STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00384239, IN00383057, IN00383773, IN00383966, and IN00384646. This visit included a State Residential Licensure Survey. Complaint IN00384239 - Unsubstantiated due to lack of evidence. Complaint IN00383057 - Substantiated. Federal/State deficiencies related to the allegations were cited at F656. Complaint IN00383773 - Substantiated. Federal/State deficiencies related to the allegations were cited at F925. Complaint IN00383966 - Substantiated. Federal/State deficiencies related to the allegations were cited at F925. Complaint IN00384646 - Unsubstantiated due to lack of evidence. Survey dates: July 6, 7, 8, 11, 12, 13, and 14, 2022 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Census Bed Type: SNF/NF: 56 SNF: 14 Residential: 52 Total: 122	F 0000	The plan of correction is to serve as Alteheim Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living's or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request desk review. Compliance date - 8/5/2022	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	Census Payor Type: Medicare: 14 Medicaid: 43 Other: 13 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 19, 2022.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to implement the plan of care for 1 of 7 residents reviewed for pressure ulcers. A physician's order for specialized cushion was not followed. (Resident B) Findings include: On 7/8/22 at 3:05 p.m., observed Resident B's powerchair. A "spectrum foam" cushion was observed on the seat portion of the powerchair. No other powerchair cushion was visible. The clinical record for Resident B was reviewed on 7/8/22 at 9:51 a.m. The diagnosis included, but was not limited to, diabetes mellitus with other circulatory complications. The Quarterly MDS (Minimum Data Set) assessment, dated 6/22/22, indicated Resident B was at risk of developing a pressure ulcer. The care plan, initially dated 3/31/21, updated on	F 0656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B has received the specialized cushion. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with physician orders for specialized cushions have the potential to be affected by the alleged deficient practice and have been audited to ensure specialized cushions are in place or have been ordered. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	7/6/22, and valid through 10/6/22, indicated "Resident is at risk of skin breakdown R/T [related to]: pain, incontinence, DM [diabetes mellitus], debility, noncompliance with preventative interventions such as ted hose and turning/repositioning and hoyer lifts for transfers..." Nursing progress notes, titled "Wound Rounds," indicated: -On 6/30/22 at 9:00 a.m., "...resident seen at this time...wounds evaluated...all areas epithelialized [restoration of damaged skin] and discharged from wound services. Due to high risk of recurrence r/t [related to] compliance inconsistency to recommendation of not sitting for extended periods...Gel or Roho cushion [specialized pressure redistribution cushion designed to prevent and decrease the development of pressure ulcers] to powerchair for pressure reduction..." On 6/23/22 at 9:00 a.m., the Wound Physician documented the following: "plan ...upgrade powerchair cushion to gel or Roho...upgrade powerchair cushion for improved pressure redistribution..." On 6/30/22 at 9:00 a.m., the Wound Physician documented the following: "plan...upgrade powerchair cushion to gel or Roho...areas are resolved; due to inconsistency of offloading compliance, recurrence is likely..." On 7/8/22 at 3:30 p.m., the DNS (Director of Nursing Services) provided a copy of the EquaGel Straight Comfort Wheelchair Equal Pressure GL 56000-31-520 cushion purchase order. A review of the purchase order indicated the cushion was ordered on 7/7/22 at 3:17 p.m. During an interview		recur? Nurse managers were educated regarding following physicians orders. Wound notes/orders will be reviewed during clinical stand up to ensure specialized cushions are provided per physician orders. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit wound physician orders to ensure specialized cushions are provided per order. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of compliance: 8/05/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	with the DNS at that time, the "spectrum foam" cushion observed on Resident B's powerchair was the one that came with the chair and was not the one ordered by the Physician. The Wound Physician's order for the gel cushion was "just ordered yesterday [7/7/22]." On 7/12/22 at 11:10 a.m., the Corporate Clinical Specialist provided a copy of the Protocol for Following Physician Orders policy, dated 4/3/17, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...we will provide the appropriate physician prescribed care to residents in our communities...all licensed staff will verify and follow the physician orders written..." This Federal tag relates to Complaint IN00383057. 3.1-35(g)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to provide the appropriate treatment and services for a resident with a history of UTIs (urinary tract infections) in a timely manner. The facility failed to obtain the collection of a STAT (immediate) urine sample as ordered for a UA (urinalysis) for 1 of 2 residents reviewed for UTIs (urinary tract infections). (Resident 46) Finding includes: On 7/7/22 at 11:50 A.M., Resident 46's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 6/16/22, indicated Resident 46 was cognitively intact. Resident 46's diagnoses included, but were not limited to, UTI, acute kidney failure, and end stage renal disease with dependence on renal dialysis. On 7/8/22 at 2:00 P.M., a new physician's order was noted for Resident 46, a review of the order	F 0690	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 46 urine was collected and sent to lab on 7/11/2022. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with stat UA orders have the potential to be affected by the alleged deficient practice and have been audited to ensure urine is collected and sent to lab timely. 3. What measures will be put into place and what systematic changes will be made to ensure	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	indicated, "Please collect urine sample STAT [immediate] for lab pick up. I&O [in and out catheterization by means of a one time non-anchored catheter] cath only. Special instructions: May d/c [discontinue] order once collected." The order stated the start date was 7/8/22 and the time the order was created and verified was 12:37 P.M. On 7/11/22 at 9:15 A.M., Resident 46's electronic medication administration record (eMAR) indicated that a STAT I and O catheterization order was still an active order. The clinical record lacked documentation that a urine sample had been obtained or that the NP (Nurse Practitioner) or MD had been notified. During an interview on 7/11/22 at 9:30 A.M., LPN 1 indicated that she did not know of any current lab orders pending for Resident 46. LPN 1 then checked the eMAR upon being queried and noted that Resident 46 had a pending UA order. LPN 1 then indicated it was a STAT order when she was queried again. LPN 1 stated that as a STAT lab, the collection of the urine sample should be attempted immediately and that she would try once Resident 46 was back from hemodialysis. On 7/111/22 at 10:30 A.M., Resident 46's clinical record was reviewed. The progress notes included, but was not limited to: -7/10/22 at 11:05 A.M., a nursing progress note indicated that I and O catheterization for Resident 46 had been attempted but nurse was "...unable to obtain due to thick mucous in catheter. Encouraged fluids." -7/11/22 at 9:40 A.M., a nursing progress note indicated that "Stat urine unable to be obtained. NP notified. keep order and try after returning from dialysis[.]"		that the deficient practice does not recur? Licensed nurses were educated regarding collecting urine STAT urine specimen as ordered using the policy on diagnostic services. Education with be provided upon hire and annually. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit STAT urinalysis orders to ensure timely collection. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 8/05/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	-7/11/22 at 10:06 A.M., a progress note from the nurse practitioner stated "Writer made aware that staff was unable to obtain urine sample due to HD [hemodialysis] and low urine output. Will order STAT CBC [complete blood count, which monitors hemoglobin, white blood cell count, etc.] for comparison until urine is able to be obtained." On 7/12/22 at 2:35 P.M., the DON provided a urinalysis result, dated 7/12/22, which indicated that Resident 46 was positive for a UTI. During an interview on 7/11/22 at 9:57 A.M., the DON indicated that the expected time frame for blood draws ordered as STAT should be completed within four hours and that for a UA it would depend on whether it was ordered I and O catheterization or clean catch but that it should be obtained "as quickly as possible." On 7/11/22 at 12:35 P.M., the DON provided a policy titled Diagnostic Services, dated 6/6/19, and indicated it was the policy currently in use. The policy stated that "...8. Orders for diagnostic services will be promptly carried out as instructed by the physician's order. 9. Emergency requests must be labeled "STAT" to assure that prompt action is taken." 3.1-41(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	Based on interview and record review, the facility failed to perform dialysis assessments for 1 of 2 residents reviewed for dialysis. Pre and Post Dialysis assessments were not completed. (Resident 46) Finding includes: On 7/7/22 at 11:50 A.M., Resident 46's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 6/16/22, indicated Resident 46 was cognitively intact. Resident 46's diagnoses included, but were not limited to, acute kidney failure and end stage renal disease with dependence on renal dialysis. Resident 46 received dialysis treatment three days a week (Monday, Wednesday, and Friday). The Physician's Orders included, but were not limited to: - Complete the Pre Dialysis Assessment observation before treatment on Mondays, Wednesdays, and Friday, ordered on 4/13/22. - Complete the Post Dialysis Assessment observation after treatment on Mondays, Wednesdays, and Fridays, ordered on 4/13/22. On 7/12/22 at 1:15 P.M., Resident 46's pre and post dialysis assessments were reviewed. The following assessments were missing: -4/15/22 (Friday) the clinical record lacked a Post Dialysis Assessment. -4/22/22 (Friday) the clinical record lacked a Post Dialysis Assessment. -5/6/22 (Friday) the clinical record lacked a Post Dialysis Assessment. -5/9/22 (Monday) the clinical record lacked a Post Dialysis Assessment. -5/11/22 (Wednesday) the clinical record lacked a	F 0698	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 46 has had a dialysis assessment with no concerns noted. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with who require hemodialysis have the potential to be affected by the alleged deficient practice and have been audited to ensure dialysis assessments are completed before and after dialysis. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were educated regarding completing pre and post dialysis assessments using the hemodialysis policy. Education with be provided upon hire and annually. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit 5 random residents to ensure pre and post dialysis assessments are completed. Audits will occur	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	Pre and Post Dialysis Assessment. -5/13/22 (Friday) the clinical record lacked a Pre and Post Dialysis Assessment. -5/16/22 (Monday) the clinical record lacked a Pre and Post Dialysis Assessment. -5/18/22 (Wednesday) the clinical record lacked a Pre and Post Dialysis Assessment. -5/20/22 (Friday) the clinical record lacked a Pre and Post Dialysis Assessment. -5/23/22 (Monday) the clinical record lacked a Post Dialysis Assessment. -5/30/22 (Monday) the clinical record lacked a Post Dialysis Assessment. -6/24/22 (Friday) the clinical record lacked a Post Dialysis Assessment. -6/29/22 (Wednesday) the clinical record lacked a Pre Dialysis Assessment. -7/1/22 (Friday) the clinical record lacked a Pre and Post Dialysis Assessment. -7/6/22 (Wednesday) the clinical record lacked a Pre and Post Dialysis Assessment. -7/8/22 (Friday) the clinical record lacked a Post Dialysis Assessment. -7/11/22 (Monday) the clinical record lacked a Post Dialysis Assessment. During an interview on 7/11/22 at 9:57 A.M., the DON indicated that some Pre and Post Dialysis assessments were missing from Resident 46's clinical record and that they should have been completed. On 7/11/22 at 12:27 P.M., a policy titled Hemodialysis Policy dated 6/4/19 was provided by the Regional Director of Operations; she indicated that this was the policy currently in use. The policy stated that staff caring for residents with ESRD (end-stage renal disease), including residents who are receiving dialysis care shall "...4. Complete a pre- and post- dialysis		daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 8/05/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	assessment." 3.1-37(a)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure food was stored in a sanitary manner for 1 of 2 observations of the resident's snack refrigerator. Food items were not discarded by the manufacturer's pre-printed use by date and the food items lacked a label to indicate whom the items belonged to. (Rehabilitation Unit) Findings include:	F 0812	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Rehabilitation Unit pantry has been audited to ensure resident food items have been discarded by the manufacturer's pre-printed use by date and are labeled with residents' names.	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	On 7/6/22 at 10:50 a.m., during the initial facility tour with the Dietary Manager (DM), observed the Rehabilitation Unit resident snack refrigerator, located behind the nurses station. Inside the resident snack refrigerator, the following food items were observed: - One unopened 8 ounce bottle of Novasource Renal and the manufacturer's pre-printed "best by - 7/1/22" date, located near the top of the bottle, was visible. The bottle lacked a resident's name to identify to whom it belonged and was past the manufacturer's use by date. - Three unopened 8 ounce bottles of Nepro with carb steady therapeutic nutrition and the manufacturer's pre-printed "best by - 7/1/22" date, located near the top of each bottle, was visible. The bottles lacked a resident's name to identify to whom it belonged and was past the manufacturer's use by date. During an interview at that time, the DM indicated the resident snack refrigerator was for resident food items only and all were to be labeled to indicate to whom the items belonged. All food items were to be monitored and discarded when past the use by date. The Rehabilitation Unit resident snack refrigerator was available for residents residing on that unit. On 7/6/22 at 2:13 p.m., the Corporate Dietary Consultant provided a copy of the Use and Storage of Food/Beverage Brought in for Residents policy, dated 1/30/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the food procurement, storage, handling, serving and consumption policies and practices required by		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who store and/or receive food items from the Rehabilitation Unit have the potential to be affected by the alleged deficient practice and have been audited to ensure food items are discarded by the manufacturers pre-printed use by date and are labelled with residents' names. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Nurse managers were educated regarding checking the pantries to ensure food items are discarded by the manufacturers pre-printed use by date and are labeled with residents' names. Education with be provided upon hire and annually. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit the pantries to ensure food items are discarded by the manufacturers pre-printed date and are labeled with residents' names. Audits will occur daily x 30 days, weekly x	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	local, state, and federal regulation are followed by CarDon Community...Members of Community staff will be designated to check resident refrigerators for proper temperatures, food containment and quality, and timely disposal of food and beverages per this policy...foods requiring refrigeration will be received by the charge nurse for labeling, dating and storage...staff will examine food for quality (packaging, appearance) to identify any potential concerns..." On 7/8/22 at 2:00 p.m., a review of the retail Food Establishment Sanitation Requirements Title 10 IAC 7-24, effective November 13, 2004, indicated "...may not exceed a manufacturer's use by date..." On 7/8/22 at 3:00 p.m., a review of the retail Food Establishment Sanitation Requirements Title 10 IAC 7-24, effective November 13, 2004, indicated "...refrigerated, ready to eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded..." 3.1-21(i)(2) 3.1-21(i)(3)		12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 8/05/2022	
F 0814 SS=E Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the area surrounding the dumpster containers were free of rubbish and all dumpster containers were kept closed when not in use for 1 of 2 observations.	F 0814	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The area surrounding the	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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: On 7/6/22 from 10:40 a.m. to 10:45 a.m., during the initial facility tour with the Dietary Manager (DM), observed the dumpster area, located adjacent to and near the kitchen's back door. The following was observed: 1. The compactor (dumpster machine) door was observed to not be closed. Inside the compactor, multiple filled trash bags were visible. No staff were visible in the area at that time. 2. The grease dumpster was located next to the compactor. The grease dumpster was approximately ¼ full of used grease and the lid was observed to not be closed. No staff were visible in the area at that time. 3. The following debris was observed surrounding the compactor and grease dumpster containers: multiple used plastic gloves; two soiled incontinent products; Hoosier scratch off lottery tickets; multiple cigarette butts; plastic bags; and partially filled plastic trash bags. No staff were visible in the area at that time. 4. The cardboard recycle dumpster unit was approximately 20 feet from the compactor and grease dumpster area. The cardboard recycle dumpster was observed to have 2 separate top loading lids. The lid on the right side of the dumpster was observed to not be closed and inside the dumpster were multiple cardboard boxes. No staff were visible in the area at that time. During an interview at that time, the DM indicated the doors and lids for each dumpster container		dumpster containers were cleaned during the survey and all dumpster containers were kept closed when not in use. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice but have remained unaffected. There are no other dumpster container areas. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Maintenance associates were educated to ensure the area surrounding the dumpster container is free of rubbish and kept closed when not in use. Education with be provided upon hire and annually. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Administrator or designee will audit the area surrounding the dumpster containers to ensure area is free of rubbish and kept closed when not in use. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	was to be kept closed when not in use. The area surrounding the dumpster's were to be kept clean and free of debris. On 7/7/22 at 2:06 p.m., the Corporate Dietary Consultant provided a copy of the Environmental Sanitation/Infection Control policy, dated 2012, and indicated it was the current policy in use by the facility. A review of the document indicated, "...trash and refuse is kept in a secure area to avoid infestation from pests and animals...all trash bags are leak-proof and are securely closed to avoid any spillage...all trash bags are placed in a dumpster or large receptacle...no trash bags are left on the ground...the dumpster lid is closed after the trash bag is deposited..." On 7/8/22 at 10:00 a.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..." 3.1-21(i)(2) 3.1-21(i)(5)		months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of compliance: 8/05/2022	
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of insects in 1 of 2 halls observed for pests. (Hall A)	F 0925	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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: During an interview on 7/6/22 at 10:15 a.m., Resident J indicated she had seen ants and gnats in her bathroom. On 7/11/22 at 1:25 p.m., the clinical record of Resident J was reviewed. The diagnoses included, but were not limited to, need for assistance with personal care, bipolar disorder, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 6/1/22, indicated Resident J was cognitively intact. During an observation on 7/6/22 from 11:00 a.m. to 11:15 a.m., observed Hall A, a minimum of 40 flying ants at the end of Hall A on the floor near the exit door, across from Room 1085. Some of the flying ants were observed to be alive, while most were not observed to be moving. During an observation on 7/7/22 at 10:33 a.m., observed Hall A a minimum of 40 flying ants on the floor, in the hall next to the exit door in front of Room 1085, Room 1082, and Room 1080. Some of the flying ants were observed to be alive and some of them were observed to not be moving. During an observation on 7/8/22 at 9:00 a.m., observed Hall A a minimum of 20 flying ants on the floor, in the hall next to the exit door across from Room 1085. All of the flying ants were observed to not be moving. During an interview on 7/7/22 at 11:00 a.m., the facility pest control personal indicated the insects on the Hall A floor, were flying ants.		Outside pest control company provided pest control services on A hall during the survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient. All halls/resident areas were checked for insects/pests and no other areas were found to be affected. There were no other residents affected. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Maintenance associates were educated to ensure the facility is free of insects/pests by using the outside pest control service at least monthly and as needed. Education with be provided upon hire and annually. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Administrator or designee will audit through direct observation of the resident areas to ensure the facility is free of insects/pests. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	During an interview on 7/8/22 at 10:22 a.m., the Director of Nursing indicated she was unaware of the flying ants in Hall A. Work orders, dated January 1, 2022 - July 10, 2022, indicated the following: Work order: #14808, undated, indicated ants were in Room 1098. Work order: #14816, undated, indicated Room 1147 needed to be sprayed for ants. Work order: #14817, undated, indicated Room 1134 had bugs everywhere. Work order: #14530, undated, indicated ants were in most rooms and hallway, A and B wing. Work order: #14535, undated, indicated ants were on floor and on the wall in Room 1114 Work order: #14525, undated, indicated ants were coming in under PTAC (heating and cooling) unit in Room 1098. Work order: #14641, undated, indicated ants were in Room 1222. Work order: #14652, undated, indicated ants were all over, Room 1079 Work order: #14653, undated, indicated ants were all over Room 1098 Work order: #14478, undated, indicated Room 1319 had ants, resident wanted traps. On 7/11/22 at 12:55 p.m., the Director of Nursing provided a policy titled: Homelike Environment, dated August 2009, and indicated it was the current policy being used by the facility. A review of the policy indicated "...2. the facility staff and management shall maximize, to the extent possible the characteristics of the facility that reflect a personalized homelike setting. These characteristics include, a. cleanliness and order."		for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5. Date of compliance: 8/05/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	This Federal tag relates to Complaints IN00383966 and IN00383773. 3.1-19(f)(4)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00384239, IN00383057, IN00383773, IN00383966, and IN00384646. Complaint IN00384239 - Unsubstantiated due to lack of evidence. Complaint IN00383057 - Substantiated. Federal/State deficiencies related to the allegations were cited at F656. Complaint IN00383773 - Substantiated. Federal/State deficiencies related to the allegations were cited at F925. Complaint IN00383966 - Substantiated. Federal/State deficiencies related to the allegations were cited at F925. Complaint IN00384646 - Unsubstantiated due to lack of evidence. Survey dates: July 6, 7, 8, 11, 12, 13, and 14, 2022 Facility number: 000103 Residential Census: 52 This State Residential Finding is cited in	R 0000	The plan of correction is to serve as Alteheim Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living's or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request desk review. Compliance date - 8/5/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	accordance with 410 IAC 16.2-5.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted monthly on each shift for 7 of 12 months reviewed. Findings include: On 7/12/22 at 1:22 p.m., the facility fire drill reports were reviewed. The facility fire drill reports lacked documentation that a fire drill was conducted in November, and	R 0092	**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The facilty has ensured fire drill have been conducted and documented within the last 30 days. **II. The facility will identify**	08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
	December 2021 and January, February, March, April and May of 2022. The facility was unable to provide any other documentation of fire drills conducted by the facility in the last year. During an interview on 7/13/22 at 10:00 a.m., the Director of Nursing indicated the facility did not have documentation of a fire and disaster drill that should have been conducted. On 7/13/22 at 9:30 a.m., the Director of Nursing indicated the facility did not have a fire drill policy, that indicated the frequency of fire drills.		**other residents that may potentially be affected by the practice.** Residents residing in the facility have the potential to be affected by the alleged deficient practice but have remained unaffected. Fire drills are conducted and documented on each shift prior to date of complaince **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Maintenance educated on fire drill requirements to be conducted and documented quarterly on each shift and at least twelve drills yearly. **IV. The facility will monitor the corrective action by implementing the following measures.** Administrator or designee will audit fire drills are conducted per guidance frequency of quarterly on each shift and at least twelve drill yearly. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months The results of these reviews will be discussed at the monthly facility Quality Assurance Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	07/14/2022

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
			meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance 8/5/22 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	