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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02			(X3) DATE SURVEY COMPLETED	
		155196	B. WING _			1	R / 04/2023
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY				3	STREET ADDRESS, CITY, STATE, ZIP CODE S525 E HANNA AVE NDIANAPOLIS, IN 46237	1 08/	04/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 0	00}			
{K 000}	Preparedness Survey conducted by the Indiaccordance with 42 (Survey Date: 08/04/2) Facility Number: 000 Provider Number: 18 AIM Number: 10029 At this PSR Emerger Altenheim Health and found in compliance Preparedness Requi Medicaid Participatin 42 CFR 483.73. The facility has 87 cethe PSR survey, the Quality Review compliance Of Post Survey Revist Code Recertification conducted on 06/22/2 Indiana Department 42 CFR 483.90(a). Survey Date: 08/04/2	23 21003 25196 20000 210	{K 0	000}			
	Facility Number: 000 Provider Number: 15 AIM Number: 10029	55196					
	At this PSR Life Safe	ty Code survey, Altenheim					
AROBATORY	NIPECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		155196	B. WING			R 08/04/2023	
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZI 3525 E HANNA AVE INDIANAPOLIS, IN 46237	IP CODE	06/04/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{K 000}	Health and Living Co compliance with Requivers Medicare/Medicaid, 4 Life Safety from Fire National Fire Protectic Life Safety Code (LS) Health Care Occupar This facility consists of the first floor of a the basement and was do (222) construction and facility has a fire alarm detection on all levels areas open to the condetectors hard wired system in the A, B and residential wings of the surveyed due to lack Building 02 consists of Rehabilitation Wings of the determined to be of The was fully sprinklered. has a fire alarm system in residential wings of the corridors, in all are has smoke detectors system in resident sletch has a capacity of 87 at the time of this PSR standards. All areas where resid were sprinklered. All services were sprinklered. All services were sprinklered.	mmunity was found in uirements for Participation in 12 CFR Subpart 483.90(a), and the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19, Existing acies and 410 IAC 16.2. If Building 01 and Building sts of the A, B and C wings are story building with a etermined to be of Type II d was fully sprinklered. The m system with smoke in the corridors and in all ridor. The facility has smoke to the building electrical d C wings. The two are first floor were also of 2 hour separation. Of the one story constructed in 2014 and was type V (111) construction and The Rehabilitation Wing are with smoke detection in eas open to the corridor and hard wired to the fire alarm deping rooms. The facility and had a census of 70 at survey. The survey are also of 2 are survey.	{K 0	00)			
{K 000}	Quality Review comp INITIAL COMMENTS		{K 0	00}			

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		155196	B. WING				R 04/2023
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			1	3	TREET ADDRESS, CITY, STATE, ZIP CODE 525 E HANNA AVE NDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{K 000}	Code Recertification conducted on 06/22/2 Indiana Department of 42 CFR 483.90(a). Survey Date: 08/04/2 Facility Number: 000 Provider Number: 15 AIM Number: 10029 At this PSR Life Safe Health and Living Co compliance with Req Medicare/Medicaid, 4 Life Safety from Fire National Fire Protecti Life Safety Code (LS Health Care Occupar This facility consists of 12 Building 01 consi of the first floor of a the basement and was do (222) construction and facility has a fire alarm detection on all levels areas open to the condetectors hard wired system in the A, B and residential wings of the surveyed due to lack Building 02 consists of Rehabilitation Wing of the surveyed due to lack Building 02 consists of Rehabilitation Wing of the surveyed due to lack Building 03 consists of Rehabilitation Wing of the surveyed due to lack Building 04 consists of Rehabilitation Wing of the surveyed due to lack Building 05 consists of Rehabilitation Wing of the surveyed due to lack Building of the surveyed due to lack	and State Licensure Survey 23 was conducted by the of Health in accordance with 23 2103 255196 20000 25ty Code survey, Altenheim mmunity was found in uirements for Participation in 42 CFR Subpart 483.90(a), and the 2012 Edition of the ion Association (NFPA) 101, C), Chapter 19, Existing ncies and 410 IAC 16.2. 25th Building 01 and Building sts of the A, B and C wings hree story building with a etermined to be of Type II and was fully sprinklered. The am system with smoke as in the corridors and in all arridor. The facility has smoke to the building electrical and C wings. The two ane first floor were also of 2 hour separation.	{K C	000}			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
{K 000}	has smoke detectors system in resident sle has a capacity of 87 the time of this PSR	hard wired to the fire alarm eeping rooms. The facility and had a census of 70 at survey. dents have customary access I areas providing facility lered.	{K 0	00)				