STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/22/23 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Emergency Preparedness survey, Altenheim Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 87 certified beds. At the time of the survey, the census was 85. Quality Review completed on 06/28/23	E 0000	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 Compliance Dear Mrs. Buroker: Please find enclosed the Plan of 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. 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	TITLE	(X6) DATE
Chirag Patel		07/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Administrator Altenheim Health and Living Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	including TIAs to chapter 7, issued August 6, 2009.. Based on observation and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and the Corporate Support Representative on 06/22/23 between 9:45 a.m. and 12:45 p.m., no documentation of an annual load bank test for the diesel powered generator was available. Documentation of an in house 4 hour test was provided but it did not meet the standard/requirements to include for the annual load bank test. The Corporate Support Representative stated that there was some confusion about the requirements and the distinctions between fuel source expectations. The Maintenance Director acknowledged a load bank test for the generator had not occurred within the past year. 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.	E 0041	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The facility failed to implement the emergency power system requirements found in the health care facility code NFPA 110. The facility failed to provide documentation of an annual load bank test for the diesel-powered generator. The annual load bank test for the diesel-powered generator was performed on 04/26/2023 and the documentation was placed in the Life Safety Book. See attached Load bank test results. See attached load bank test that was completed on 4/26/2023. The annual test was completed on time but not available for review at the time of inspection. To ensure future load bank test documentation will be available for review we will change the POC to read CarDon Corporate Facility will audit the Life Safety Binder to ensure the proper generator paperwork is in there for review. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			-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 Administrator and Maintenance Supervisor will review maintenance 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 during their annual Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0000 Bldg. 01				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/22/23 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The two residential wings of the first floor were also surveyed due to lack of 2 hour separation. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility	K 0000	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 Compliance Dear Mrs. Buroker: Please find enclosed the Plan of 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. If you have any further questions, please do not hesitate to contact me at 317-919-1500. Sincerely, Chirag Patel, HFA Administrator Altenheim Health and Living	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has a capacity of 87 and had a census of 85 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/28/23		Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1) Based on observation and interview, the facility failed to ensure 3 of over 8 corridors were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60	K 0211	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The motorized wheelchair was being stored in front of and obstructing the	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects all residents in the facility. Findings include: Based on observations and interview during a 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., the following was observed; (1) A motorized wheelchair was being stored in front of and obstructing the stairwell exit door in the rehab hallway near RR# 1129. The Maintenance Director removed the obstruction during the survey and stated he was unsure who stored it or why the motorized wheelchair was being stored in front of the stairwell exit door. (3) In the corridors near Resident Room #1208 and near Resident room #1305, Personal Protective Equipment (PPE) carts were in use but not equipped with wheels allowing the carts to be move out of the hall during an emergency. The Maintenance Director looked for wheels in the drawers but was unable to locate the missing wheels. These finding were acknowledged by the Maintenance Director and the Corporate Support		stairwell exit door in the rehab hallway near #1129. The motorized wheelchair was immediately removed from the area. Observation 2– In the corridors near resident rooms #1208, #1305 PPE carts were used without wheels – all PPE carts used in the corridors near resident rooms #1208, and #1305 was replaced with PPE carts equipped with wheels. Observation 3– The facility failed to ensure 1 of over 8 exit discharges was in accordance with Chapter 7 states the width of any means of egress shall be not less than 36 inches where another part of this chapter do not specify minimum width. – A new sidewalk was installed to meet the accordance with Chapter 7 and Chapter11 near A-B nurses station. See attached picture of 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 to be affected by this deficient practice. **III. The facility will put into**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. 2) Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges was in accordance with Chapter 7. LSC 7.3.4.1(2) states the width of any means of egress shall be not less than 36 inches where another part of this chapter and Chapters 11 through 43 do not specify a minimum width. This deficient practice affects at least 25 residents in the facility. Findings include: The exit discharge near the A-B Nursing Station, was marked "Emergency Exit" with a 46-inch exit door. The exit discharge sidewalk was obstructed with a large block wall constructed partially in the path of exit discharge which restricted the width of the exit discharge to 31 inches, as measured by the Maintenance Director. 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)		**place the following systematic changes to ensure that the deficient practice does not recur.** There is an existing weekly TELS task to audit hallways/ path of egress/ exits. See attached TELS task labeled “Altenheim Pathway TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all existing sidewalks and paths of egress during their annual CQR process. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023.	
K 0271 SS=E	NFPA 101 Discharge from Exits			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents and staff. Findings include: Based on observations and interview during a 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., the exit discharge near the A-B Nursing Station, was marked "Emergency Exit" and the exit discharge pathway terminated at the kitchen service drive with a step ledge of approximately 4-5 inches leading down to the service drive. 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)	K 0271	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The facility failed to ensure 1 of over 8 exit discharges was in accordance with Chapter 7 states the width of any means of egress shall be not less than 36 inches where another part of this chapter do not specify minimum width. – A new sidewalk was installed to meet the accordance with Chapter 7 and Chapter11 near A-B nurses station. See attached picture of new 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 to be affected by this deficient practice.	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. This is a permanent fix to this issue so no follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all existing sidewalks and paths of egress during their annual CQR process. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023.	
K 0281 SS=F Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on interview and observation, it was determined that the facility failed to provide exterior emergency lighting for all exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for	K 0281	**K 281** **I. The corrective actions to be accomplished for those residents found to have been**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency. Findings include: Based on observations and interview during a 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., the exit discharge path leading to the public way from the Southwest Stairwell Exit was not illuminated. No lights were visible which would illuminate the path of exit discharge. The Corporate Support Representative was unable to locate lighting for the exit discharge path. 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)		**affected by the deficient practice.** Observation – The exit discharge path leading to the public way from the Southwest stairwell exit was not luminated – New lights were immediately installed to illuminate the path of exit discharge. This is the tag where we asked you for clarification of the area. You responded back and copied the surveyor on it. He could not remember what location. I have walked the community and do not see any area that needs additional lighting. The building sits at a weird angle and has many branch hallways so we are unsure where the south west exit is. See attached aerial view of the campus. How do we resolve this issue where no one remembers this issue. Do we need to have the surveyor come back and meet 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 other residents that may potentially be affected by the deficient practice.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Staff and residents in the community that use this sidewalk have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new monthly TELS task for the Maintenance Supervisor to walk the corridors to ensure that all exit signs are illuminated. **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	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 6 staff. Findings include: Based on observations and interview during a 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., the following was noted: (1) The kitchen exit door into the service hall, equipped with a self-closing device, failed to self-close and latch into the door frame. At	K 0321	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – 1 – The kitchen exit door into the service hall, equipped with a self-closing device failed to self-close and latch into the door frame. The door was fixed by the Maintenance Supervisor. Observation – 2 – The clean utility corridor door on the rehab hall equipped with a self-closing device	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appeared that the door was rubbing near the top of the door. The Maintenance Director applied a hammer to the metal door but was unable to remedy the aforementioned issue. The kitchen contained large trash receptacles. (2) the clean utility corridor door on the Rehab Hall equipped with a self-closing device, failed to self-close and latch in the door frame. These findings were 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)		failed to self-close and latch in the door frame. The door was fixed by the Maintenance Supervisor. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the A wing have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a 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 completion date.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Plan of Completion date is July 10th, 2023	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Solarium room was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 50 residents and staff. Findings include: Based on observations and interview during a 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., the Solarium area contained two wick burning candles. The Corporate Support Representative removed the candles and stated that candles are	K 0753	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that there were no candles with wicks inside the community. The two wick burning candles in the solarium area were removed and the Church leadership educated that candles with wicks are not permitted inside the community.	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occasionally found in this area and hard to eliminate completely. 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)		**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 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 Facilities and Corporate Environmental Services will inspect solarium and all other hallways and rooms during their annual CQR to ensure they are free from any combustible decorations and wicked candles. **V. Plan of Correction completion date.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.		Plan of Completion date is July 10th, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to exercise 1 of 1 generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and the Corporate Support Representative on 06/22/23 between 9:45 a.m. and 12:45 p.m., no documentation of an annual load bank test for the diesel powered generator was available. Documentation of an in house 4 hour test was provided but it did not meet the standard/requirements to include for the annual load bank test. The Corporate Support	K 0918	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The facility failed to implement the emergency power system requirements found in the health care facility code NFPA 110. The facility failed to provide documentation of an annual load bank test for the diesel-powered generator. The annual load bank test for the diesel-powered generator was performed on 04/26/2023 and the documentation was placed in the Life Safety Book. See attached Load bank test results. See attached load bank test that was completed on 4/26/2023. The annual test was completed on time but not available for review at the time of inspection. To ensure future load bank test documentation will be available for review we will change the POC to read CarDon Corporate Facility will audit the Life Safety Binder to ensure the proper generator paperwork is in there for review. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Representative stated that there was some confusion about the requirements and the distinctions between fuel source expectations. The Maintenance Director acknowledged a load bank test for the generator had not occurred within the past year. 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)		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 Administrator and Maintenance Supervisor will review maintenance 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 during their annual Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023 **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			practice.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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 1363A 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 meet other UL standards. All 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), TIA 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 to provide power equipment with a high current draw. 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 community. The power strip in the	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observations and interview during a 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 resident room 1119 a power strip was being used to power a coffee machine (high power draw equipment). 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)		resident room #1119 was being used to power a coffee machine was removed. **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 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			completion date. Plan of Completion date is July 10th, 2023	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect all residents. Findings include: Based on observations and interview during a 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., the oxygen trans-filling room near the Rehab area had drywall on the ceiling which appeared to be 1 layer of 5/8 drywall The Maintenance Director and the Corporate Support Representative were unsure of the ceiling thickness in the oxygen	K 0927	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The surveyor asked us to prove that the rehab oxygen room that was constructed in 2014 has a 1 hour fire rated ceiling. See attached set of plans labeled Altenheim Rehab Plans. Page A4.1 shows wall section S-1-A4.1 has the wall section for this room. These plan went through ISDH plan review, multiple life safety and state fire marshal surveys. We cut a hole in the ceiling and confirmed that there is metal hat	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room, or if multiple layers of drywall were present on the ceiling and would have to check further. 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. 2. Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include: Based on observations and interview during a 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., the oxygen storage/transfer room (1) on the A-B Hall and (2) Near the Rehab area did not have a posted sign making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. The posted sign indicated that transferring of oxygen was always occurring. This finding was acknowledged by the Maintenance Director and the Corporate Support		channel running perpendicular to the ceiling joists with 1 layer of 5/8" drywall on there. This construction type meets a 1 hour fire rating. Do I need to call our architect and get a more formal response? Observation- The new signage was placed to ensure 2 x 2 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. **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.** A new monthly TELS task has been created to inspect all interior signage. See attached TELS task Labeled "Altenheim Signage TELS Task. **IV The facility will monitor the corrective action by**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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)		**implementing the following measures.** CarDon Corporate Facilities will inspect the oxygen rooms during their annual CQR to ensure the proper signage is in place. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/22/23 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings	K 0000	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 Compliance Dear Mrs. Buroker: Please find enclosed the Plan of 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The two residential wings of the first floor were also surveyed due to lack of 2 hour separation. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 85 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/28/23		Community credible allegation of compliance. We allege substantial compliance on July 10th, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-919-1500. Sincerely, Chirag Patel, HFA Administrator Altenheim Health and Living Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0222 SS=F	NFPA 101 Egress Doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 02	Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interview during a 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., the exterior glass exit door near the Elevator on the AL Hall failed to open when tried. After several attempts the door was opened but the Maintenance Director and the Corporate Support Representative agreed the door had issues and	K 0222	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The exterior glass exit door near the elevator on the AL hall did not function correctly. Your Automatic Door was called out to repair. Your Automatic Door repaired the glass door on 7/13/2023. See attached work order and invoice for the completed work. **II. The facility will identify**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	required excessive force to open in the direction of egress travel. 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)		**other residents that may potentially be affected by the deficient practice.** All Staff and residents on the south side of the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor will audit all exit doors to ensure that all doors are functioning properly. There is a monthly task in TELS to check door functions monthly. See attached TELS task labeled "Altenheim Exterior Door TELS Task. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects the exit doors during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0293 SS=E	NFPA 101 Exit Signage			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 02	Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 1 exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect up to 15 residents. Findings include: Based on observations and interview during a 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., outside the Southwest Exit Stairwell there were multiple options to exit to the public way. No directional signage was evident pointing which way to go to follow the exit discharge and arrive at the public way. The Corporate Support Representative agreed the exit would need to have directional signage. This finding was acknowledged by the Maintenance Director and the Corporate Support	K 0293	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The exit discharge path leading to the public way from the Southwest exit door was not posted – The new exterior directional exit sign was installed. See attached picture showing a 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 sidewalk 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**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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)		**recur.** There is a new weekly TELS task for the Maintenance Supervisor to walk the corridors to ensure all exit signage are posted. See TELS task labeled “Altenheim Pathways TELS Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all existing sidewalks and paths of egress during their annual CQR process. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 4 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 12 residents and staff. Findings include: Based on observations and interview during a	K 0363	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The door stop at the nursing service office on the 1200 hall was removed. Observation 2- The door stop at AL living area door was removed.	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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., the following corridor doors were propped open: A) The Nursing Services Office on the 1200 Hall had a door stop. B) The AL living Area had a door stop. C) The Door into the Dialysis Unit had a door stop. D) RR #1312 would not latch, the door plate appeared to be missing. 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)		Observation 3- The door stops at on the door of dialysis unit was removed. Observation 4 - #1312, Resident room door was looked at by Your Automatic door. Your Automatic Door repaired the glass door on 7/13/2023. See attached work order and invoice for the completed work. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a 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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			CarDon Corporate Facilities will inspect all doors during their annual site visits. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 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. Findings include: Based on observations and interview during a 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 the	K 0511	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – In the southwest exit stairwell from assisted living there were some exposed wires where the cover was missing from a ventilation unit. The large ventilation cover was reinstalled, and wires were covered. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Southwest Exit Stairwell, a large ventilation cover was missing and multiple wires were exposed. The Maintenance Director stated that the apparatus was being repaired. The cover was outside the facility on the sidewalk. 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)		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.** This is a permanent fix to this issue so no follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects these doors annually during the door audit. **V. Plan of Correction completion date.** Plan of Completion date is July 10th, 2023	
K 0741 SS=F Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect everyone. Findings include: 1. Based on observations and interview during a 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., smoking on the property was evident in Resident Room 1211. Cigarette smoke was smelled in the corridor outside the room with door closed. As the room was entered there was overwhelming and fresh smell of burnt cigarettes. The Corporate Support Representative acknowledged that clearly the resident had been smoking in the room.	K 0741	**. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to enforce the campus smoking policy. Observation 2 – The cigarettes butts in the grass and near the side walk, near the west exit were picked up and the area was cleaned. Assisted Living residents educated about the facility's smoking policy.	07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Based on observations and interview during a 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., smoking on the property was evident due to 25 plus cigarette butts in the grass and near the sidewalk near the West exit. Based on records review the smoking policy stated smoking is not allowed on the facility's property and no designated smoking area was provided. These findings were 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)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the 1200 Hall have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new weekly TELS task created for the Maintenance Supervisor or designee to walk the 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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 02 B. WING	06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Plan of Completion date is July 10th, 2023	