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	08/15/2022

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/15/22 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Emergency Preparedness survey, Altenheim Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 87 certified beds. At the time of the survey, the census was 82. Quality Review completed on 08/22/22	E 0000	August 31, 2022 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: RZD621 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 15, 2022. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance. We allege substantial compliance on Sept 1, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-919-1500. Sincerely, Chirag Patel, HFA	

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

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			Administrator Altenheim Health and Living Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information			

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	§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility	E 0031	**E 031**	09/02/2022

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	failed to ensure the emergency preparedness communication plan includes contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with Corporate Support personnel and the Maintenance Director on 08/15/22 between 10:25 a.m. and 1:45 p.m., the provided emergency preparedness communication plan failed to include contact information for The Office of the State Long-Term Care Ombudsman. Based on interview at the time of record review, the Corporate Support personnel confirmed the contact information for the Office of the State Long-Term Care Ombudsman could not be located in the Emergency Preparedness plan. This finding was reviewed with the Corporate Support personnel and Maintenance Director at the exit conference.		**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Emergency Preparedness Plan included to the contact information for the State Long-Term Care Ombudsman. The Administrator has updated the contact sheet in the EP Binder to include the Ombudsman. See attached EER sheet showing their information at the bottom. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Administrator and Maintenance Supervisor will review all contacts to ensure they are correct during the Emergency	

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			Preparedness Program annual review. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will also review this information during their annual Corporate Quality Review. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:			

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	(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:			

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	(i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation			

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	of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in			

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	its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise			

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	that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is			

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	community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual,			

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	facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The			

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	RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed	E 0039	**E 039** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Emergency Preparedness Plan included an annual full-scale community-based exercise during the last 12 months. There was no exercise at the beginning of 2022. A full-scale tornado exercise was conducted on 9/1/2022 with in the community. Jason Oskay, CarDon Facilities was the outside observer of this exercise. See attached exercise summary, after action reports, in-services. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	09/02/2022

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	155196	A. BUILDING -- B. WING	08/15/2022

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the Emergency Preparedness Plan on 08/15/22 from 10:25 a.m. to 1:25 p.m. with the Corporate Support personnel and the Maintenance Director, documentation of a community based disaster drill within the most recent twelve month period was not available for review. Documentation of a tabletop exercise dated 10/28/2021 was available for review. Based on an interview at the time of record review, the Corporate Support personnel confirmed there was no documentation of a community based exercise available for review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference.		All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Administrator and Maintenance Supervisor will conduct another full-scale exercise in Q1 of 2023 to ensure we are compliant moving forward. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will review this information during their annual Corporate Quality Review to ensure the frequency of exercises is compliant. **V. Plan of Correction completion date.** Plan of Completion date is Sept 1, 2022.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	August 31, 2022	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/15/22 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The two residential wings of the first floor were also surveyed due to lack of 2 hour separation. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 82 at the		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: RZD621 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 15, 2022. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance. We allege substantial compliance on Sept 1, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-919-1500. Sincerely, Chirag Patel, HFA Administrator Altenheim Health and Living	

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	time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/22/22		Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type			

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	1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on observation and interview, the facility failed to maintain the required building construction type for Type II (222) construction in 1 of 1 2-hour separation walls. This deficient practice could affect over 20 residents, staff and visitors in C Wing and Rehab Hall. Findings include:	K 0161	**K 161** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community	09/02/2022

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	Based on observations with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, the barrier doors in the 2 hour separation wall from Building 1 Type II (222) into Building 2 Type V (111) failed to latch when tested multiple times. Based on interview at the time of observation, the Corporate Support personnel confirmed the barrier doors did not latch into the frame and stated the astragal appeared to be preventing the doors from latching. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		failed to ensure that the set of fire doors that separated the LTC and Assisted living latched and functioned correctly. The Maintenance Supervisor has reworked this set of fire doors and they are latching correctly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled “Door Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects these doors annually during the door audit.	

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			V. Plan of Correction completion date. Plan of Completion date is August 30th, 2022.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 powered door assemblies were in accordance with NFPA 101, Chapter 7. Section NFPA 7.2.1.9.1 states where means of egress door leaves are operated by power upon the approach of a person or are provided with power-assisted manual operation, the design shall be such that, in the event of power failure, the leaves open manually to allow egress travel or close when necessary to safeguard the means of egress. Section 7.2.1.9.1.1 states the forces required to manually open the door leaves specified in 7.2.1.9.1 shall not exceed those required in 7.2.1.4.5, except that the force required to set the leaf in motion shall not exceed 50 lbf (222 N). Section 7.2.1.9.1.2 states the door assembly shall be designed and installed so that, when a force is applied to the door leaf on the side from which egress is made, it shall be capable of swinging from any position to provide full use of the required width of the opening in which it is installed. (See 7.2.1.4.) Section 7.2.1.9.1.3 states a readily visible, durable sign in letters not less than	K 0211	**K 211** **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 set of glass retractable entry doors functioned as designed. The Maintenance Supervisor has contacted Your Automatic Door to make the repairs. See attached invoice from the completed work. Observation 2 - The community failed to ensure that the path egress was not maintained in 5 of 8 corridors. a) The shred box and countertop were removed from the	09/02/2022

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	1 in. (25 mm) high on a contrasting background that reads as follows shall be located on the egress side of each door opening: IN EMERGENCY, PUSH TO OPEN This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, the main entrance doors to the facility inside the main entrance lobby is a powered door assembly consisting of a horizontal sliding glass door and an additional glass door in the horizontal plane of the sliding glass door. The powered door could be opened by an access control pad at the reception desk. In addition, the sliding glass door was equipped with "EMERGENCY EXIT" "Push to Open" signage. When Corporate Support personnel pushed on the sliding door, it failed to open. Based on interview at the time of the observations, the Maintenance Director stated that after reception staff leave, there is no way to open the sliding glass door of the main entrance to exit the building, and agreed the means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Corpoorate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and staff interview, the facility failed to maintain the means of egress free		basement corridor. b) The wood racking in the basement corridor has been removed. See attached picture labeled “Basement Hallway” c) The temporary table in the entry way used to sign in and out has been removed. d) The chair sitting in the corridor by resident room 1097 has been removed. e) There were multiple isolation carts in the hallways by resident room doors. These were replaced with new ones that are wheeled. See attached picture labeled “Wheeled Isolation Carts” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new weekly TELS task for the Maintenance Supervisor to walk the corridors to ensure that no associates have put items in the path of egress. See TELS task labeled “Corridor Inspection”.	

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	from obstructions in 5 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 30 residents, staff and visitors. Findings include: Based on observations made with the Corporate Support personnel and the Maintenance Director on 08/15/22 during a tour of the facility between 1:25 p.m. and 4:35 p.m. the following was noted: a) there was a paper shred box, an approximate eight foot long counter top stored in the egress corridor by medical records in the basement. b) in the basement, there was a five to six foot tall L-shaped wooden constructed shelving unit in the corner of the egress corridor by the Maintenance Shop door. Several cardboard boxes of housekeeping supplies such as toilet paper holders, floor buffing pads, wastebaskets and masks were stored on this shelving unit. c) a six foot table being used as a resident sign out area was sitting perpendicular to the reception desk in the main entrance egress corridor, reducing the egress area by the table to		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects the corridors during their site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 26th, 2022.	

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	approximately three feet. d) an upright chair was observed sitting in the corridor outside room 1097 at 10:10 a.m. during the initial walk through and again at 3:25 p.m. during a tour of the facility. Based on an interview with the Corporate Support personnel and the Maintenance Director at the time of the observations, he agreed that there was storage in the egress corridors in the above mentioned locations. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS			

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	Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler			

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	system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to maintain 1 of 13 egress doors in accordance with LSC 19.2.1. LSC 19.2.1 states every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10.1 states means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 states no furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect at least 14 residents and staff of the 1200 residential wing. Findings include: During a tour of the facility with the Corporate Support personnel and Maintenance Director on 08/15/22 during a tour of the facility from 1:25 p.m. to 4:35 p.m., the egress door at the east exit stairwell was blocked on the outside by a four foot wooden bench. Based on interview at the time of observation, the Maintenance Director agreed that the exit door was obstructed from opening. The bench was moved from in front of the exit door, so that it could fully open in case of an emergency. This finding was reviewed with the Corporate Support personnel and Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 13 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring	K 0222	**K 222** **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 exit door in the east stairwell was blocked outside by a wood bench. The bench has since been relocated. Observation 2- The community failed to ensure that the codes were posted at fire exit doors that were not delayed egress. All doors have been audited and codes posted at them. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the south side of the community have the potential to be affected 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 will	09/02/2022

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	specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect at least 30 residents, staff and visitors. Findings include: Based on observation with the Corporate Support personnel and the Maintenance Director on 08/15/22 during a tour of the facility from 1:25 p.m. 4:35 p.m., the exit doors by resident room 1216, resident room 1099, and the stairwell door by A/B Wing nurse station were marked as a facility exits, were magnetically locked, and could be opened by entering a four-digit code on the keypads, but the codes were not posted at the keypads. Based on interview at the time of observations, the Maintenance Director agreed the code to open the aforementioned exit doors were not posted by the keypads. The findings were reviewed with Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		audit all exit doors to ensure that the codes that are posted are not removed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects the corridors during their site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 19th, 2022.	
K 0225 SS=D Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 1 of 4 interior fire escape stairways would not interfere with egress.	K 0225	**K 225** **I. The corrective actions to be**	09/02/2022

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	LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect staff using the exit stairwell by the Laundry. Findings include: Based on observations with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, the exit stairwell near the basement Laundry was marked as a facility exit. Two wicker lounge chair, an ottoman and a rug were stored in the exit stairwell outside the Laundry in the basement. Based on interview at the time of the observation, the Maintenance Director agreed the aforementioned stairwell in the basement was used for storage which could interfere with egress. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice.** Observation 1 - The community failed to ensure that the path of egress from the laundry room to the exit stairwell corridor was free of obstruction. The Maintenance Supervisor has relocated these items from the stairwell. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new weekly TELS task for the Maintenance Supervisor to walk the corridors to ensure that no associates have put items in the path of egress. See TELS task labeled “Corridor Inspection”. **IV The facility will monitor the corrective action by implementing the following**	

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			measures. CarDon Corporate Facilities inspects the corridors during their site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 26th, 2022.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of over 15 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 20 residents as well as staff and visitors. Findings include: Based on observations on 08/15/22 from 1:25 p.m. to 4:35 p.m. during a tour of the facility with the Maintenance Director and Corporate Support personnel, the exit means of egress sidewalk from the Activities room that ran along the southeast side of B Wing was equipped with one exterior	K 0281	**K 281** **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 path of egress from the main activity room to the outside parking lot had proper illumination. The Current wall pack has been upgraded to Led and a separate LED fixture has been added next to it to ensure it meets code of double lighting.	09/02/2022

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	light fixture with only one bulb. Based on interview at the time of observation, the Corporate Support personnel agreed the sidewalk in the above mentioned area was equipped with one light and one bulb. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community that use this sidewalk have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new weekly TELS task for the Maintenance Supervisor to walk the corridors to ensure that no associates have put items in the path of egress. See TELS task labeled “Corridor Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** No further audits will be needed since this is a permanent fix. **V. Plan of Correction completion date.** Plan of Completion date is August 29th, 2022.	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

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Bldg. 01	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 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 the corridor door to 2 of over 5 hazardous areas, such as a Medical Records storage room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	09/02/2022

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	frame. This deficient practice could affect 23 residents and staff in A Hall plus staff in the basement. Findings include: Based on observations on 08/15/22 during a tour of the facility from 1:25 p.m. to 4:35 p.m. with the Corporate Support personnel and the Maintenance Director, the corridor door to the Medical Records storage room in the basement was not equipped with a self closing device. This room was over 50 square feet and was being used for storage of 14 cardboard boxes and paper goods. Additionally, resident room 1073 on A Wing contained 50 cardboard boxes of various items stored in the room. The corridor door of resident room 1073 was not equipped with a self closing device. Based on interview at the time of observations, the Corporate Support personnel and Maintenance Director agreed both rooms containing combustible supplies were not equipped with self closing devices. These findings were reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		Observation 1– The community failed to ensure that the medical records room had less than the allowed number of combustible materials. The items in this room were removed under 50% to ensure that it is compliant. Observation 2- The community failed to ensure that resident room 1073 was free and clear of combustible materials. The Administrator has worked with the resident and their family to reduce the amount of items in this resident room. Observation 3- The soiled utility room on the Rehab Hall had a door that would not latch. The Maintenance Supervisor has reworked the door to ensure that it latches. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the A wing have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new Monthly TELS	

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			tasks that was created to inspect these areas to ensure that the amount of items in these areas are compliant. See attached TELS Task Labeled “Altenheim Combustible Item Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Environmental Services will audit the building during their site visits to ensure we are not compliant with the amount of combustible items in these rooms. **V. Plan of Correction completion date.** Plan of Completion date is August 25th, 2022.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.			

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	In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Dining Room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 20 residents in the Dining Room by entrance to B Wing. Findings include: Based on observation with the Maintenance Director on 08/15/22 during a tour of the facility from 1:25 p.m. to 4:35 p.m., a sprinkler head at the barrier doors leading into B Wing had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing. This finding was reviewed with the Corporate Support personnel and Maintenance Director at the exit conference. 3.1-19(b)	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The community failed to ensure that the sprinkler head leading into the B wing had the proper escutcheon. The Maintenance Supervisor has installed a new escutcheon ring on the sprinkler head. See attached Picture Labeled “Escutcheon Ring” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the B wing have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic**	09/02/2022

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			changes to ensure that the deficient practice does not recur. There is a current TELS task to inspect the community for debris free sprinkler heads and proper escutcheon rings. See attached TELS task labeled “Sprinkler Head Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Environmental Services will audit the building during their site visits to ensure all sprinkler heads are compliant. **V. Plan of Correction completion date.** Plan of Completion date is August 17th, 2022.	
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.			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, 8.3.1.1 states that electric engine-driven fire pumps shall be operated monthly. Table 8.1.1.2 states fire pumps systems shall be visually inspected monthly in accordance with Section 8.3.1.2. NFPA 25, 2011 Edition, Section 8.3.2 No-Flow Condition states A test of the fire pump assemblies shall be conducted without flowing water. 8.3.2.2 states the test shall be conducted by starting the pump automatically. Then finally at Section 8.3.2.3 states the electric pump shall run a minimum of 10 minutes. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Director on 08/15/22 from 10:25 a.m. to 1:25 p.m., documentaiton was provided of annual inspection on 04/18/22 of the electric motor-driven fire pump. The facility was unable to provide documentation of monthly operational testing of the electric motor-driven fire pump. Also, the facility was unable to provide documentation of a weekly	K 0353	**K 353** **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 fire pump was maintained and inspected per NFPA guidelines. Cardon Corporate Facilities has educated the Maintenance Supervisor on the proper way to test and documents the fire pump. Observation 2- The community failed to ensure that the ceiling in the elevator room had all the ceiling tiles installed. The Maintenance Supervisor has installed new ceiling tiles. See attached picture labeled “Ceiling Tiles” Observation 3- The community failed to ensure that the spare fire sprinkler heads are kept in an approved cabinet. The Maintenance Supervisor installed another spare head cabinet. See	09/02/2022

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	visual inspection according to the list in NFPA 25, 2011 Edition, Section 8.2.2. Based on an interview at the time of record review, the Maintenance Director stated that he has been on the job for 8 months and was unaware of the fire pump testing and inspection requirements and there were no inspection documentation to review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 elevator equipment rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff in the basement. Findings include: Based on observation with the with the Maintenance Director on 08/15/22 at 1:40 p.m., in the basement elevator equipmment room, a suspended ceiling tile was missing which exposed the area above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observation, the Maintenance Director agreed there was a ceiling tile missing. This finding was reviewed with the Corporate Support personnel and the Maintenance Director		attached picture labeled “Sprinkler Cabinet” Observation 4- The community failed to ensure that the sprinkler head located near the kitchen was debris free. The Maintenance Supervisor has cleaned the sprinkler head. See attached picture labeled “Sprinkler Head” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on what to look for in regards to the sprinkler system. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit these areas as part of the	

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	at the exit conference. 3. Based on observation and interview, the facility failed to ensure the sprinkler systems were maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/15/22 at 1:45 p.m., there was a spare sprinkler cabinet at the basement riser, located in dry storage room, with two of eight spare sprinklers lying loose in the cabinet. Based on interview at the time of the observation, the Maintenance Director confirmed the spare sprinkler cabinet had two sprinklers lying loose in the cabinet. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 4. Based on observation, and interview; the		annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 31st, 2022.	

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	facility failed to ensure 1 of over 100 sprinkler heads in the facility covered with lint were cleaned or replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect 10 residents and staff near the kitchen entrance by the elevator. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, a sprinkler located in the corridor near the kitchen entrance was heavily covered with dust and lint. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned automatic sprinkler was loaded with dust and lint.			

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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 finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)			
K 0355 SS=D 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 1. Based on observation and interview, the facility failed to ensure all portable fire extinguishers were installed in accordance with NFPA 10. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect all staff in the basement breakroom. Findings include: Based on observation with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, the portable fire extinguisher located in the basement breakroom was sitting unsupported on a wooden cart. Based on interview at the time of observation, the Corporate Support personnel agreed the fire extinguisher sitting on the wooden cart was not mounted and stated that the mounting bracket had fallen out of the wall at some point.	K 0355	**K355** **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 fire extinguisher located in the basement break room was properly mounted on the wall. The Maintenance Supervisor has re mounted the bracket for the fire extinguisher to the wall. See attached picture labeled "Breakroom Fire Extinguisher" Observation 2– The community failed to ensure that the fire extinguisher located in the kitchen was always assessable. The kitchen staff has been in-serviced on not to block the fire extinguisher with any cart or racking. See attached paperwork	09/02/2022

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	This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers in the Kitchen were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.1 states Fire extinguishers shall not be obstructed or obscured from view. This deficient practice would affect staff in the kitchen. Findings include: Based on observation made with the Corporate Support personnel and the Maintenance Director during a tour of the facility on 08/15/22 from 1:25 p.m. to 4:35 p.m., an ABC portable fire extinguisher located in the kitchen was obstructed by a metal rack being used to store pots and pans. This obstruction was removed by the Corporate Support personnel upon its discovery. Based on interview at the time of observation, the Corporate Support personnel agreed the fire extinguisher as being obstructed, and not readily accessible in the event of a fire emergency. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		labeled “Kitchen in-service” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by these deficient practices. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** A current TELS Task for this community is in place to inspect the fire extinguishers monthly. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Environmental Services will audit the building during their site visits to ensure all fire extinguishers are compliant. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	

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K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 6 resident areas open to the corridor were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect at least 15 residents, as well as staff and visitors. Findings include: Based on observations on 08/15/22 between 1:25 p.m. and 4:35 p.m. during a tour of the facility with the Corporate Support personnel and the Maintenance Director, the 1300 Hall Library was open to the corridor without direct supervision from a 24 hour station (Nurses' Station). Furthermore, LSC 19.3.6.1(7) was not met because the Library was not protected by an electrically supervised automatic smoke detection system.	K 0361	**K361** **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 “1300 Hall Library” was open to the corridor but did not have a smoke deter located within the proper distance. The Maintenance Supervisor has contacted Cintas Fire to relocate a smoke detector into this area. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the 1300 Hall have the potential to be affected by these deficient practices. **III. The facility will put into**	09/02/2022

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	Based on interview at the time of observation, the Corporate Support personnel and Maintenance Director agreed the Library was not provided with an electrically supervised automatic smoke detector or a door to the egress corridor and the Library was not directly supervised by a 24 hour station (Nurses' Station). This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		**place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix and no additional audit will be required. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix and no additional audit will be required. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m. on 08/15/22, the following was noted for corridor doors in the facility: a. the door to resident room 1088 took	K 0363	**K 363** **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 resident room 1088 door failed to latch. The Maintenance Supervisor has adjusted the door to ensure that it is latching.	09/02/2022

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	considerable effort to close and latch as it rubbed onto the door frame. b. the door to the storage room that contained the oxygen transfil/storage room had a self closing device on the door, but was equipped with a kick down door stop that impeded the door from closing. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance room door to the corridor would completely resist the passage of smoke. This deficient practice was not in a patient area and would affect staff in the vicinity of the basement Maintenance room. Findings include: Based on observation on 08/15/22 at 2:27 p.m. during a tour of the facility with the Corporate Support personnel and the Maintenance Director, the corridor door to the Maintenance room in the basement had a one-quarter inch opening above the handle to the door that was open to the corridor. A flashlight was used on the corridor side of the hole, which illuminated through the door; demonstrating the door was not smoke tight. Based on interview at the time of observation, the Maintenance Director agreed there was an opening above the handle of Maintenance room and would have the door handle adjusted to make the door smoke tight.		Observation 2- The community failed to ensure that the door to the 1st floor storage area had a kick down door hold open device. The Maintenance Supervisor has removed the kick down device. See attached picture labeled “Kick Plate” Observation 3- The community failed to ensure that the Maintenance area door lock was compliant. There was a gap at the top of the door that was repaired. See attached picture labeled “Maintenance Door Lock” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled “Door Inspection”. **IV The facility will monitor**	

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	This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		**the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all doors during their site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 31st, 2022.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper	K 0374	**K 374** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	09/02/2022

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	operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 25 residents, staff, and visitors. Findings include: Based on observations made during a tour of the facility from 1:25 p.m. to 4:35 p.m. with the Corporate Support personnel and the Maintenance Director on 08/15/22, the B Wing set of barrier doors had a one-inch gap where the doors came together in the closed position. This was verified by the Corporate Support personnel at the time of observation and he agreed the doors would not restrict the movement of smoke. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		Observation 1- The community failed to ensure that the B Hall set of fire doors had the approved gap between them. The Maintenance Supervisor has reworked this set of fire doors so they close properly. Observation 2- The community failed to ensure that the set of fire doors in rehab by resident room 1138 functioned correctly. The Maintenance Supervisor has reworked this set of fire doors and they are close properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled “Door Inspection”. **IV The facility will monitor the corrective action by**	

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			implementing the following measures. CarDon Corporate Facilities inspects these doors annually during the door audit. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation, and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms	K 0711	**K 711** **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	09/02/2022

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	(5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on records review of with the Corporate Support personnel and the Maintenance Director 1:15 p.m. on 08/15/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m., patient lifts and med-carts were in the corridors throughout the building. Based on interview at the time of records review and observations, the Maintenance Director acknowledged there was patient wheeled equipment in the halls and the Corporate Support personnel stated the written		communities written safety plan included a policy for wheeled equipment in the corridors. The emergency plan has been updated in a few different sections to include what to do with wheeled equipment during an emergency. These policies are for review onsite. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor will include the wheeled cart policy and procedure during his new employee training. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the community is	

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	fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		aware of this policy during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life	K 0712	**K 712** **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 Fire Drills were conducted during each month and compliant with CMS standards for frequency. Observation 2- The community failed to document the Fire Drills	09/02/2022

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	safety procedures and the fire protection devices in their assigned area. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Director on 08/15/22 between 10:25 a.m. and 1:25 p.m., the following quarters and shifts were missing documentation of a completed fire drill or documented orientation training: a) First, Second, Third shist of the First Quarter of 2022 b) Third Shift of the third quarter 2021/2022. c) First, Second and Third Shifts of the Fourth Quarter of 2021. Based on interview with the Maintenance Director, he confirmed the aforementioned fire drills were not available for review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		for multiple activations. The Maintenance Supervisor has been re educated from CarDon Corporate Facilities on the timing and frequency of these drills. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to activate the fire system and conduct a fire drill within the community. See TELS task labeled “Fire Drills”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities audit the Fire Drill Logs for accuracy during their annual CQR. **V. Plan of Correction**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			completion date. Plan of Completion date is August 28th, 2022.	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice	K 0741	**K 741**	09/02/2022

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	155196	A. BUILDING 01 B. WING	08/15/2022

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	could affect all staff and residents. Findings include: Based on observation during a tour of the facility from 1:25 p.m. to 4:35 p.m.with the Corporate Support personnel and the Maintenance Director on 08/15/22, smoking on property was evident due to a smoking tower on the sidewalk outside the east exit of the 1200 residential wing. At the time of observation, there was a resident who was smoking in the area who stated she always smokes at that location. Based on record review, documentation titled "Smoking Regulations" dated 05/12 states 'Effective July 1, 2012, all buildings owned or operated will become smoke free." Based on interview with the Maintenance Director, he stated the facility is smoke free. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		**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 enforce the campus smoking policy. 2 Residents were smoking on a bench outside of the 1200 wing emergency exit. The benches have been removed and residents made aware that the Altenheim is a smoke free campus. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the 1200 Hall have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new monthly TELS task created for the Maintenance Supervisor or designee to walk the campus to ensure the smoking policy is being enforced. See TELS task labeled “Campus Smoking Inspection”.	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities and Administrator will walk the campus frequently to ensure smoking is not taking place. **V. Plan of Correction completion date.** Plan of Completion date is August 28th, 2022.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility	K 0754	**K 754**	09/02/2022

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	failed to ensure trash and dirty linen receptacles were maintained in accordance with 19.7.5.7. This deficient practice could affect as many as 25 residents an staff. Findings include: Based on observation on 08/15/22 at 3:32 p.m. during a tour of the facility with the Corporate Support personnel and the Maintenance Director, there was an unattended 50-gallon yellow trash container that was over half full being stored in the corridor across from resident room 1091. Based on interview at the time of the observation, the Maintenance Director agreed the trash container was stored unattended in the corridor and stated staff move the container up and down the corridor when collecting trash then place it back in soiled utility room. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		**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 to keep all trash containers over 32 gallons in a secure location that are rated for a hazardous area. The Maintenance Supervisor has removed this trash container by resident room 1091 and placed back in the proper secured location. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Nursing and Housekeeping staff have been in-serviced on the trash container policy and that they need to be stored in a hazardous location. See attached	

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			documentation labeled “Trash Inservice” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Corporate Environmental Services will inspect all corridors and rooms during their annual CQR to ensure the containers are being kept in the proper location. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022	
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			

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	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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to document emergency generator monthly load testing for 6 months of the most recent 12-month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at	K 0918	**K 918** **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 Generator had the proper monthly load tests completed. The Maintenance Supervisor has contacted Cummins Crosspoint Generators to re educate him on how to operate the generator and what documentation is needed. **II. The facility will identify other residents that may potentially be affected by the**	09/02/2022

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	not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve-month period with the Maintenance Director during record review from 10:25 a.m. to 1:25 p.m. on 08/15/22, monthly load testing documentation for the facility's diesel fired emergency generator for August, September, November, December 2021 and June, July of 2022 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility earlier in 2022 and agreed monthly load testing documentation for the aforementioned months were not available for review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		**deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current weekly TELS task for the Maintenance Supervisor to test and inspect the diesel generator in the basement. See TELS task labeled “Generator Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities audit the documents for the generator during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and			

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	Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring throughout the facility. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the basement, Administrator office and 2 residents in A Wing. Findings include: Based on observations with the Corporate	K 0920	**K 920** **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 power strip in the elevator room was attached to the wall. The Maintenance Supervisor has removed the power strip. Observation 2- The community failed to ensure that there was a	09/02/2022

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	Support personnel and the Maintenance Director on 08/15/22 during a tour of the facility from 1:25 p.m. to 4:35 p.m., the following was noted: a) in the basement generator room, a power strip was plugged into an outlet and powering an internet cabinet and a router. The unmounted power strip was hanging down at an angle causing stress on the power cords. b) in the Medical Records office located in the basement, a refrigerator was plugged into a power strip. c) a toaster was plugged into a power strip in the basement Maintenance Office d) a power strip was plugged into an extention cord which was plugged into a power strip which powered computer equipment in the basement Maintenance Office. e) a multiplug adapter was plugged into an outlet in the Administrator's office f) a refrigerator and toaster was plugged into a power strip in resident room #1071 Based on interview at the time of each observation, the Corporate Support personnel and Maintenance Director agreed that flexible cords were being used as a substitute for fixed wiring in the aforementioned locations. These findings were reviewed with the Corporate Support personnel and Maintenance Director at the exit conference. 3.1-19(b)		power strip used in the medical records room to power a refrigerator. The Maintenance Supervisor has removed the power strip. Observation 3- The community failed to ensure that the Maintenance office did not have any power strips in use. The Maintenance Supervisor has removed the power strip in this area. Observation 4- The community failed to ensure that the Maintenance area did not have any power strips in use. The Maintenance Supervisor has removed all cords and power strip in this area. Observation 5- The community failed to ensure that the Administrators office did not use any type of multi plug device. The Maintenance Supervisor has removed the device from the wall. Observation 6- The community failed to ensure that there was no power strip being used in resident room 1071. The Maintenance Supervisor has removed the power strip from this resident room. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to	

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			be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Department has been re educated on the power strip policy and what are approved type and uses. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect offices and resident rooms as part of their CQR to ensure there are no non approved power strips or uses within the community. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	August 31, 2022 Brenda Buroker, Director	

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	Survey Date: 08/15/22 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The two residential wings of the first floor were also surveyed due to lack of 2 hour separation. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 82 at the time of this survey. All areas where residents have customary access		Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: RZD621 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 15, 2022. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance. We allege substantial compliance on Sept 1, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-919-1500. Sincerely, Chirag Patel, HFA Administrator Altenheim Health and Living	

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	were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/22/22		Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free	K 0211	**K 211**	09/02/2022

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	from obstructions in 5 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 13 residents, staff and visitors. Findings include: Based on observations made with the Corporate Support personnel and the Maintenance Director on 08/15/22 during a tour of the facility between 1:25 p.m. and 4:35 p.m. the following was noted: a) there was a small three drawer contact isolation cart being used to store personal protective equipment in the corridor immediately outside Resident room #1123. This cart was not on wheels. b) there was a small three drawer contact isolation cart being used to store personal protective equipment in the corridor immediately outside Resident room #1132 and #1133. This cart was not on wheels. c) there was a small three drawer contact isolation cart being used to store personal protective equipment in the corridor immediately outside Resident room #1135 & 1137. This cart was not on		**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 set of glass retractable entry doors functioned as designed. The Maintenance Supervisor has contacted Your Automatic Door to make the repairs. See attached invoice from the completed work. Observation 2 - The community failed to ensure that the path egress was not maintained in 5 of 8 corridors. a) The shred box and countertop were removed from the basement corridor. b) The wood racking in the basement corridor has been removed. See attached picture labeled “Basement Hallway” c) The temporary table in the entry way used to sign in and out has been removed. d) The chair sitting in the corridor by resident room 1097 has been removed. e) There were multiple isolation carts in the hallways by resident room doors. These were replaced with new ones that are wheeled. See attached picture labeled “Wheeled Isolation Carts” **II. The facility will identify**	

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(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
	wheels. Based on an interview with the Corporate Support personnel and the Maintenance Director at the time of the observations, he agreed that the aforementioned carts stored in the corridors were not on wheels. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(b)		**other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new weekly TELS task for the Maintenance Supervisor to walk the corridors to ensure that no associates have put items in the path of egress. See TELS task labeled “Corridor Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects the corridors during their site visits. **V. Plan of Correction completion date.** Plan of Completion date is August 26th, 2022.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	155196	A. BUILDING 02 B. WING	08/15/2022

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	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 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 1 Rehab hall soiled utility rooms was protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient practice could 12 residents in the Rehab hall. Findings include:	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	09/02/2022

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	Based on observations with the Corporate Support personnel and the Maintenance Director on 08/15/22 at 4:18 p.m., the soiled utility room (which contained a large storage container) on the Rehab Hall was equipped with a self closing device, but did not latch into the door frame when tested several times. Based on interview at the time of observation, the Maintenance Director agreed the soiled utility room door would not latch into the frame. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference. 3.1-19(a)		Observation 1– The community failed to ensure that the medical records room had less than the allowed number of combustible materials. The items in this room were removed under 50% to ensure that it is compliant. Observation 2- The community failed to ensure that resident room 1073 was free and clear of combustible materials. The Administrator has worked with the resident and their family to reduce the amount of items in this resident room. Observation 3- The soiled utility room on the Rehab Hall had a door that would not latch. The Maintenance Supervisor has reworked the door to ensure that it latches. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the A wing have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new Monthly TELS tasks that was created to inspect	

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			these areas to ensure that the amount of items in these areas are compliant. See attached TELS Task Labeled “Altenheim Combustible Item Inspection” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Environmental Services will audit the building during their site visits to ensure we are not compliant with the amount of combustible items in these rooms. **V. Plan of Correction completion date.** Plan of Completion date is August 25th, 2022.	
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			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, 8.3.1.1 states that electric engine-driven fire pumps shall be operated monthly. Table 8.1.1.2 states fire pumps systems shall be visually inspected monthly in accordance with Section 8.3.1.2. NFPA 25, 2011 Edition, Section 8.3.2 No-Flow Condition states A test of the fire pump assemblies shall be conducted without flowing water. 8.3.2.2 states the test shall be conducted by starting the pump automatically. Then finally at Section 8.3.2.3 states the electric pump shall run a minimum of 10 minutes. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Director on 08/15/22 from 10:25 a.m. to 1:25 p.m., documentaiton was provided on annual inspection on 04/18/22 of the electric motor-driven fire pump. The facility was unable to provide documentation of monthly operational testing of the electric motor-driven fire pump. Also, the facility was unable to provide documentation of a weekly visual inspection according to the list in NFPA 25, 2011 Edition, Section 82.2. Based on an interview at the time of record review, the Maintenance Director stated that he has been on the job for 8 months and was unaware of the fire	K 0353	**K 353** **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 fire pump was maintained and inspected per NFPA guidelines. Cardon Corporate Facilities has educated the Maintenance Supervisor on the proper way to test and documents the fire pump. Observation 2- The community failed to ensure that the ceiling in the elevator room had all the ceiling tiles installed. The Maintenance Supervisor has installed new ceiling tiles. See attached picture labeled “Ceiling Tiles” Observation 3- The community failed to ensure that the spare fire sprinkler heads are kept in an approved cabinet. The Maintenance Supervisor installed another spare head cabinet. See attached picture labeled “Sprinkler Cabinet” Observation 4- The community failed to ensure that the sprinkler head located near the kitchen was	09/02/2022

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	pump testing and inspection requirements and there were no inspection documentation to review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/15/22 at 1:45 p.m., there was a spare sprinkler cabinet at the basement riser, located in dry storage room, with two of eight spare sprinklers lying loose in the cabinet. Based on interview at the time of the observation, the Maintenance Director confirmed the spare sprinkler cabinet had two sprinklers lying loose in the cabinet.		debris free. The Maintenance Supervisor has cleaned the sprinkler head. See attached picture labeled “Sprinkler Head” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on what to look for in regards to the sprinkler system. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit these area as part of the annual CQR. **V. Plan of Correction completion date.**	

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	This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		Plan of Completion date is August 31st, 2022.	
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 15 residents, staff and visitors. Findings include:	K 0374	**K 374** **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 B Hall set of fire doors had the approved gap between them. The Maintenance Supervisor has reworked this set of fire doors so they close properly.	09/02/2022

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	Based on observation on 08/15/22 between 1:25 p.m. and 4:35 p.m. during a tour of the facility with the Corporate Support personnel and the Maintenance Director, the set of smoke barrier doors in the Rehab hall near room 1138 did not close completely when tested several times. There was a quarter inch gap between the doors when closed to their fullest. Based on interview during the time of observation, the Corporate Support personnel agreed the set of smoke barrier doors did not close completely when tested. This finding was reviewed with the Corporate Support personnel and Maintenance Director during the exit conference. 3.1-19(b)		Observation 2- The community failed to ensure that the set of fire doors in rehab by resident room 1138 functioned correctly. The Maintenance Supervisor has reworked this set of fire doors and they are close properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to test and inspect all fire doors within the community. See TELS task labeled “Door Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities inspects these doors annually during the door audit.	

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			V. Plan of Correction completion date. Plan of Completion date is August 30th, 2022.	
K 0711 SS=F Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation, and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required	K 0711	**K 711** **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 communities written safety plan included a policy for wheeled equipment in the corridors. The emergency plan has been updated in a few different sections to include what to do with wheeled equipment during an emergency.	09/02/2022

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	width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on records review of with the Corporate Support personnel and the Maintenance Director 1:15 p.m. on 08/15/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Corporate Support personnel and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:35 p.m., patient lifts and med-carts were in the corridors throughout the building. Based on interview at the time of records review and observations, the Maintenance Director acknowledged there was patient wheeled equipment in the halls and the Corporate Support personnel stated the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. This finding was reviewed with the Corporate Support personnel and the Maintenance Director during the exit conference.		These policies are for review onsite. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor will include the wheeled cart policy and procedure during his new employee training. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will ensure that the community is aware of this policy during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August	

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	3.1-19(b)		30th, 2022.	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance	K 0712	**K 712** **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 Fire Drills were conducted during each month and compliant with CMS standards for frequency. Observation 2- The community failed to document the Fire Drills for multiple activations. The Maintenance Supervisor has been re educated from CarDon Corporate Facilities on the timing and frequency of these drills. **II. The facility will identify**	09/02/2022

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	Director on 08/15/22 between 10:25 a.m. and 1:25 p.m., the following quarters and shifts were missing documentation of a completed fire drill or documented orientation training: a) First, Second, Third shist of the First Quarter of 2022 b) Third Shift of the third quarter 2021/2022. c) First, Second and Third Shifts of the Fourth Quarter of 2021. Based on interview with the Maintenance Director, he confirmed the aforementioned fire drills were not available for review at the time of the survey. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		**other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a monthly TELS task for the Maintenance Supervisor to activate the fire system and conduct a fire drill within the community. See TELS task labeled “Fire Drills”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities audit the Fire Drill Logs for accuracy during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 28th, 2022.	
K 0741 SS=F	NFPA 101 Smoking Regulations			

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Bldg. 02	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect all staff and residents. Findings include: Based on observation during a tour of the facility from 1:25 p.m. to 4:35 p.m.mwith the Corporate Support personnel and the Maintenance Director	K 0741	**K 741** **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 enforce the campus	09/02/2022

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	155196	A. BUILDING 02 B. WING	08/15/2022

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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	on 08/15/22, smoking on property was evident due to a smoking tower on the sidewalk outside the east exit of the 1200 residential wing. At the time of observation, there was a resident who was smoking in the area who stated she always smokes at that location. Based on record review, documentation titled "Smoking Regulations" dated 05/12 states 'Effective July 1, 2012, all buildings owned or operated will become smoke free." Based on interview with the Maintenance Director, he stated the facility is smoke free. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)		smoking policy. 2 Residents were smoking on a bench outside of the 1200 wing emergency exit. The benches have been removed and residents made aware that the Altenheim is a smoke free campus. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the 1200 Hall have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a new monthly TELS task created for the Maintenance Supervisor or designee to walk the campus to ensure the smoking policy is being enforced. See TELS task labeled “Campus Smoking Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities and Administrator will walk the	

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			campus frequently to ensure smoking is not taking place. **V. Plan of Correction completion date.** Plan of Completion date is August 28th, 2022.	
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			

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	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)			
	Based on record review and interview, the facility failed to document emergency generator monthly load testing for 6 months of the most recent 12-month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators:	K 0918	**K 918** **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 Generator had the proper monthly load tests completed. The Maintenance Supervisor has contacted Cummins Crosspoint Generators to re educate him on how to operate the generator and what documentation is needed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not**	09/02/2022

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	Test Generator Under Load" documentation for the most recent twelve-month period with the Maintenance Director during record review from 10:25 a.m. to 1:25 p.m. on 08/15/22, monthly load testing documentation for the facility's diesel fired emergency generator for August, September, November, December 2021 and June, July of 2022 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility earlier in 2022 and agreed monthly load testing documentation for the aforementioned months were not available for review at the time of the survey. This finding was reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**recur.** There is a current weekly TELS task for the Maintenance Supervisor to test and inspect the diesel generator in the basement. See TELS task labeled “Generator Inspection”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities audit the documents for the generator during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is August 30th, 2022.	