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	01/13/2020

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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/13/20 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Emergency Preparedness survey, Altenheim Health and Living Community was found 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 83. Quality Review completed on 01/16/20	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/13/20 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health	K 0000		

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

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	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 facility has a capacity of 87 and had a census of 83 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 01/16/20			
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour			

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	fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 1 of 6 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, the stairwell door to the basement on the first floor by the facility exit with the fabric canopy was equipped with a self closing device but the door failed to fully self close and latch into the door frame when tested to close multiple times. The stairwell door was equipped with a 90 minute fire resistance rating label. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned stairwell door failed to self close and latch into the door frame to enclose the vertical opening with a minimum 1-hour fire resistance rating. 3.1-19(b)	K 0311	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The facility failed to ensure that the door leading to the basement near the employee entrance failed to latch. The Maintenance Supervisor has adjusted the door closure and latch. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents that use this exit 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 currently a TELS Task in place to inspect fire and exit doors. (See attached tasked label door inspections) **IV The facility will monitor the corrective action by**	01/30/2020

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			implementing the following measures. CarDon Corporate Facilities will inspect all fires doors during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
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 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			

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	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 1 of over 11 hazardous areas such as trash collection rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, a three inch gap was noted in between the corridor door to the kitchen and the door frame on the door handle side of the door when the door was tested to self close multiple times. The door was equipped with a self closing device but the door failed to self close due to air flowing through the opening. In addition, a metal cover installed vertically over the entire face of the door on the hinge side of the door in the kitchen extended above the door and gouged the ceiling drywall cutting a one half deep gouge which also served to aid in preventing the door from fully self closing. The kitchen contained three partially filled 30 gallon trash carts. Based on interview at the time of the observations, the Maintenance Director stated the door would self close if the kitchen range hood fan was not in operation, the cover plate for the hinges needed to be cut off where it extends	K 0321	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1 – Facility failed to ensure that the door from the corridor to the kitchen would shut and latch properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Kitchen employees could 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 currently a TELS Task in place to inspect fire and exit doors. (See attached tasked label door inspections **IV The facility will monitor**	01/30/2020

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	above the door and agreed the corridor door to the kitchen would not self close when tested to close multiple times due to air flowing through the opening. 3.1-19(b)		**the corrective action by implementing the following measures.** The Corporate Facilities Staff will audit these types of doors and areas during their quarterly inspections. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient**	01/30/2020

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	Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, the following was noted: a. a white data cable was affixed with data cables to a 10 foot length of horizontal sprinkler piping above the transfer switches in the emergency generator room in the basement. b. a fluorescent lighting fixture was hung with chains affixed to a horizontal sprinkler pipe in the Mechanical Room for air handling equipment in the basement. c. three cables were resting on a horizontal sprinkler pipe in the Mechanical Room for air handling equipment in the basement. The cables were next the a fluorescent lighting fixture also hung from the sprinkler pipe. Based on interview at the time of the observations, the Director of Maintenance agreed the sprinkler piping was used to support non-system components at the aforementioned three locations. 3.1-19(b)		**practice.** Observation A- A white data cable was attached to a piece of vertical sprinkler pipe in the generator room. Observation B- A fluorescent lights was hung with chain from a sprinkler pipe. Observation C- Three cables were resting on the sprinkler pipe in the basement mechanical room. The Maintenance Supervisor has worked with CarDon IT to have these wires relocated. He has also re mounted the light fixture from the ceiling. (See attached Pictures) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could 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 Supervisor has been re educated on what to look for during building inspections.	

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			IV The facility will monitor the corrective action by implementing the following measures. The Maintenance Supervisor and Corporate Facilities Staff will ensure that all sprinkler heads meet NFPA 25 testing requirements. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 53 portable fire extinguishers was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the	K 0355	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- Facility failed to ensure that the fire extinguisher in located in the AL Med Storage was inspected monthly. The Maintenance Supervisor has noted inspections for each month. See attached pic of the fire extinguisher tag.	01/30/2020

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	manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the AL Med Storage Room by the elevator on the first floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, the portable fire extinguisher located in the AL Med Storage Room by the elevator on the first floor had an affixed maintenance tag which did not document a monthly inspection after May 2019. The affixed maintenance stated documented the annual fire extinguisher inspection was conducted by a contractor in January 2019. Based on interview at the time of the observations, the Director of Maintenance agreed monthly inspection documentation after May 2019 for the portable fire extinguisher was not available for review. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and staff in the Assisted Living area could 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 current TELS task for the inspection of the fire extinguishers. See Attached Tels Task **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all fire extinguishers during their annual Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 2 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Social Services Office near the B Hall Dining Room. Findings include: Based on observations with the Director of	K 0372	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- There was a ¾' hole in the wall above the electrical panel in the Social Services Office on B Hall. The Maintenance Supervisor has repaired the hole. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the B Hall have the potential to be affected by this deficient practice.	01/30/2020

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	Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, a three quarter inch in diameter hole was noted above the wall mounted electrical panel identified as "1-D" in the closet of the Social Services Office neat the B Hall Dining Room which was not firestopped. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned opening in the ceiling was not protected to maintain the fire resistance rating of the ceiling smoke barrier. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been reeducated on the proper way to inspect a building, communicating with vendors that they need to fill any hole they make, and the proper material to fill the hole with. **IV The facility will monitor the corrective action by implementing the following measures.** A current TELS task is in place for every 6 months to inspect fire walls. See attached Tels Task. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
K 0521 SS=D Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility	K 0521	**I. The corrective actions to be**	01/30/2020

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	failed to ensure 1 of 34 smoke dampers in the facility could close to maintain the one half hour fire fire resistance rating of the smoke barrier. LSC 9.2 requires air conditioning, heating, ventilation ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.5.1 states all fire dampers shall close automatically. This deficient practice could affect over 2 staff and visitors in the vicinity of the Maintenance Office in the basement. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, one fire damper was installed in the smoke barrier wall in the Maintenance Office in the basement above the corridor door to the room. The aforementioned fire damper shutter was in the fully open position with two blue data cables passing through the open fire damper which prevented the damper from fully closing. Based on interview at the time of observation, the Director of Maintenance agreed the data cables provided an impediment to the fire damper closing. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The building failed to ensure that all fire dampers we in the fully opened position without obstruction. The Maintenance Supervisor worked with CarDon IT to remove the data wires from the damper. See attached picture showing the wires removed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could 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.** Maintenance Staff has been reeducated on the proper way to inspect fire dampers to ensure the open and close freely. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			CarDon Corporate Facilities will audit all fire dampers during their annual Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
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			

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	01/13/2020

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

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	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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel fuel fired generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance from 8:30 a.m. to 11:25 a.m. on 01/13/20, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and stated documentation of an annual fuel quality test for diesel fuel within the most recent twelve month period was not available for review at the time of the survey.	K 0918	**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 the annual fuel quality test for the generator was completed in the last 12 months. MaCalister has been contracted to do the annual fuel samples. We have requested documentation and will upload once received. Observation 2- The community failed to ensure that the annual 4 hour load bank test for the generator was completed in the last 36 months. The test was completed on January 15th, 2020. See attached report from MaCalister Power Systems. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could be	01/30/2020

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	3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance from 8:30 a.m. to 11:25 a.m. on 01/13/20, documentation of a four hour load test conducted within the most recent 36 month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed four hour load testing documentation conducted within the the past 36 months was not available for review at the time of the survey. 3.1-19(b)		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 current Tels Task has been updated to include the diesel fuel samplings every year. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor and Corporate Facilities Staff will review the inspection process during the yearly Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container			

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	Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			

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	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage and transfilling rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over twenty residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the B Hall Dining Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, three of nine 'E' type oxygen cylinders were freestanding on the floor inside the oxygen storage and transfilling room by the B Hall Dining Room and were not supported in a proper cylinder stand or otherwise secured from falling. The oxygen storage and transfilling room had 6 liquid oxygen containers and 9 'E' type oxygen cylinders stored in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling. 3.1-19(b)	K 0923	**K 923** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- the facility failed to ensure cylinders of nonflammable gasses such as oxygen were properly secured from falling. The maintenance director secured all cylinders appropriately to ensure they could not fall. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could 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.** Maintenance and Nursing staff have been reeducated on the proper way to secure oxygen so it cannot fall. **IV The facility will monitor the corrective action by implementing the following measures.**	01/30/2020

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			A current TELS task is in place monthly to ensure oxygen cylinders are stored and secured properly. See attached Tels Task. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/13/20 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 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	K 0000	January 30, 2020 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: ODMH21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on January 13, 2020. 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	

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	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 83 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.		on January 30,2020. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-885-7050 Sincerely, Megan White, 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.	

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K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 1:40 p.m. on 01/13/20, a white data cable was affixed with data cables to a 10 foot	K 0353	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- A white data cable was attached to a piece of vertical sprinkler pipe in the generator room. Observation B- A fluorescent lights was hung with chain from a sprinkler pipe. Observation C- Three cables were resting on the sprinkler pipe in the basement mechanical room.	01/30/2020

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	length of horizontal sprinkler piping above the transfer switches in the emergency generator room in the basement of Building 01. Based on interview at the time of the observations, the Director of Maintenance agreed the sprinkler piping was used to support non-system components at the aforementioned location. 3.1-19(b)		The Maintenance Supervisor has worked with CarDon IT to have these wires relocated. He has also re mounted the light fixture from the ceiling. (See attached Pictures) **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could 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 Supervisor has been re educated on what to look for during building inspections. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor and Corporate Facilities Staff will ensure that all sprinkler heads meet NFPA 25 testing requirements. **V. Plan of Correction completion date.**	

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K 0918 SS=F Bldg. 02	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 January 30, 2020.	

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	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel fuel fired generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance from 8:30 a.m. to 11:25 a.m. on 01/13/20, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and stated documentation of an annual fuel quality test for diesel fuel within the most recent twelve month period was not available for review at the time of the survey. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power	K 0918	**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 the annual fuel quality test for the generator was completed in the last 12 months. MaCalister has been contracted to do the annual fuel samples. We have requested documentation and will upload once received. Observation 2- The community failed to ensure that the annual 4 hour load bank test for the generator was completed in the last 36 months. The test was completed on January 15th, 2020. See attached report from MaCalister Power Systems. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the**	01/30/2020

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	Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance from 8:30 a.m. to 11:25 a.m. on 01/13/20, documentation of a four hour load test conducted within the most recent 36 month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed four hour load testing documentation conducted within the the past 36 months was not available for review at the time of the survey. 3.1-19(b)		**deficient practice does not recur.** The current Tels Task has been updated to include the diesel fuel samplings every year. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor and Corporate Facilities Staff will review the inspection process during the yearly Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is January 30, 2020.	