially be affected by the deficient practice.			

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

Event ID:

NY0L21 Facility ID: 000103

If continuation sheet

Page 35 of 39

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	O2	(X3) DATE SURVEY COMPLETED 06/22/2023
	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	N (X5)  SEE RIATE COMPLETION DATE
	was missing and m Maintenance Direct	rwell, a large ventilation cover altiple wires were exposed. The for stated that the apparatus The cover was outside the walk.		Staff and residents in the community have the potenti be affected by this deficient practice.	
	Representative at the again at the exit con Director, Corporate Development Coord	or and the Corporate Support the time of observation and ofference with the Maintenance Support Representative, Staff linator, Corporate Infection		III. The facility will put into place the following system changes to ensure that the deficient practice does not recur.	aatic e t
	Preventionist, Clinical Specialist and Assistant Administrator all present.			This is a permanent fix to the issue so no follow up is nee	
	3.1-19(b)			IV The facility will moniton the corrective action by implementing the following measures.	
				CarDon Corporate Facilities inspects these doors annua during the door audit.	
				V. Plan of Correction completion date.	
				Plan of Completion date is 3 10th, 2023	July
K 0741 SS=F Bldg. 02	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib				

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet Page 36 of 39

i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/22/2023	
	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 LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	signs that read NO posted with the interpretation smoking.  (2) In health care smoking is prohibited prominently place secondary signs was moking shall not (3) Smoking by paresponsible shall I (4) The requirement apply where the parent supervision.  (5) Ashtrays of notes affected as a smoking is (6) Metal contained devices into which shall be readily awas moking is permitted as a smoking is permitted as a smoking policited could affect everyore.  In Based on observation interview, the facility was and the Corporate Story of the facility was a story of	d at all major entrances, with language that prohibits be required. Itients classified as not be prohibited. In of 18.7.4(3) shall not atient is under direct ancombustible material and be provided in all areas permitted. It is with self-closing cover a ashtrays can be emptied ailable to all areas where ted.  In on, records review, and the ty failed to enforce 1 of 1 less. This deficient practice	K 0'	741	. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation 1- The communit failed to enforce the campus smoking policy.  Observation 2 – The cigarette butts in the grass and near the side walk, near the west exit with picked up and the area was cleaned. Assisted Living resided ucated about the facility's smoking policy.	n dy es e were	07/10/2023

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

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155196	ľ í	02	COMPLETED 06/22/2023				
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	STREET ADDRESS, CITY, STATE, ZIP COD  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL PREFIX	PROVIDERS PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE					
	2. Based on observations and interview durin tour of the facility with the Maintenance Dire and the Corporate Support Representative on 06/22/23 between 12:45 p.m. and 3:45 p.m., smoking on the property was evident due to 2 plus cigarette butts in the grass and near the sidewalk near the West exit. Based on record review the smoking policy stated smoking is	ector 25	II. The facility will identify other residents that may potentially be affected by the deficient practice.  Staff and residents in the 120 Hall have the potential to be affected by this deficient pract	0				
	allowed on the facility's property and no designated smoking area was provided.  These findings were acknowledged by the Maintenance Director and the Corporate Sup Representative at the time of observation and again at the exit conference with the Mainten Director, Corporate Support Representative, Development Coordinator, Corporate Infection Preventionist, Clinical Specialist and Assistated Administrator all present.  3.1-19(b)	l nance Staff on	III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  There is a new weekly TELS to created for the Maintenance Supervisor or designee to wal campus to ensure the smoking policy is being enforced. See TELS task labeled "Altenheim Campus Smoking Policy TELS Task".  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate Facilities and Administrator will walk the campus frequently to ensure smoking is not taking place.  V. Plan of Correction completion date.	ask k the g				

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

Event ID:

NY0L21

Facility ID: 000103

If continuation sheet

Page 38 of 39

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PH		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED		
	155196		B. WING			06/22/2023		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
					Plan of Completion date is July 10th, 2023	y		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NY0L21 Facility ID: 000103 If continuation sheet Page 39 of 39