I	EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES O								
Γ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
l	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED				

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155196	A. BU B. W	JILDING ING		COMPLETED 08/15/2022
	PROVIDER OR SUPPLII	ER VING COMMUNITY	•	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the accordance with 4 Survey Date: 08/1 Facility Number: Provider Number: AIM Number: 10 At this Emergency Altenheim Health found not in comp Preparedness Req Medicaid Particip CFR 483.73. The facility has 8' the survey, the center of the accordance of the survey of th	000103 155196 00290000 y Preparedness survey, and Living Community was bliance with Emergency uirements for Medicare and ating Providers and Suppliers, 42	E 00	000	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 Complian Event ID: RZD621 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licens Survey conducted on August 1 2022. This letter is to inform y that the plan of correction attached is to serve as Altenhe Health & Living Community credible allegation of complian We allege substantial complian We allege substantial complian on Sept 1, 2022. We are requesting paper compliance f this plan of correction. If you have any further questio please do not hesitate to conta me at 317-919-1500. Sincerely, Chirag Patel, HFA	of sure 15, ou eim ace. ace

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196		UILDING	ONSTRUCTION	(X3) DATE COMPI 08/15	LETED	
	PROVIDER OR SUPPLIEI	₹ YING COMMUNITY		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
					Administrator Altenheim Health and Living			
					Submission of this plan of correction in no way constitute an admission by Altenheim He and Living or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or oth services provided in this facility. The Plan of Correction is prepand executed solely because i required by Federal and State Law. This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	is a the ner y. ared t is		
E 0031 SS=C Bldg	441.184(c)(2), 48	6.54(c)(2), 418.113(c)(2), 2.15(c)(2), 483.475(c)(2), .102(c)(2), 485.625(c)(2),						

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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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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155196	B. WING		08/15/2022
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAU	§403.748(c)(2), §48 §441.184(c)(2), §48 §441.184(c)(2), §48 §483.73(c)(2), §48 §485.68(c)(2), §48 §485.920(c)(2). [(c) The [facility] man emergency prepart that complies local laws and must least every 2 yeth facilities]. The coninclude all of the formation of	416.54(c)(2), §418.113(c)(2), 460.84(c)(2), §482.15(c)(2), 33.475(c)(2), §484.102(c)(2), 35.625(c)(2), §485.727(c)(2), 486.360(c)(2), §491.12(c)(2), 486.360(c)(2), §481.12(c)(2), 486.360(c)(2), 486.360			DATE
		view and interview, the facility	E 0031	E 031	09/02/2022

RZD621

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	155196	B. WIN		-	08/15/2022
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹			HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE
		emergency preparedness n includes contact information			I The compositive actions to	. .
	_	i) Federal, State, tribal, regional,			I. The corrective actions to I accomplished for those	be
		preparedness staff (ii) The			n	
		l Certification Agency (iii) The			residents found to have been affected by the deficient	11
	_	Long-Term Care Ombudsman			practice.	
		of assistance in accordance			practice.	
		3(c) (2). This deficient practice			Observation - The community	,
	could affect all occ	•			failed to ensure that the	
	·				Emergency Preparedness Pla	an
	Findings include:				included to the contact inform	
					for the State Long-Term Care	
	Based on record rev	view and interview with			Ombudsman. The Administrati	
	Corporate Support personnel and the				has updated the contact shee	t in
	Maintenance Direct	tor on 08/15/22 between 10:25			the EP Binder to include the	
	a.m. and 1:45 p.m.,	the provided emergency			Ombudsman. See attached E	EER
		nunication plan failed to			sheet showing their information	on at
		ormation for The Office of the			the bottom.	
	_	are Ombudsman. Based on				
		e of record review, the			II. The facility will identify	
		personnel confirmed the			other residents that may	
		for the Office of the State			potentially be affected by the	9
	_	mbudsman could not be located			deficient practice.	
	in the Emergency P	reparedness plan.			All staff and a staff as	
	This finding	wigwad with the Camparata			All staff and residents in the	to
	_	viewed with the Corporate and Maintenance Director at			community have the potential	IO
	the exit conference.				be affected by this deficient	
	the exit conference.	•			practice.	
					III. The facility will put into	
					place the following systemat	tic
					changes to ensure that the	
					deficient practice does not	
					recur.	
					The Administrator and	
					Maintenance Supervisor will r	eview
					all contacts to ensure they are	
					correct during the Emergency	

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	r of health and hui R medicare & medic						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/15/2022		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	403.748(d)(2), 410 441.184(d)(2), 481 483.73(d)(2), 485 485.68(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2)	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)		IAU	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 dutheir annual Corporate Quality Review. V. Plan of Correction completion date. Plan of Completion date is Aug 30th, 2022.	l ring	DATE
	CMHCs at §485.9	nicer §403.727, nico, RHCs/FQHCs at RD Facilities at §494.62]:					

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following:

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 5/2022
	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP CO HANNA AVE IAPOLIS, IN 46237	D	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	community-based (A) When a commot accessible, confunctional exercise. (B) If the [fact natural or man-materization of the exempt from endominity-based functional exercise actual event. (ii) Conduct an additional exercise actual event. (ii) Conduct an additional exercise (ii) of this section in include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exempled by a facilitator discussion using a clinically-relevant set of problem star messages, or present to challenge an endominity exercises, and endominity exercises, and endominity exercises, and endominity exercises at (2) Testing for how the patient's home conduct exercises.	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed.				

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Event ID:

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Facility ID: 000103

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIE	R VING COMMUNITY	:	3525 E H	DDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	PF	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(i) Participate in a	a full-scale exercise that is					
		every 2 years; or					
	, ,	nunity based exercise is not					
		ıct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
	1	based exercise or individual					
	facility-based functional exercise following the onset of the emergency event.						
	' '	dditional exercise every 2					
	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)						
		conducted, that may					
		limited to the following:					
	, ,	-scale exercise that is					
		or a facility based					
	functional exercis						
	(B) A mock disas						
		ercise or workshop that is and includes a group					
	discussion using	• •					
		emergency scenario, and a					
		itements, directed					
		pared questions designed					
	to challenge an e	·					
	and the second s						
	(3) Testing for ho	spices that provide inpatient					
	` '	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	accessible, condu	ıct an annual individual					
		ctional exercise; or					
		experiences a natural or					
		ency that requires activation					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	LETED
		155196	B. W	ING		08/15	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
		THE COMMONT		111017111	, a olio, av 10207		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	' '	dditional 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						
		udes a group discussion					
	using a narrated,	-					
		rio, and a set of problem					
		red messages, or prepared					
	questions designe	ed to challerige an					
	emergency plan.	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	the hospice's eme	rigericy plan, as needed.					
	*[For PRFTs at 84	141.184(d), Hospitals at					
	§482.15(d), CAHs	• •					
	` ` / '	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	- · · · · · · · · · · · · · · · · · · ·					
	_	an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
	accessible, conduct an annual individual,						
	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences						
	,	or man-made emergency					
		ration of the emergency					
		is exempt from engaging in					

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CENTERS FOR	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	<u></u>	COMPI	LETED
		155196	B. WING			08/15	/2022
		<u> </u>		TDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			HANNA AVE		
ALTENIL		/INIC COMMUNITY					
ALIENT	IEIIVI NEALTH & LIV	/ING COMMUNITY	"	NDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	NATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	its next required f	ull-scale community based					
		ity-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	1 ' '	nat may include, but is not					
	limited to the follo	-					
		-scale exercise that is					
	community-based						
	1	ctional exercise; or					
		ock disaster drill; or					
		p exercise or workshop that					
	1 ' '	tor and includes a group					
	discussion, using	• .					
	_	emergency scenario, and a					
	1	atements, directed					
		pared questions designed					
	to challenge an e	· · · · · · · · · · · · · · · · · · ·					
	_	the [facility's] response to					
	1 ' '	umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	omey of omorgonoy plant, ao					
	noodod.						
	*[For PACE at §4	60 84(d)·1					
	-	PACE organization must					
		s to test the emergency					
	plan at least annu						
	organization mus	-					
		an annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	1 ' '	uct an annual individual,					
		ctional exercise; or					
		xperiences an actual natural					
	` '	ergency that requires					
		engency that requires emergency plan, the PACE					
		ngaging in its next required					
		nity based or individual,					
	racility-based fund	ctional exercise following the	1				

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onset of the emergency event.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155196	B. WING		08/15/2022		
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD			
				HANNA AVE			
AL I ENH	EIM HEALTH & LIV	ING COMMUNITY	INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	· ·		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	` '	n additional exercise every					
		he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to the following: (A) A second full-scale exercise that is						
		or individual, a facility					
based functional exer							
	(B) A mock disas						
	(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 sta						
		pared questions designed					
	to challenge an er						
		PACE's response to and nation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	l life PACE's efficit	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	(2) The [LTC facili	ity] must conduct exercises					
	to test the emerge	ency plan at least twice per					
	year, including un	announced staff drills using					
	the emergency pro	ocedures. The [LTC facility,					
	ICF/IID] must do t	he following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund	tional exercise.					
		ility] facility experiences an					
		nan-made emergency that					
	requires activation of the emergency plan, the						
	1	mpt from engaging its next					
	1	lle community-based or					
		based functional exercise					
	following the onse	et of the emergency event.					

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(ii) Conduct an additional annual exercise

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155196	UILDING	NSTRUCTION	COMPI 08/15	LETED
NAM	E OF PROVIDER OR SUPPLIE	R		DDRESS, CITY, STATE, ZIP COD		
ALT	ENHEIM HEALTH & LIV	ING COMMUNITY		APOLIS, IN 46237		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF			(X5)
PREF TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IA		but is not limited to the	TAG			DATE
	following:	but to flot inflitted to the				
	_	-scale exercise that is				
	community-based or an individual, facility					
	based functional	exercise; or				
	(B) A mock disas					
	1 ' '	ercise or workshop that is				
	led by a facilitator includes a group					
	discussion, using a narrated,					
clinically-relevant emergency scenario, and a						
	•	ntements, directed				
		pared questions designed				
	to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's					
	response to and maintain documentation of					
	· · · · · ·	exercises, and emergency				
	•	e the [LTC facility] facility's				
	emergency plan,					
	*[For ICF/IIDs at §	\$483.475(d)]:				
		CF/IID must conduct				
	1 ' '	he emergency plan at least				
		ne ICF/IID must do the				
	following:					
	(i) Participate in a	n annual full-scale exercise				
	that is community					
	` ′	nunity-based exercise is not				
		ıct an annual individual,				
	·	ctional exercise; or.				
		experiences an actual				
		ade emergency that requires				
		mergency plan, the ICF/IID				
	· · · · · · · · · · · · · · · · · · ·	ngaging in its next required				
		nity-based or individual, ctional exercise following the				
	onset of the emer	•				
		ditional annual exercise				
		but is not limited to the				
	following:	acto not minor to the				
	_	scale exercise that is				
	1 ' '					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/15/2022				LETED	
	PROVIDER OR SUPPLIER		•	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237	•	
				<u> </u>	- ,		77.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
1710	community-based			1710			DATE
	•	ctional exercise; or					
	(B) A mock disast						
	` '	ercise 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						
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	and for find a cinion	goney plan, ac necaca.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test the	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	` '	ommunity-based exercise					
		conduct an annual based functional exercise					
	every 2 years; or.	Dadoa landional Excluse					
		A experiences an actual					
	, ,	ade emergency that requires					
		mergency plan, the HHA is					
		iging in its next required					
	full-scale commun	nity-based or individual,					
	•	tional exercise following the					
	onset of the emer	-					
	• •	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
		limited to the following:					
	(A) A second	full-scale exercise that is					

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

PRINTED: 09/09/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIEI		35	25 E F	DDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility-based function (B) A mock of (C) A tabletor is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the H maintain documer exercises, and en the HHA's emerger *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor or workshop at lea exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing e of the emergency (ii) Analyze the Omaintain documer exercises, and en the [RNHCI's and needed.	ctional exercise; or isaster drill; or preserved exercise or workshop that tor and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] 96.0PO must conduct he emergency plan. The following: er-based, tabletop exercise east annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lift the OPO experiences an inan-made emergency that in of the emergency plan, the own engaging in its next exercise following the onset event. PO's response to and intation of all tabletop mergency events, and revise OPO's] emergency plan, as					
	, , , ,	3.748]: e RNHCI must conduct he emergency plan. The					

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Event ID:

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	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	- 1	JILDING		COMPL	
		155196	B. Wl	NG		08/15/	2022
	FPROVIDER OR SUPPLIEF			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
TAG	RNHCI must do the (i) Conduct a paper at least annually. group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enter the RNHCI's emel Based on record restailed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a communaccessible, conduct facility-based funct b. If the LTC facility or man-made emergory promengaging its in community-based of full-scale functional the onset of the actual (ii) Conduct an addinclude, but is not I a. A second full-scale functional exercise. b. A mock disaster c. A tabletop exercifacilitator that incluant anarrated, clinically anarrated, clinically an arrated, clinically and a clinically arrated and an arrated and arrated and arrated arrated and arrated arrated and arrated arrated arrated arrated and arrated a	ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a v-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCl's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency er year, including drills using the exercise that di; or ity-based exercise is not an annual individual, ional exercise. Ey experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based I exercise for I year following tall event. itional exercise that may imited to the following: all exercise that is or an individual, facility-based	E 00		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 Plaincluded an annual full-scale community-based exercise duthe last 12 months. There was exercise at the beginning of 20 A full-scale tornado exercise word conducted on 9/1/2022 with incommunity. Jason Oskay, CarDon Facilities was the outs observer of this exercise. See attached exercise summary, a action reports, in-services. II. The facility will identify other residents that may potentially be affected by the deficient practice.	n ring s no 022. /as the side	09/02/2022

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Event ID:

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022		
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	challenge an emerg (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer	C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in		All staff and residents in the community have the potential be affected by this deficient practice.	to
	deficient practice co	CFR 483.73(d)(2). This buld affect all occupants.		III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.	tic
	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			The Administrator and Maintenance Supervisor will conduct another full-scale exercise in Q1 of 2023 to enswe are compliant moving forw	
	on an interview at the Corporate Support properties of the Corporate Support produced available for review of the Corporate o	the time of record review, the personnel confirmed there was if a community based exercise at the time of the survey.		IV The facility will monitor the corrective action by implementing the following measures.	
		viewed with the Corporate and the Maintenance Director ce.		CarDon Corporate facilities w review this information during annual Corporate Quality Rev to ensure the frequency of exercises is compliant.	their
				V. Plan of Correction completion date. Plan of Completion date is Se 2022.	ept 1,
K 0000					
Bldg. 01	A Life Safety Code	Recertification and State	K 0000	August 31, 2022	

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Event ID:

RZD621 Facility ID: 000103

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155196	B. WI	NG		08/15/	2022
			<u> </u>				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	15	DATE
	Licensure Survey v	vas conducted by the Indiana					
		lth in accordance with 42 CFR					
	483.90(a).				Brenda Buroker, Director		
					Long-Term Care Division		
	Survey Date: 08/15	5/22			Indiana State Department of		
					Health		
	Facility Number: (000103			2 North Meridian Street		
	Provider Number:				Indianapolis, IN 46204		
	AIM Number: 100				maianapone, ne rozo i		
					Re: Allegation of Compliar	nce	
	At this Life Safety	Code survey, Altenheim Health			The finegation of Compilar		
	-	unity was found not in			Event ID: RZD621		
	_	equirements for Participation in			Evenicis: (LESOE)		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				Dear Mrs. Buroker:		
	Life Safety from Fire and the 2012 Edition of the				Boar Wile. Barokor.		
		ction Association (NFPA) 101,			Please find enclosed the Plan	of	
		LSC), Chapter 19, Existing			Correction for the State Licens		
		ancies and 410 IAC 16.2.			Survey conducted on August		
	Trouver care coup				2022. This letter is to inform y		
	This facility consis	ts of Building 01 and Building			that the plan of correction	ou	
		nsists of the A, B and C wings			attached is to serve as Altenh	eim	
		a three story building with a			Health & Living Community	J	
		determined to be of Type II			credible allegation of compliar	nce	
		and was fully sprinklered. The			We allege substantial complia		
		arm system with smoke			on Sept 1, 2022. We are		
		els in the corridors and in all			requesting paper compliance	for	
		orridor. The facility has smoke			this plan of correction.		
	_	d to the building electrical			and plan or correction.		
		and C wings. The two			If you have any further questic	nns	
	I -	f the first floor were also			please do not hesitate to conta		
		k of 2 hour separation.			me at 317-919-1500.	101	
	Building 02 consist	•					
		g constructed in 2014 and was			Sincerely,		
		f 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				Chirag Patel, HFA		
					Administrator		
					Altenheim Health and Living		
		sleeping rooms. The facility			, atomicim ricalar and Living		
		7 and had a census of 82 at the					
	I mad a capacity of 6	and had a company of the at the	1				

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIEF		3525	r address, city, state, zip cod E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) BE COMPLETION DATE
	All areas where rest were sprinklered. A services were sprink	idents have customary access		Submission of this plan of	
				correction in no way constiran admission by Altenheim and Living or its manageme company that the allegation contained in the survey reptrue and accurate portrayal provision of nursing care of services provided in this farmather than the Plan of Correction is pand executed solely becaurequired by Federal and St Law. This statement of deficience plan of correction will be re-	Health ent ent ens oort is a of the r other cility. repared se it is ate
				at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0161 SS=E Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, ur 19.1.6.2 through 1 19.1.6.4, 19.1.6.5	tion Type and Height tion Type and Height ion type and stories meets less otherwise permitted by 19.1.6.7			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155196	B. WING		08/15/2022	
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1 I (442), I of stories	(332), II (222) Any number				
	or stories	non-sprinklered and				
	sprinklered	non opinimorea ana				
	'					
	2 II (111)	One story				
	non-sprinklered					
		Maximum 3 stories				
	sprinklered					
	3 II (000)	Not allowed				
	non-sprinklered	rtot allowed				
	4 III (211)	Maximum 2 stories				
	sprinklered					
	5 IV (2HH)					
	6 V (111)					
	7 111 (200)	Nat allawad				
	7 III (200) non-sprinklered	Not allowed				
	8 V (000)	Maximum 1 story				
	sprinklered					
		s must be sprinklered				
	throughout by an	approved, supervised				
	_	in accordance with section				
	9.7. (See 19.3.5)					
		iption, in REMARKS, of the				
		number of stories, including				
		on which patients are of smoke or fire barriers and				
	· ·	Complete sketch or attach				
		the building as appropriate.				
	•	on and interview, the facility	K 0161	K 161	09/02/2022	
		ne required building				
	• • •	or Type II (222) construction in		I. The corrective actions to I	pe	
	_	ation walls. This deficient		accomplished for those		
	-	t over 20 residents, staff and		residents found to have been	1	
	visitors in C Wing a	ши кепар нап.		affected by the deficient practice.		
	Findings include:			ριασίισε.		
				Observation - The community		

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/15/2022		
NAME OF F	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on observation Support personnel and during a tour of the p.m. on 08/15/22, the separation wall from Building 2 Type V of multiple times. Based observation, the Confirmed the barries frame and stated the preventing the door. This finding was reconstructed.	ons with the Corporate and the Maintenance Director facility from 1:25 p.m. to 4:35 the barrier doors in the 2 hour in Building 1 Type II (222) into (111) failed to latch when tested ed on interview at the time of reporate Support personnel er doors did not latch into the exastragal appeared to be so from latching.			failed to ensure that the set of doors that separated the LTC Assisted living latched and functioned correctly. The Maintenance Supervisor has reworked this set of fire doors 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 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 the Maintenance Supervisor to test and inspect all fire doors within the community. See Totask 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.	and and tic for o ELS	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155196 B. WING 08/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE V. Plan of Correction completion date. Plan of Completion date is August 30th. 2022. K 0211 **NFPA 101** SS=E Means of Egress - General Bldg. 01 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 K 211 K 0211 09/02/2022 failed to ensure 1 of 1 powered door assemblies were in accordance with NFPA 101, Chapter 7. I. The corrective actions to be Section NFPA 7.2.1.9.1 states where means of accomplished for those egress door leaves are operated by power upon residents found to have been the approach of a person or are provided with affected by the deficient power-assisted manual operation, the design shall practice. be such that, in the event of power failure, the leaves open manually to allow egress travel or Observation 1 - The community close when necessary to safeguard the means of failed to ensure that the set of egress. Section 7.2.1.9.1.1 states the forces glass retractable entry doors required to manually open the door leaves functioned as designed. The specified in 7.2.1.9.1 shall not exceed those Maintenance Supervisor has required in 7.2.1.4.5, except that the force required contacted Your Automatic Door to to set the leaf in motion shall not exceed 50 lbf make the repairs. See attached

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(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

installed. (See 7.2.1.4.) Section 7.2.1.9.1.3 states a readily visible, durable sign in letters not less than

the required width of the opening in which it is

Event ID:

RZD621

Facility ID: 000103

8 corridors.

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invoice from the completed work.

Observation 2 - The community

egress was not maintained in 5 of

countertop were removed from the

failed to ensure that the path

The shred box and

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
		155196	B. W	ING		08/15/	/2022
	ROVIDER OR SUPPLIEF		•	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEGLIDERIC IV. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	1 in. (25 mm) high	on a contrasting background			basement corridor.		
	that reads as follow	s shall be located on the			b) The wood racking in the		
	egress side of each				basement corridor has been		
	IN EMERGENCY,				removed. See attached pictur	re	
	_	ice could affect all residents,			labeled "Basement Hallway"		
	staff and visitors.				c) The temporary table in th		
	Findings include:				entry way used to sign in and has been removed.	out	
	i manigo merade.				d) The chair sitting in the		
	Based on observations with the Corporate Support personnel and the Maintenance Director				corridor by resident room 109	7	
					has been removed.	•	
	* * *	facility from 1:25 p.m. to 4:35			e) There were multiple isola	ation	
	•	he main entrance doors to the			carts in the hallways by reside		
	facility inside the main entrance lobby is a				room doors. These were repla		
	powered door assen	nbly consisting of a horizontal			with new ones that are wheele		
	sliding glass door a	nd an additional glass door in			See attached picture labeled		
	the horizontal plane	of the sliding glass door. The			"Wheeled Isolation Carts"		
	powered door could	l be opened by an access					
	control pad at the re	eception desk. In addition, the			II. The facility will identify		
	sliding glass door w				other residents that may		
		XIT" "Push to Open" signage.			potentially be affected by the)	
	_	apport personnel pushed on			deficient practice.		
	_	failed to open. Based on					
		e of the observations, the			All staff and residents in the		
		tor stated that after reception			community have the potential	to	
		no way to open the sliding			be affected by this deficient		
	-	ain entrance to exit the d the means of egress was not			practice.		
	0. 0	ained free of all obstructions			III. The facility will put into		
	_	full instant use in the case of			III. The facility will put into place the following systemat	tic	
	fire or other emerge				changes to ensure that the	.10	
	ine of other emerge	····· · · · · · · · · · · · · · · · ·			deficient practice does not		
	This finding was re	viewed with the Corpoorate			recur.		
	Support personnel and the Maintenance Director						
	during the exit conf				There is a new weekly TELS t	ask	
					for the Maintenance Superviso		
	3.1-19(b)				walk the corridors to ensure th		
					no associates have put items		
	2. Based on observa	ation and staff interview, the			the path of egress. See TELS		
	facility failed to ma	intain the means of egress free			task labeled "Corridor Inspecti		

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155196		A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/15/2022		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIV		STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
PREFIX (EACH DEFICIEN TAG REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
from obstructions in facility. LSC 19.2.3 required width shall equipment, provide conditions are met: (a) The wheeled equipment clear unobstructed on in. (1525 mm.) (b) The health care training program and wheeled equipment emergency. (c) The wheeled equipment in use ii. Medical emerger iii. Patient lift and the This deficient pract 30 residents, staff and Findings include: Based on observations are metrically as a series of the	n 5 of 8 corridors within the .4(4) states, projections into the labe permitted for wheeled d that all of the following uipment does not reduce the corridor width to less than 60 occupancy fire safety plan and dress the relocation of the during a fire or similar uipment is limited to the and carts in use and carts in use are equipment into in use ransport equipment ice could affect approximately ons made with the Corporate and the Maintenance Director	TAG	IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities inspects the corridors during the site visits. V. Plan of Correction completion date. Plan of Completion date is Au 26th, 2022.	their		
on 08/15/22 during 1:25 p.m. and 4:35 a) there was a paper eight foot long cour corridor by medical b) in the basement, L-shaped wooden c the corner of the eg Maintenance Shop of housekeeping su holders, floor buffir masks were stored c) a six foot table b out area was sitting	a tour of the facility between p.m. the following was noted: r shred box, an approximate nter top stored in the egress records in the basement. there was a five to six foot tall onstructed shelving unit in					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155196	B. W	ING		08/15/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	-			HANNA AVE		
ALTENHE	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	approximately three						
		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	3.					
	This C. 1:	.:					
		viewed with the Corporate nd the Maintenance Director					
	during the exit conf						
	during the exit com-	erence.					
	3.1-19(b)						
K 0222	NFPA 101						ļ
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
	_	d means of egress shall not					
	-	a latch or a lock that					
		f a tool or key from the					
	-	s using one of the following					
	special locking arr	-					
	•	OR SECURITY THREAT					
	LOCKING						
	Where special locl	king arrangements for the					
	clinical security ne	eds of the patient are					
	used, only one loc	king device shall be					
	permitted on each	door and provisions shall					
	be made for the ra	pid removal of occupants					
		of locks; keying of all					
	locks or keys carri	ed by staff at all times; or					
	-	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	3					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		A. BUILDING B. WING			COMPLETED 08/15/2022			
		ROVIDER OR SUPPLIER			3525 E	NDDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
PR	(4) ID REFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended loc space); and both it systems are arranupon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRESARRANGEMENTSApproved, listed disystems installed in 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, super detection system of automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTRLOCKING ARRANACCESS-CONTRLOCKING ARRANACCESS-CONTRLOCKING ARRANACCESS-CONTRUCKING ARRANACCESS-CONTR	elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised r system. 2.4 OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155196	B. WI	NG	_	08/15/2022	
NAMEOU	DROWNER OF GURBLIEF			STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C .			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	system.	0.4					
	18.2.2.2.4, 19.2.2		17.0	222	14 000	00/02/2022	
		ation and interview, the facility of 13 egress doors in	K 0	222	K 222	09/02/2022	
		SC 19.2.1. LSC 19.2.1 states			I. The corrective actions to	ha	
		eway, corridor, exit discharge,				De	
		ccess shall be in accordance			accomplished for those residents found to have been	nn l	
		ess otherwise modified by			affected by the deficient	711	
	_	2.11. LSC 7.1.10.1 states means			practice.		
	_	ontinuously maintained free of			practice.		
	_	mpediments to full instant use			Observation 1- The commun	itv	
		r other emergency. LSC			failed to ensure that the exit of	-	
		furnishings, decorations, or			in the east stairwell was bloc		
		obstruct exits or their access			outside by a wood bench. Th		
	-	efrom, or visibility thereof.			bench has since been reloca		
	_	ice could affect at least 14			Observation 2- The commun	ity	
	_	of the 1200 residential wing.			failed to ensure that the code	•	
					were posted at fire exit doors	that	
	Findings include:				were not delayed egress. All		
					doors have been audited and	ı	
	During a tour of the	e facility with the Corporate			codes posted at them.		
		and Maintenance Director on					
	_	our of the facility from 1:25 p.m.			II. The facility will identify		
		ress door at the east exit		other residents that			
		ed on the outside by a four			potentially be affected by the	ie	
		. Based on interview at the			deficient practice.		
		, the Maintenance Director					
		door was obstructed from			All staff and residents on the		
		was moved from in front of			south side of the community		
		at it could fully open in case of			the potential to be affected by	y tnis	
	an emergency.				deficient practice.		
	This finding was re	viewed with the Corporate					
	Support personnel a	and Maintenance Director at			III. The facility will put into		
	the exit conference.				place the following systema	ntic	
					changes to ensure that the		
		ation and interview, the facility			deficient practice does not		
		means of egress through 3 of			recur.		
		facility were readily accessible					
	for residents withou	at a clinical diagnosis requiring			The Maintenance Supervisor	will	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155196	B. W	ING		08/15/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			HANNA AVE		
ALTENH	EIM HEALTH & LIV	VING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	specialized securit	y measures. Doors within a			audit all exit doors to ensure t	nat	
		egress shall not be equipped			the codes that are posted are		
	-	k that requires the use of a tool			removed.		
		ress side unless otherwise			Tomovou.		
		19.2.2.2.4. Door-locking			IV The facility will monitor		
		be permitted in accordance			the corrective action by		
	-	This deficient practice could			implementing the following		
		esidents, staff and visitors.			measures.		
	Findings include:				CarDon Corporate Facilities		
Based on observation with the Corporate					inspects the corridors during t	hoir	
		ion with the Corporate Support			site visits.	IICII	
	personnel and the Maintenance Director on				Site visits.		
	-	tour of the facility from 1:25 p.m.			V. Plan of Correction		
	_	doors by resident room 1216,			completion date.		
	-	9, and the stairwell door by A/B			Completion date.		
		were marked as a facility exits,			Plan of Completion data is Au	auat	
	-	locked, and could be opened by			Plan of Completion date is Au	gusi	
		git code on the keypads, but the			19th, 2022.		
		sted at the keypads. Based on					
	-	ne of observations, the					
		etor agreed the code to open the					
		it doors were not posted by the					
		it doors were not posted by the					
	keypads.						
	The findings were	reviewed with Corporate					
		and the Maintenance Director					
	during the exit con						
	during the exit con	morenee.					
	3.1-19(b)						
K 0225	NFPA 101						
SS=D		nokeproof Enclosures					
Bldg. 01	-	nokeproof Enclosures					
Diag. 01		nokeproof enclosures used					
	•	cordance with 7.2.					
		4, 19.2.2.3, 19.2.2.4, 7.2					1
		ion and interview, the facility	K 0	225	K 225		09/02/2022
	_abba on obbervan		1 IX U	44 3	··· ====		1 07/04/4044

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failed to ensure items stored in 1 of 4 interior fire escape stairways would not interfere with egress.

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I. The corrective actions to be

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	OF CORRECTION	IDENTIFICATION NUMBER 155196	A. BUILI B. WING	DING	01	COMPLI 08/15/2	ETED
	ROVIDER OR SUPPLIER		3	3525 E I	DDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	LSC 7.2.2.5.3.1 state enclosure shall not be has the potential to deficient practice constainwell by the Laur Findings include: Based on observation Support personnel aduring a tour of the p.m. on 08/15/22, the basement Laundry of Two wicker lounge were stored in the extra Laundry in the base the time of the observation of the observ	es open space within the exit be used for any purpose that interfere with egress. This hold affect staff using the exit ndry. In the Corporate of the Maintenance Director facility from 1:25 p.m. to 4:35 of exit stairwell near the exist marked as a facility exit. In the chair, an ottoman and a rug with stairwell outside the ment. Based on interview at revation, the Maintenance aforementioned stairwell in the for storage which could in the corporate of the Maintenance Director of the Maintenance Direct		rAG	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 the exit stairwell corridor was for obstruction. The Maintenant 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 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 to for the Maintenance Supervisor walk the corridors to ensure the no associates have put items if the path of egress. See TELS task labeled "Corridor Inspection."	ty of to free nce e to ask or to nat in	DATE
			1		implementing the following		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be either or capable of auto manual intervention 18.2.8, 19.2.8 Based on observation failed to ensure the means of egress was would not leave the requires illumination the failure of any sirresult in an illumination foot-candle in any of practice could affect as staff and visitors. Findings include: Based on observation to 4:35 p.m. during Maintenance Direct personnel, the exit in the Activities room	ans of Egress ans of egress, including exit nged in accordance with 7.8 r continuously in operation matic operation without on. on and interview, the facility lighting for 1 of over 15 exit s properly maintained and area in darkness. LSC 7.8.1.4 n shall be arranged so that that ngle lighting unit does not ation level of less than 0.2 lesignated area. This deficient t at least 20 residents as well	K 0281	CarDon Corporate Facilities inspects the corridors during the site visits. V. Plan of Correction completion date. Plan of Completion date is Aug 26th, 2022. K 281 I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. Observation 1 - The communificated to ensure that the path egress from the main activity to the outside parking lot had proper illumination. The Currewall pack has been upgraded Led and a separate LED fixture has been added next to it to ensure it meets code of doublinghting.	ogust 09/02/2022 be n ity of room ent to re

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIE	R VING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	interview at the tin Support personnel	nly one bulb. Based on ne of observation, the Corporate agreed the sidewalk in the area was equipped with one		II. The facility will identify other residents that may potentially be affected by the deficient practice.		
	_	eviewed with the Corporate and the Maintenance Director ference.		All staff and residents in the community that use this sidewa have the potential to be affecte by this deficient practice.		
	3.1-17(0)			III. The facility will put into place the following systemati changes to ensure that the deficient practice does not recur.	С	
				There is a new weekly TELS to for the Maintenance Superviso walk the corridors to ensure the no associates have put items in the path of egress. See TELS task labeled "Corridor Inspection	r to at 1	
				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.	d	
				Plan of Completion date is Aug	ust	

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NFPA 101

Hazardous Areas - Enclosure

K 0321

SS=E

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		INSTRUCTION 01	(X3) DATE COMPL				
		155196	B. WI	B. WING 08		08/15/	
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		re	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ic	DATE
Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gall f. Combustible Stotover 50 square feg. Laboratories (if	are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the dic fire extinguishing system de areas shall be separated de by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have depplied protective plates that dinches from the bottom of dand zone locations of that are deficient in Automatic Sprinkler N/A d-Fired Heater Rooms der than 100 square feet) diance, and Paint Shops doms (exceeding 64 der Rooms dons) dorage Rooms/Spaces det) classified as Severe					
		on and interview, the facility corridor door to 2 of over 5	K 0.	321	K 321		09/02/2022
	hazardous areas, suc storage room, a stor supplies over 50 squ with a self-closing o	ch as a Medical Records age room of combustible uare feet in size, was provided device which would cause the			I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/15/2022 155196 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE frame. This deficient practice could affect 23 residents and staff in A Hall plus staff in the Observation 1– The community basement. failed to ensure that the medical records room had less than the Findings include: allowed number of combustible materials. The items in this room Based on observations on 08/15/22 during a tour were removed under 50% to of the facility from 1:25 p.m. to 4:35 p.m. with the ensure that it is compliant. Corporate Support personnel and the Observation 2- The community Maintenance Director, the corridor door to the failed to ensure that resident room Medical Records storage room in the basement 1073 was free and clear of was not equipped with a self closing device. This combustible materials. The room was over 50 square feet and was being used Administrator has worked with the for storage of 14 cardboard boxes and paper resident and their family to reduce goods. Additionally, resident room 1073 on A the amount of items in this Wing contained 50 cardboard boxes of various resident room. items stored in the room. The corridor door of Observation 3- The soiled utility resident room 1073 was not equipped with a self room on the Rehab Hall had a closing device. Based on interview at the time of door that would not latch. The observations, the Corporate Support personnel Maintenance Supervisor has and Maintenance Director agreed both rooms reworked the door to ensure that it containing combustible supplies were not latches. equipped with self closing devices. II. The facility will identify These findings were reviewed with the Corporate other residents that may Support personnel and the Maintenance Director potentially be affected by the at the exit conference. deficient practice. 3.1-19(b) 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

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recur.

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changes to ensure that the deficient practice does not

There is a new Monthly TELS

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OMB NO. 0938-039		CENTERS FOR MEDICARE & MEDICAID SERVICES				
CTION (X3) DATE SURVEY	MULTIPLE CO	X1) PROVIDER/SUPPLIER/CLIA	NT OF DEFICIENCIES	STATEMEN		
COMPLETED	BUILDING	IDENTIFICATION NUMBER	OF CORRECTION	AND PLAN		
08/15/2022	WING	155196				
C CITY CTATE ZIR COD	CTDEET A					
S, CITY, STATE, ZIP COD	3525 E	ć	NAME OF PROVIDER OR SUPPLIER			
IS, IN 46237		ING COMMUNITY	IEIM HEALTH & LIV	ALTENH		
PROVIDER'S PLAN OF CORRECTION (X5)	ID	STATEMENT OF DEFICIENCIE	SUMMARY	(X4) ID		
COMPLETION CS-REFERENCED TO THE APPROPRIATE COMPLETION	PREFIX	CY MUST BE PRECEDED BY FULL	(EACH DEFICIEN	PREFIX		
DEFICIENCY) DATE	TAG	LSC IDENTIFYING INFORMATION	REGULATORY OR	TAG		
s that was created to inspect e areas to ensure that the unt of items in these areas compliant. See attached S Task Labeled "Altenheim bustible Item Inspection" The facility will monitor corrective action by menting the following sures. Ion Corporate Facilities and commental Services will audit uilding during their site visits sure we are not compliant the amount of combustible is in these rooms. Ian of Correction pletion date. of Completion date is August 2022.						
		Installation nd hospitals where required	by construction type throughout by an a sprinkler system in 13, Standard for the Systems.	K 0351 SS=E Bldg. 01		
conmental Services will audit uilding during their site visits sure we are not compliant the amount of combustible s in these rooms. Ian of Correction pletion date. of Completion date is August		Installation Ind hospitals where required pe, are protected approved automatic accordance with NFPA ne Installation of Sprinkler	Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, at by construction type throughout by an a sprinkler system ir 13, Standard for th Systems. In Type I and II co	SS=E		

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sprinklers.

substituted for sprinkler protection in specific areas where state or local regulations prohibit

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155196	A. BU B. WI		01	- COMPLETED 08/15/2022	
		133190	B. W1			00/13/2022	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
IAG	In hospitals, sprin	klers are not required in		mo		DATE	
		patient sleeping rooms					
		the closet does not exceed sprinkler coverage covers					
	•	t as required by NFPA 13,					
		llation of Sprinkler					
	Systems.	mader of optimies					
		, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	K 351	09/02/2022	
		ne ceiling construction in 1 of 1					
	_	cordance with NFPA 13,			I. The corrective actions to I	эе	
		stallation of Sprinkler Systems.			accomplished for those		
	•	tion, Section 6.2.7.1 states			residents found to have been	n	
	_	or other devices used to pace around a sprinkler shall			affected by the deficient practice.		
	-	be listed for use around a			practice.		
	· ·	cient practice could affect staff			Observation – The community	,	
	_	dents in the Dining Room by			failed to ensure that the sprink		
	entrance to B Wing				head leading into the B wing h		
					the proper escutcheon. The		
	Findings include:				Maintenance Supervisor has		
					installed a new escutcheon rir	•	
		on with the Maintenance			the sprinkler head. See attacl	ned	
		2 during a tour of the facility			Picture Labeled "Escutcheon		
	_	:35 p.m., a sprinkler head at the g into B Wing had a missing			Ring"		
		on interview at the time of			II. The facility will identify		
		aintenance Director confirmed			other residents that may		
	the escutcheon was				potentially be affected by the	9	
					deficient practice.		
	_	viewed with the Corporate					
		and Maintenance Director at			All staff and residents on the B	3	
	the exit conference.				wing have the potential to be		
	3.1-19(b)				affected by this deficient pract	ice.	
	3.1-19(b)						
					III. The facility will put into	tic	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/09/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				changes to ensure that the deficient practice does not recur.		
				There is a current TELS task to inspect the community for debt free sprinkler heads and prope escutcheon rings. See attached TELS task labeled "Sprinkler Hanspection"	ris er ed	
				IV The facility will monitor the corrective action by implementing the following measures.		
				CarDon Corporate Facilities ar Environmental Services will au the building during their site vis to ensure all sprinkler heads ar compliant.	udit sits	
				V. Plan of Correction completion date.		
				Plan of Completion date is Aug 17th, 2022.	gust	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with I Inspection, Testin	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of Protection Systems.				

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Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155196	B. W	B. WING		08/15	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
A1 TENU		UNIO CONTRALINUTY			HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a) Date sprinkler	system last checked					
	' '	,					
	b) Who provided	system test					
	, ,	,					
	c) Water system	supply source					
	,	,,,					
	Provide in REMAF	RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,						
		review and interview, the	$ _{K0}$	353	K 353		09/02/2022
		intain 1 of 1 fire pumps system	110				0570272022
	-	NFPA 25. LSC 9.7.5 requires all			I. The corrective actions to I	oe .	
		nall be inspected, tested, and			accomplished for those		
		dance with NFPA 25, Standard			residents found to have been	n	
		Γesting, and Maintenance of			affected by the deficient	•	
	_	rotection Systems. NFPA 25,			practice.		
		1 states that electric			practice.		
	·	numps shall be operated			Observation 1– The communi	tv	
	-	1.2 states fire pumps systems			failed to ensure that the fire pu	-	
	· ·	spected monthly in accordance			was maintained and inspected	-	
	-	2. NFPA 25, 2011 Edition,			NFPA guidelines. Cardon	1 poi	
		ow Condition states A test of			Corporate Facilities has educa	ated	
		ablies shall be conducted			the Maintenance Supervisor of		
		ter. 8.3.2.2 states the test shall			proper way to test and docum		
	_	arting the pump automatically.			the fire pump.		
	_	ion 8.3.2.3 states the electric			Observation 2- The communit	V	
	_	inimum of 10 minutes. This			failed to ensure that the ceiling		
	deficient practice at				the elevator room had all the	<i>5</i> ···	
	practice an				ceiling tiles installed. The		
	Findings include:				Maintenance Supervisor has		
					installed new ceiling tiles. See	e.	
	Based on record rev	view with the Maintenance			attached picture labeled "Ceili		
		2 from 10:25 a.m. to 1:25 p.m.,			Tiles"	ອ	
		provided of annual inspection			Observation 3- The communit	V	
		electric motor-driven fire pump.			failed to ensure that the spare	-	
		able to provide documentation			sprinkler heads are kept in an		
		onal testing of the electric			approved cabinet. The		
		ump. Also, the facility was			Maintenance Supervisor insta	المط	
	_	ocumentation of a weekly					
	unable to provide di	ocumentation of a weekly			another spare head cabinet.	3 66	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155196	B. W	ING		08/15/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(V4) ID	CIMMADV	CTATEMENT OF DEFICIENCIE	1	ID	Ī	(V5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		ecording to the list in NFPA 25,		9	attached picture labeled "Sprir		
	_	on 8.2.2. Based on an interview			Cabinet"	INICI	
	· · · · · · · · · · · · · · · · · · ·	d review, the Maintenance			Observation 4- The community	,	
		he has been on the job for 8			failed to ensure that the sprink		
		aware of the fire pump testing			head located near the kitchen		
	and inspection requ	irements and there were no			debris free. The Maintenance		
	inspection documer	ntation to review at the time of			Supervisor has cleaned the		
	the survey.				sprinkler head. See attached		
					picture labeled "Sprinkler Hea	d"	
		viewed with the Corporate					
		and the Maintenance Director			II. The facility will identify		
	at the exit conference	ce.			other residents that may		
					potentially be affected by the	•	
		ation and interview, the facility			deficient practice.		
		he ceiling construction of 1 of 1					
		rooms. The ceiling tiles trap					
	_	ound the sprinkler and cause			All staff and residents have th		
		rate at a specified temperature.			potential to be affected by this		
		tion, 8.5.4.11 states the distance er deflector and the ceiling			deficient practice.		
	_	eted based on the type of					
		pe of construction. This			III. The facility will put into		
		ould affect staff in the			place the following systemat	ic	
	basement.	oute arrest starr in the			changes to ensure that the		
					deficient practice does not		
	Findings include:				recur.		
	_						
	Based on observation	on with the with the			The Maintenance Supervisor	has	
	Maintenance Direct	tor on 08/15/22 at 1:40 p.m., in			been re educated on what to le	ook	
	the basement elevat	tor equipmment room, a			for in regards to the sprinkler		
		ile was missing which exposed			system.		
		suspended ceiling. This					
		ay the activation of the					
	_	on the suspended ceiling.			IV The facility will monitor		
		at the time of the observation,			the corrective action by		
		irector agreed there was a			implementing the following		
	ceiling tile missing.				measures.		
	This finding was to	viewed with the Corporate			CarDon Corporate facilities wil	ı	
	_	and the Maintenance Director			CarDon Corporate facilities wi		

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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		B. WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		E SURVEY LETED 5/2022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTION CORREC		COMMUNITY	3525	E HANNA AVE	P COD	
at the exit conference. 3. Based on observation and interview, the facility failed to ensure the sprinkler systems were annual CQR. V. Plan of Correction completion date.	PREFIX TAG (EACH DEFICIENCY REGULATORY OR LS at the exit conference. 3. Based on observation failed to ensure the spr	UST BE PRECEDED BY FULL DENTIFYING INFORMATION and interview, the facility kler systems were	PREFIX	each correction cross-referenced to the Deficiency) annual CQR. V. Plan of Correction	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 2.5, 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 abinet 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. Based on interview at the time of the observation, the Maintenance Director confirmed the spare sprinkler schinet. This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference.	maintained with spare cabinet and a sprinkler NFPA 25, Standard for and Maintenance of W Systems, 2011 Edition supply of spare sprinkl shall be maintained on sprinklers that have be any way can be promp shall correspond to the ratings of the sprinkler sprinklers shall be kep the temperature in whi no time exceed 100 de sprinkler wrench shall cabinet to be used in the of sprinklers. This definall residents and staff if Findings include: Based on observations with the Maintenance of p.m., there was a spare basement riser, located two of eight spare sprincabinet. Based on interest observation, the Maint the spare sprinkler cabinet in the cabin the spare sprinkler cabinet in the cabin the spare sprinkler cabinet in the cabin the exit conference.	rinklers, a spare sprinkler rench on the premises. He Inspection, Testing, per-Based Fire Protection ection 5.4.1.4 states a so (never fewer than six) the premises so that any operated or damaged in replaced. The sprinklers are and temperature on the property. The in a cabinet located where they are subjected will at the ses Fahrenheit. A special provided and kept in the removal and installation ent practice could affect the facility. The interpolation of the facility rector on 08/15/22 at 1:45 to brinkler cabinet at the interpolation of the facility rector confirmed et had two sprinklers in the facility of the fa		Plan of Completion d	late is August	

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155196	UILDING	01	COMPL 08/15/	ETED
	F PROVIDER OR SUPPLIEF		3525 E	ddress, city, state, zip cod Hanna ave Apolis, in 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	heads in the facility or replaced in accor 25, Standard for the Maintenance of Wa Systems, 2011 Edit sprinklers shall not be free of corrosion physical damage; at correct orientation (sidewall). Furthern that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not This deficient pract and staff near the kelevator. Findings include: Based on observation of the discovered with dust at the time of observariant and staff near the kelevator.	painted by the sprinkler sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the touch the sprinkler. ice could affect 10 residents itchen entrance by the on with the Maintenance our of the facility from 1:25 p.m. 15/22, a sprinkler located in the techen entrance was heavily nd lint. Based on interview at tion, the Maintenance Director mentioned automatic sprinkler				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155196 B. WING 08/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS. IN 46237 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE This finding was reviewed with the Corporate Support personnel and the Maintenance Director at the exit conference. 3.1-19(b)K 0355 **NFPA 101** SS=D Portable Fire Extinguishers Bldg. 01 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 K 0355 K355 09/02/2022 failed to ensure all portable fire extinguishers were installed in accordance with NFPA 10. Section I. The corrective actions to be 6.1.3.4 states portable fire extinguishers other than accomplished for those wheeled extinguishers shall be installed using any residents found to have been of the following means. (1) Securely on a hanger affected by the deficient intended for the extinguishers. (2) In the bracket practice. supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a Observation 1- The community cabinet or wall recess. This deficient practice was failed to ensure that the fire not in a resident care area but could affect all staff extinguisher located in the in the basement breakroom. basement break room was properly mounted on the wall. The Findings include: Maintenance Supervisor has re mounted the bracket for the fire Based on observation with the Corporate Support extinguisher to the wall. See personnel and the Maintenance Director during a attached picture labeled tour of the facility from 1:25 p.m. to 4:35 p.m. on "Breakroom Fire Extinguisher" 08/15/22, the portable fire extinguisher located in Observation 2- The community the basement breakroom was sitting unsupported failed to ensure that the fire

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some point.

on a wooden cart. Based on interview at the time

of observation, the Corporate Support personnel

agreed the fire extinguisher sitting on the wooden

mounting bracket had fallen out of the wall at

cart was not mounted and stated that the

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extinguisher located in the kitchen

kitchen staff has been in-serviced

racking. See attached paperwork

was always assessable. The

extinguisher with any cart or

on not to block the fire

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIER		3525 F	CADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
	SUMMARY SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR This finding was resupport personnel aduring the exit confusion of the Kitchen were in NFPA 10, Standard 2010 Edition. Section extinguishers shall a from view. This defistaff in the kitchen. Findings include: Based on observation Support personnel aduring a tour of the p.m. to 4:35 p.m., at located in the kitcher rack being used to substruction was remusupport personnel aduring a tour of the p.m. to 4:35 p.m., at located in the kitcher rack being used to substruction was remusupport personnel aduring obstructed, are event of a fire emery. This finding was remusulated the substructed of a fire emery.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION viewed with the Corporate and the Maintenance Director ference. Attion and interview, the facility To portable fire extinguishers in stalled in accordance with for Portable Fire Extinguishers, on 6.1.3.1 states Fire not be obstructed or obscured ficient practice would affect on made with the Corporate and the Maintenance Director facility on 08/15/22 from 1:25 and ABC portable fire extinguisher are was obstructed by a metal tore pots and pans. This anoved by the Corporate appon its discovery. Based on the of observation, the Corporate agreed the fire extinguisher as and not readily accessible in the gency. viewed with the Corporate and the Maintenance Director	3525 F	E HANNA AVE	e ne esse
				completion date. Plan of Completion date is At 30th, 2022.	ugust

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/15/2022 155196 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0361 **NFPA 101** SS=E Corridors - Areas Open to Corridor Bldg. 01 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 K 0361 K361 09/02/2022 failed to ensure 1 of 6 resident areas open to the corridor were separated from the corridor by a I. The corrective actions to be partition capable of resisting the passage of accomplished for those smoke as required in a sprinklered building, or met residents found to have been an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states affected by the deficient that spaces other than patient sleeping rooms, practice. treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, Observation 1– The community provided: (a) The space and corridors which the failed to ensure that the "1300 Hall space opens onto in the same smoke compartment Library" was open to the corridor are protected by an electrically supervised but did not have a smoke deter automatic smoke detection system in accordance located within the proper with 19.3.4, and (b) Each space is protected by an distance. The Maintenance automatic sprinklers, and (c) The space does not Supervisor has contacted Cintas to obstruct access to required exits. This deficient Fire to relocate a smoke detector practice could affect at least 15 residents, as well into this area. as staff and visitors. II. The facility will identify Findings include: other residents that may potentially be affected by the Based on observations on 08/15/22 between 1:25 deficient practice. p.m. and 4:35 p.m. during a tour of the facility with the Corporate Support personnel and the All staff and residents on the 1300 Maintenance Director, the 1300 Hall Library was Hall have the potential to be open to the corridor without direct supervision affected by these deficient from a 24 hour station (Nurses' Station). practices. Furthermore, LSC 19.3.6.1(7) was not met because the Library was not protected by an electrically supervised automatic smoke detection system. III. The facility will put into

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY	_	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			
		155196	B. W	NG		08/15/2022	
				_	_		_
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					HANNA AVE		
ALIENH	IEIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
	Based on interview	at the time of observation, the			place the following systemat	ic	
		personnel and Maintenance			changes to ensure that the		
		Library was not provided with			deficient practice does not		
	_	rvised automatic smoke			recur.		
		o the egress corridor and the			1.000		
Library was not directly supervised by a 24 hour				This is a permanent fix and no	,		
	station (Nurses' Station).				additional audit will be required		
This finding was reviewed with the Corporate				additional addit will be required			
				IV The facility will monitor			
	_	and the Maintenance Director			the corrective action by		
	during the exit conf				implementing the following		
					measures.		
	3.1-19(b)						
					This is a permanent fix and no	,	
					additional audit will be required		
					audinonai audin niii bo roquii o		
					V. Plan of Correction		
					completion date.		
					Plan of Completion date is Au	gust	
					30th, 2022.		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting of	corridor openings in other					
	than required enc	losures of vertical openings,					
	-	is areas resist the passage					
	of smoke and are	made of 1 3/4 inch					
	solid-bonded core	wood or other material					
	capable of resisting	ng fire for at least 20					
		fully sprinklered smoke					
		e only required to resist the					
	1	e. Corridor doors and doors					
	to rooms containir						
		rials have positive latching					
		atches are prohibited by					
		These requirements do not					
	_	spaces that do not contain	1		1	ĺ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155196	B. W	ING		08/15/	2022
	PROVIDER OR SUPPLIEF			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		T.C.	COMPLETION
TAG	REGULATORY OF	Y OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
	covering is not ex doors complying vif provided with a the door closed with applied. There is closing of the doorelease when the permitted. Nonrate unlimited height a meeting 19.3.6.3.4 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc.	en bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire s or frames in window Parts 403, 418, 460, 482, KS details of doors such as angs, automatics closing					
		ation and interview, the facility	K 0	363	K 363		09/02/2022
	impediment to closs frame and would re This deficient pract residents, staff and	f over 50 corridor doors had no ing and latching into the door sist the passage of smoke. ice could affect over 20 visitors.			I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		
	Findings include:						
	Director during a to	_			Observation 1– The communit failed to ensure that resident re 1088 door failed to latch. The Maintenance Supervisor has adjusted the door to ensure this latching.	oom	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155196 B. WING 08/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE considerable effort to close and latch as it rubbed Observation 2- The community onto the door frame. failed to ensure that the door to b. the door to the storage room that contained the the 1st floor storage area had a oxygen transfil/storage room had a self closing kick down door hold open device. device on the door, but was equipped with a kick The Maintenance Supervisor has down door stop that impeded the door from removed the kick down device. closing. See attached picture labeled "Kick Based on interview at the time of the Plate" observations, the Maintenance Director agreed Observation 3- The community the aforementioned corridor doors each had an failed to ensure that the impediment to closing and latching into the door Maintenance area door lock was frame and would not resist the passage of smoke. compliant. There was a gap at the top of the door that was repaired. This finding was reviewed with the Corporate See attached picture labeled Support personnel and the Maintenance Director "Maintenance Door Lock" during the exit conference. II. The facility will identify 2. Based on observation and interview, the facility other residents that may failed to ensure 1 of 1 Maintenance room door to potentially be affected by the the corridor would completely resist the passage deficient practice. of smoke. This deficient practice was not in a patient area and would affect staff in the vicinity of the basement Maintenance room. All staff and residents have the potential to be affected by this Findings include: deficient practice. Based on observation on 08/15/22 at 2:27 p.m. during a tour of the facility with the Corporate III. The facility will put into Support personnel and the Maintenance Director, place the following systematic the corridor door to the Maintenance room in the changes to ensure that the basement had a one-quarter inch opening above deficient practice does not the handle to the door that was open to the recur. corridor. A flashlight was used on the corridor side of the hole, which illuminated through the There is a monthly TELS task for door; demonstrating the door was not smoke the Maintenance Supervisor to

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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.

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test and inspect all fire doors

within the community. See TELS

task labeled "Door Inspection".

IV The facility will monitor

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	_	viewed with the Corporate and the Maintenance Director ce.		the corrective action by implementing the following measures.	
	3.1-19(b)			CarDon Corporate Facilities was inspect all doors during their suisits.	
				V. Plan of Correction completion date.	
				Plan of Completion date is Au 31st, 2022.	gust
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that r Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of provides a minimulator swinging or ho 19.3.7.6, 19.3.7.8, Based on observation	esists fire for 20 minutes. We plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors. 19.3.7.9 on and interview, the facility	K 0374	K 374	09/02/2022
	would restrict the m 20 minutes. LSC, S doors in smoke barn Section 8.5.4. LSC, in smoke barriers to	6 6 sets of smoke barrier doors novement of smoke for at least ection 19.3.7.8 requires that riers shall comply with LSC, Section 8.5.4.1 requires doors a close the opening leaving blearance necessary for proper		I. The corrective actions to I accomplished for those residents found to have been affected by the deficient practice.	be

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		r í	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 08/15/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	- L			ADDRESS, CITY, STATE, ZIP COD		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	operation which is	defined as 1/8 inch to restrict			Observation 1- The communit	У	
	the movement of smoke. This deficient practice affects 25 residents, staff, and visitors.				failed to ensure that the B Hal		
	affects 25 residents,	, staff, and visitors.			of fire doors had the approved between them. The Maintena		
	Findings include:				Supervisor has reworked this		
					of fire doors so they close		
	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				properly.		
					Observation 2- The communit failed to ensure that the set of	-	
		for on 08/15/22, the B Wing set			doors in rehab by resident roc		
	of barrier doors had a one-inch gap where the				1138 functioned correctly. Th		
	doors came together in the closed position. This				Maintenance Supervisor has		
	was verified by the Corporate Support personnel at the time of observation and he agreed the doors				reworked this set of fire doors they are close properly.	and	
		ne movement of smoke.			liley are close property.		
					II. The facility will identify		
		viewed with the Corporate			other residents that may		
	Support personnel a at the exit conference	and the Maintenance Director			potentially be affected by the	€	
	at the exit conference	Je.			deficient practice.		
	3.1-19(b)				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 systems	tic	
					changes to ensure that the deficient practice does not		
					recur.		
					There is a manufacture TELOCAL	£	
					There is a monthly TELS task the Maintenance Supervisor to		
					test and inspect all fire doors	-	
					within the community. See T		
					task labeled "Door Inspection"	· .	
					IV The facility will monitor		
					the corrective action by		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				implementing the following measures. CarDon Corporate Facilities inspects these doors annually during the door audit	
				during the door audit. V. Plan of Correction completion date. Plan of Completion date is Aug	gust
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are perkept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3	V 0711	30th, 2022.	
	interview; the facili plan that addressed written fire plans. I health care occupan provide for the follo (1) Use of alarms (2) Transmission of	riew, observation, and ty failed to provide a written all components in 1 of 1 LSC 19.7.2.2 requires a written cy fire safety plan that shall owing: alarm to fire department ne call to fire department	K 0711	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Observation 1- The community	
	(4) Response to alar	<u>-</u>		failed to ensure that the	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL	
		155196	B. WING	<u></u>	08/15/	
						
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
AL TENILI		(INIC COMMUNITY		HANNA AVE		
ALIENT	EIIVI NEALTH & LIV	/ING COMMUNITY	INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	(5) Isolation of fire			communities written safety pla	n	
	(6) Evacuation of in			included a policy for wheeled		
	(7) Evacuation of s	moke compartment		equipment in the corridors. Th	e	
	(8) Preparation of f	loors and building for		emergency plan has been upd	ated	
	evacuation			in a few different sections to		
	(9) Extinguishment	of fire		include what to do with wheele	ed	
	Section 19.2.3.4(4)	Projections into the required		equipment during an emergend	cy.	
	width shall be perm	nitted for wheeled equipment,		These policies are for review		
	provided that all of	the following conditions are		onsite.		
	met:					
	(a) The wheeled eq	uipment does not reduce the				
	clear unobstructed	corridor width to less than 60		II. The facility will identify		
	inches.			other residents that may		
	(b) The health care	occupancy fire safety plan and		potentially be affected by the		
	training program ac	ddress the relocation of the		deficient practice.		
	wheeled equipment	t during a fire or similar				
	emergency.			All staff and residents in the		
	(c)The wheeled equ	aipment is limited to the		community have the potential t	io	
	following:			be affected by this deficient		
	i. Equipment in use	and carts in use		practice.		
	ii. Medical emerger	ncy equipment not in use				
	iii. Patient lift and t	ransport equipment				
	This deficient pract	tice could affect all occupants.		III. The facility will put into		
				place the following systemati	ic	
	Findings include:			changes to ensure that the		
				deficient practice does not		
	Based on records re	eview of with the Corporate		recur.		
	Support personnel	and the Maintenance Director				
		/22, the written fire safety plan		The Maintenance Supervisor v	vill	
	did not address the	relocation of wheeled		include the wheeled cart policy	1	
	equipment during a	fire or similar emergency.		and procedure during his new		
		on with the Corporate Support		employee training.		
	personnel and the N	Maintenance Director during a				
	tour of the facility t	from 1:25 p.m. to 4:35 p.m.,		IV The facility will monitor		
		d-carts were in the corridors		the corrective action by		
	throughout the buil	ding. Based on interview at		implementing the following		
		review and observations, the		measures.		
		tor acknowledged there was				

patient wheeled equipment in the halls and the

Corporate Support personnel stated the written

CarDon Corporate Facilities will

ensure that the community is

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155196	B. W	NG		08/15/	/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	KOVIDEK OK SUI I EIEK			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		not address the relocation of			aware of this policy during thei	ır	
		during a fire or similar			annual CQR.		
	emergency.						
					V. Plan of Correction		
		viewed with the Corporate			completion date.		
		and the Maintenance Director					
	during the exit conf	erence.			Plan of Completion date is Aug 30th, 2022.	gust	
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
		he transmission of a fire					
		simulation of emergency fire					
	-	ills are held at expected					
		mes under varying					
	-	t quarterly on each shift.					
		r with procedures and is					
		re part of established					
		ills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	•					
	19.7.1.4 through 1	9.7.1.7					
	•	view and interview, the facility	K 0	712	K 712		09/02/2022
	failed to conduct fir	e drills or documented					
	orientation training	on each shift for 3 of 4			I. The corrective actions to b	e	
	quarters. LSC 19.7.	1.6 states drills shall be			accomplished for those		
	conducted quarterly	on each shift to familiarize			residents found to have been	1	
	facility personnel (n	urses, interns, maintenance			affected by the deficient		
	engineers, and admi	inistrative staff) with the			practice.		
	signals and emerger	ncy action required under					
	varied conditions. (QSO-20-31 1135 temporary			Observation 1- The community	y	
	waiver states in lieu	of a physical fire drill, a			failed to ensure that the Fire D	rills	
		tion training program related			were conducted during each		
		an, which considers current			month and compliant with CMS	S	
	_	is acceptable. The training will			standards for frequency.		
		including existing, new or			Observation 2- The community	y	
	temporary employed	es, on their current duties, life			failed to document the Fire Dri	lls	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		NAPOLIS, IN 46237	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION and the fire protection devices	TAG	for multiple activations. The	DATE
		ea. This deficient practice		Maintenance Supervisor has re educated from CarDon	been
	Findings include:			Corporate Facilities on the time and frequency of these drills.	ning
	Director on 08/15/2 p.m., the following missing documentar documented orientar	riew with the Maintenance 2 between 10:25 a.m. and 1:25 quarters and shifts were tion of a completed fire drill or tion training: ird shist of the First Quarter of		II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents in the	е
	c) First, Second and Quarter of 2021. Based on interview	e third quarter 2021/2022. d Third Shifts of the Fourth with the Maintenance ned the aforementioned fire		community have the potential be affected by this deficient practice.	to
	drills were not avail the survey.	able for review at the time of		III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.	tic
	Support personnel a at the exit conference 3.1-19(b) 3.1-51(c)	and the Maintenance Director		There is a monthly TELS task the Maintenance Supervisor t 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 at the Fire Drill Logs for accurace during their annual CQR.	l l
				V. Plan of Correction	

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 08/15/2022	
NAME OF	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
ALTENH	IEIM HEALTH & LIV	ING COMMUNITY			HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					completion date.	ļ	
					Plan of Completion date is Aug 28th, 2022.	gust	
K 0741 SS=F Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib used or stored an location, and such signs that read NO posted with the insmoking. (2) In health care smoking is prohib prominently place secondary signs warding shall not (3) Smoking by paresponsible shall (4) The requirement apply where the pare supervision. (5) Ashtrays of notes a device sinto which shall be readily award smoking is permit 18.7.4, 19.7.4	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ited and signs are d at all major entrances, with language that prohibits be required. atients classified as not be prohibited. ent of 18.7.4(3) shall not atient is under direct ncombustible material and be provided in all areas permitted. ers with self-closing cover a ashtrays can be emptied railable to all areas where	K 0	741			09/02/2022

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interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
	<u> </u>			1	<u> </u>	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	` `	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
1710	could affect all staff		1710	I. The corrective actions to		
	Based on observation from 1:25 p.m. to 4 Support personnel at on 08/15/22, smoking to a smoking tower east exit of the 1200 of observation, ther smoking in the area smokes at that locat documentation titled dated 05/12 states 'I buildings owned or	on during a tour of the facility 135 p.m.with the Corporate 136 p.m.with the Corporate 136 p.m.with the Corporate 137 p.m.with the Corporate 138 p.m.with the Corporate 139 p.m.with th		accomplished for those residents found to have bee affected by the deficient practice. Observation 1- The communificated to enforce the campus smoking policy. 2 Residents smoking on a bench outside 1200 wing emergency exit. The benches have been removed residents made aware that the Altenheim is a smoke free campus.	were of the The	
	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			II. The facility will identify other residents that may potentially be affected by the deficient practice.	ie	
	at the exit conference	ce.		All staff and residents in the	1200	
	3.1-19(b)			Hall have the potential to be affected by this deficient prac	etice.	
				III. The facility will put into place the following systems changes to ensure that the deficient practice does not recur. There is a new monthly TELS created for the Maintenance Supervisor or designee to wa campus to ensure the smokin policy is being enforced. Se TELS task labeled "Campus Smoking Inspection".	S task alk the ag	

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RZD621 Facility ID: 000103

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/09/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0754 SS=E Bldg. 01	Soiled Linen and Soiled linen or trashall not exceed average density of room or space ships gallons/square fecapacity of 32 gal within any 64 square linen or trash collecapacities greater located in a room area when not attended to be experimented to be experimented to be experimented to gand containers for	ash collection receptacles 32 gallons in capacity. The of container capacity in a all not exceed 0.5 et. A total container llons shall not be exceeded are feet area. Mobile soiled ection receptacles with or than 32 gallons shall be protected as a hazardous ended. solely for recycling are excluded from the above ere each container is less 16 gallons unless attended, or combustibles are labeled eting FM Approval Standard of the solution of the		IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities a Administrator will walk the campus frequently to ensure smoking is not taking place. V. Plan of Correction completion date. Plan of Completion date is Au 28th, 2022.	

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Based on observation and interview, the facility

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K 0754

Facility ID: 000103

K 754

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIEF	NING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP COI E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) JLD BE COMPLETION ROPRIATE DATE
	were maintained in	sh and dirty linen receptacles accordance with 19.7.5.7. This ould affect as many as 25		I. The corrective action accomplished for those residents found to have affected by the deficien practice.	e been
	during a tour of the Support personnel a there was an unatte container that was a the corridor across Based on interview the Maintenance Di container was store and stated staff most the corridor when c back in soiled utilit This finding was re	viewed with the Corporate and the Maintenance Director		Observation 1- The commanded to ensure to keep a containers over 32 gallor secure location that are inhazardous area. The Masupervisor has removed container by resident roomand placed back in the process of the proce	all trash as in a rated for a aintenance this trash om 1091 roper atify by by the the ential to ent anto tematic the
				recur. The Nursing and Housek staff have been in-service trash container policy and they need to be stored in hazardous location. See	ed on the d that ı a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155196	B. W	ING		08/15/	/2022
	PROVIDER OR SUPPLIER		<u> </u>	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·	DATE
					documentation labeled "Trash Inservice" IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities at Corporate Environmental Servill inspect all corridors and roduring their annual CQR to en the containers are being kept in the proper location. V. Plan of Correction completion date. Plan of Completion date is Aug 30th, 2022	nd vices poms sure in	
K 0918	NFPA 101						
SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the pocess shall be provided to nis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inths for 4 continuous hours.					

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Scheduled test under load conditions include

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155196		r í	JILDING	onstruction 01	(X3) DATE COMPL 08/15 /	ETED			
		ROVIDER OR SUPPLIER	ING COMMUNITY		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237			
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		loads, and are corpersonnel. Mainteenergy power sour accordance with Noticuit breakers are program for period components is estimated and inclusive and readily available and circuits are mand separate from Minimizing the power consideration for reference failed to document load testing for 6 m. 12-month period to NFPA 110, 2010 Edemorgency and States. Section 8.4.2 service shall be exert for a minimum of 3 following methods: (1) Loading that mand gas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) name 8.4.2.3 states dieseld do not meet the requester of the state of the sta	ual transfer of all EES inducted by competent nance and testing of stored rces (Type 3 EES) are in IFPA 111. Main and feeder is inspected annually, and a dically exercising the stablished according to direments. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, an normal power circuits. sibility of damage of the source is a design new installations. (NFPA 99), NFPA 110, 0 (NFPA 70) where and interview, the facility emergency generator monthly onths of the most recent meet the requirements of dition, the Standard for andby Powers Systems, Chapter e states diesel generator sets in rcised at least once monthly, 0 minutes, using one of the	K 0	918	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 Gene had the proper monthly load to completed. The Maintenance Supervisor has contacted Cummins Crosspoint Generate to re educate him on how to operate the generator and who documentation is needed. II. The facility will identify other residents that may potentially be affected by the	y rator ests ors	09/02/2022	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155196	A. BU B. WI	JILDING ING	01	08/15/2022	
		100100	В. 111			00/10/2022	
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	_	cent of the EPS nameplate kW uous minutes and at not less			deficient practice.		
	_	he EPS nameplate kW rating			All staff and residents in the		
	_	ur for a total test duration of			community have the potential	to	
		ntinuous hours. This deficient			be affected by this deficient		
	practice could affec	et all residents, staff and			practice.		
	visitors.						
	Findings include:				III. The facility will put into place the following systemat	tic	
	Based on review of	Direct Supply TELS Logbook			changes to ensure that the		
		nergency Power Generators:			deficient practice does not		
	Test Generator Und	ler Load" documentation for			recur.		
	the most recent twe	lve-month period with the					
		tor during record review from			There is a current weekly TEL	.S	
		o.m. on 08/15/22, monthly load			task for the Maintenance		
	_	on for the facility's diesel fired			Supervisor to test and inspect	: the	
		or for August, September,			diesel generator in the		
		per 2021 and June, July of 2022			basement. See TELS task	,,	
		or review. Based on interview d review, the Maintenance			labeled "Generator Inspection	".	
		tarted working at the facility			IV The facility will monitor		
		agreed monthly load testing			the corrective action by		
		the aforementioned months			implementing the following		
		for review at the time of the			measures.		
	survey.						
					CarDon Corporate Facilities a	udit	
		viewed with the Corporate			the documents for the genera		
		and the Maintenance Director			during their annual CQR.		
	at the exit conference	ce.					
	21.10(1)				V. Plan of Correction		
	3.1-19(b)				completion date.		
					Plan of Completion date is Au 30th, 2022.	gust	
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens						
	Electrical Equipme	ent - Power Cords and					

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.30 Based on observation failed to ensure flex substitute for fixed LSC 9.1.2 requires shall be in accordant Electrical Code. NF 400.8 requires that, flexible cords and consultation of the substitute for fixed deficient practice code.	patient care vicinity are only	K 0920	K 920 I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. Observation 1- The communit failed to ensure that the powe strip in the elevator room was attached to the wall. The Maintenance Supervisor has removed the power strip. Observation 2- The community	09/02/2022 be n

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Based on observations with the Corporate

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failed to ensure that there was a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155196	B. WING		08/15/2022
		_	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIER	· ·	3525 E	HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	INDIAN	IAPOLIS, IN 46237	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		and the Maintenance Director		power strip used in the medic	al
	_	a tour of the facility from 1:25		records room to power a	
	p.m. to 4:35 p.m., t	he following was noted:		refrigerator. The Maintenance	e
	a) in the basement g	generator room, a power strip		Supervisor has removed the p	oower
	was plugged into a	n outlet and powering an		strip.	
	internet cabinet and	l a router. The unmounted		Observation 3- The communit	y
	power strip was har	nging down at an angle		failed to ensure that the	
	causing stress on th	e power cords.		Maintenance office did not ha	ve
	b) in the Medical R	ecords office located in the		any power strips in use. The	
	basement, a refrige	rator was plugged into a power		Maintenance Supervisor has	
	strip.			removed the power strip in thi	s
	c) a toaster was plu	gged into a power strip in the		area.	
	basement Maintena	ince Office		Observation 4- The communit	y
	d) a power strip wa	s plugged into an extention		failed to ensure that the	
		gged into a power strip which		Maintenance area did not hav	е
	powered computer	equipment in the basement		any power strips in use. The	
	Maintenance Office	2.		Maintenance Supervisor has	
	e) a multiplug adap	ter was plugged into an outlet		removed all cords and power	strip
	in the Administrato	r's office		in this area.	
	f) a refrigerator and	l toaster was plugged into a		Observation 5- The communit	y
	power strip in resid	ent room #1071		failed to ensure that the	
	Based on interview	at the time of each		Administrators office did not u	se
	observation, the Co	rporate Support personnel and		any type of multi plug device.	The
	Maintenance Direct	tor agreed that flexible cords		Maintenance Supervisor has	
	were being used as	a substitute for fixed wiring in		removed the device from the	wall.
	the aforementioned	locations.		Observation 6- The communit	у
				failed to ensure that there was	s no
	These findings wer	e reviewed with the Corporate		power strip being used in resi	dent
	Support personnel	and Maintenance Director at		room 1071. The Maintenance	;
	the exit conference.			Supervisor has removed the p	oower
				strip from this resident room.	
	3.1-19(b)				
				II. The facility will identify	
				other residents that may	
				potentially be affected by the	
				deficient practice.	
				denote in practice.	
				All staff and residents in the	

community have the potential to

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	FOF HEALTH AND HUR MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	ľ í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIE	R /ING COMMUNITY		3525 E	ADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) be affected by this deficient	TE	(X5) COMPLETION DATE
K 0000					III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur. The Maintenance Department been re educated on the powe strip policy and what are approtype and uses. IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities winspect offices and resident roas part of their CQR to ensure there are no non approved postrips or uses within the community. V. Plan of Correction completion date. Plan of Completion date is Augustin and Completion date.	has er oved ill oms wer	

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483.90(a).

A Life Safety Code Recertification and State

Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR

Bldg. 02

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K 0000

Facility ID: 000103

August 31, 2022

Brenda Buroker, Director

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CROSS-REFERENCED TO THE APPROPRIATE	(X5)
ALTENHEIM HEALTH & LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION FLACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OR LSC IDENTIFYING INFORMATION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) I DEFICIENCY	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMBET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) I	MDI ETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) I	MPLETION
Long-Term Care Division	DATE
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 LAC 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 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.	DATE
All areas where residents have customary access	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE (A. BUILDING B. WING	construction 02	(X3) DATE SURVEY COMPLETED 08/15/2022
	ROVIDER OR SUPPLIER		3525	FADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	were sprinklered. A services were sprink	All areas providing facility clered.			
	Quality Review con	npleted on 08/22/22		Submission of this plan of correction in no way constitut an admission by Altenheim H and Living or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or or services provided in this facili. The Plan of Correction is prepand executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revise at the Monthly Quality Assurance/Assessment Committee meeting.	ealth t t is a f the ther ty. pared it is
K 0211 SS=E Bldg. 02	in accordance with of egress is contin all obstructions to emergency, unless	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2			
			K 0211	K 211	09/02/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 02 COMPLETED 155196 B. WING 08/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE from obstructions in 5 of 8 corridors within the I. The corrective actions to be facility. LSC 19.2.3.4(4) states, projections into the accomplished for those required width shall be permitted for wheeled residents found to have been equipment, provided that all of the following affected by the deficient conditions are met: practice. (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 Observation 1 - The community in. (1525 mm.) failed to ensure that the set of (b) The health care occupancy fire safety plan and glass retractable entry doors training program address the relocation of the functioned as designed. The wheeled equipment during a fire or similar Maintenance Supervisor has emergency. contacted Your Automatic Door to (c) The wheeled equipment is limited to the make the repairs. See attached following: invoice from the completed work. i. Equipment in use and carts in use ii. Medical emergency equipment not in use Observation 2 - The community iii. Patient lift and transport equipment failed to ensure that the path This deficient practice could affect approximately egress was not maintained in 5 of 13 residents, staff and visitors. 8 corridors. The shred box and Findings include: countertop were removed from the basement corridor. Based on observations made with the Corporate b) The wood racking in the Support personnel and the Maintenance Director basement corridor has been on 08/15/22 during a tour of the facility between removed. See attached picture 1:25 p.m. and 4:35 p.m. the following was noted: labeled "Basement Hallway" a) there was a small three drawer contact isolation The temporary table in the cart being used to store personal protective entry way used to sign in and out equipment in the corridor immediately outside has been removed. Resident room #1123. This cart was not on d) The chair sitting in the wheels. corridor by resident room 1097 b) there was a small three drawer contact isolation has been removed. cart being used to store personal protective e) There were multiple isolation equipment in the corridor immediately outside carts in the hallways by resident Resident room #1132 and #1133. This cart was not room doors. These were replaced on wheels. with new ones that are wheeled. c) there was a small three drawer contact isolation See attached picture labeled

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cart being used to store personal protective

equipment in the corridor immediately outside Resident room #1135 & 1137. This cart was not on

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"Wheeled Isolation Carts"

II. The facility will identify

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	JILDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
PREFIX TAG	wheels. Based on an interview personnel and the Matime of the observation aforementioned carront on wheels. This finding was re-	ew with the Corporate Support Maintenance Director at the cions, he agreed that the its stored in the corridors were viewed with the Corporate and the Maintenance Director	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	e I to Itic Itask For to hat In S Ition".
				Plan of Completion date is Au 26th, 2022.	ugust
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure			
Blda. 02	Hazardous Areas				

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	Г OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTI A. BUILD B. WING		INSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/15/2022	
NAME OF 1	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	4G	DEFICIENCY)		DATE
		are protected by a fire					
	_	our fire resistance rating					
	1 '	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
	approved automat	tic fire extinguishing system					
		e 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						
		applied protective plates that					
	do not exceed 48	inches from the bottom of					
	the door.						
	Describe the floor	and zone locations of					
	hazardous areas t	that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	! ·	N/A					
		-Fired Heater Rooms					
		er than 100 square feet)					
		nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	,	classified as Severe					
	Hazard - see K32	•					
		on and interview, the facility	K 0321		K 321		09/02/2022
		f 1 Rehab hall soiled utility					
	_	d as a hazardous area with a			I. The corrective actions to	be	
	self-closing door th	at would automatically latch			accomplished for those		

into the frame. This deficient practice could 12

residents in the Rehab hall.

Findings include:

residents found to have been

affected by the deficient

practice.

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		L	1_			I		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPL	ETED	
		155196	B. W	ING		08/15	/2022	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			HANNA AVE			
∆I T⊏NI⊔I	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237				
ALICINA	LIIVI I IEALI III & LIV	ING COMMUNITY		INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE.	DATE	
					Observation 1– The communi	tv		
	Based on observation	ons with the Corporate			failed to ensure that the medic	-		
		and the Maintenance Director			records room had less than th	e		
		p.m., the soiled utility room			allowed number of combustible			
		large storage container) on the			materials. The items in this ro			
	*	sipped with a self closing			were removed under 50% to	,0111		
	_	latch into the door frame when			ensure that it is compliant.			
	· · ·	Based on interview at the			Observation 2- The communit	V		
		, the Maintenance Director			failed to ensure that resident r	-		
		ility room door would not			1073 was free and clear of	COIII		
	latch into the frame				combustible materials. The			
	laten into the frame	•			Administrator has worked with	the		
	This finding was no	viewed with the Component						
	_	viewed with the Corporate			resident and their family to rec	auce		
		and the Maintenance Director			the amount of items in this			
	during the exit conf	ference.			resident room.			
					Observation 3- The soiled utili	-		
	3.1-19(a)				room on the Rehab Hall had a			
					door that would not latch. The	9		
					Maintenance Supervisor has			
					reworked the door to ensure the	hat it		
					latches.			
					II. The facility will identify			
					other residents that may			
					1	_		
					potentially be affected by the deficient practice.	3		
					aonoioni praotios.			
					All staff and residents in the A	A		
					wing have the potential to be			
					affected by this deficient pract	ice.		
					'			
					III. The facility will put into			
					place the following systemat	tic		
					changes to ensure that the			
					deficient practice does not			
					recur.			
					There is a new Monthly TELS			
					tasks that was created to insp	ect		

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	OF CORRECTION	IDENTIFICATION NUMBER 155196	A. BUILDIN B. WING	IG <u>02</u>	COM	PLETED 5/2022
	ROVIDER OR SUPPLIER		352	EET ADDRESS, CITY, STATE, ZIF 25 E HANNA AVE DIANAPOLIS, IN 46237	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle	Maintenance and Testing Maintenance and Testing Maintenance and Testing and standpipe systems and, and maintained in		these areas to ensuramount of items in the are compliant. See a TELS Task Labeled Combustible Item Institute Combustible Item Institute Corrective action implementing the formeasures. CarDon Corporate Farencies Environmental Service the building during the toensure we are not with the amount of contents in these rooms. V. Plan of Correction Completion date. Plan of Completion de 25th, 2022.	nese areas attached "Altenheim spection" monitor n by ollowing acilities and ces will audit neir site visits compliant combustible i.	
	accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available. System last checked				
	b) Who provided	<u> </u>				

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Event ID:

RZD621

Facility ID: 000103

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 08/15/2022 155196 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0353 K 353 09/02/2022 facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. LSC 9.7.5 requires all I. The corrective actions to be sprinkler systems shall be inspected, tested, and accomplished for those maintained in accordance with NFPA 25, Standard residents found to have been for the Inspection, Testing, and Maintenance of affected by the deficient Water-Based Fire Protection Systems. NFPA 25, practice. 2011 Edition, 8.3.1.1 states that electric engine-driven fire pumps shall be operated Observation 1– The community monthly. Table 8.1.1.2 states fire pumps systems failed to ensure that the fire pump shall be visually inspected monthly in accordance was maintained and inspected per with Section 8.3.1.2. NFPA 25, 2011 Edition. NFPA guidelines. Cardon Section 8.3.2 No-Flow Condition states A test of Corporate Facilities has educated the fire pump assemblies shall be conducted the Maintenance Supervisor on the without flowing water. 8.3.2.2 states the test shall proper way to test and documents be conducted by starting the pump automatically. the fire pump. Then finally at Section 8.3.2.3 states the electric Observation 2- The community pump shall run a minimum of 10 minutes. This failed to ensure that the ceiling in deficient practice affects all occupants. the elevator room had all the ceiling tiles installed. The Findings include: Maintenance Supervisor has installed new ceiling tiles. See Based on record review with the Maintenance attached picture labeled "Ceiling Director on 08/15/22 from 10:25 a.m. to 1:25 p.m., Tiles" documentaiton was provided on annual Observation 3- The community inspection on 04/18/22 of the electric motor-driven failed to ensure that the spare fire fire pump. The facility was unable to provide sprinkler heads are kept in an documentation of monthly operational testing of approved cabinet. The the electric motor-driven fire pump. Also, the Maintenance Supervisor installed facility was unable to provide documentation of a another spare head cabinet. See weekly visual inspection according to the list in attached picture labeled "Sprinkler NFPA 25, 2011 Edition, Section 82.2. Based on an Cabinet"

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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

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If continuation sheet

Observation 4- The community

failed to ensure that the sprinkler

head located near the kitchen was

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 02 COMPLETED 155196 B. WING 08/15/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE pump testing and inspection requirements and debris free. The Maintenance there were no inspection documentation to review Supervisor has cleaned the at the time of the survey. sprinkler head. See attached picture labeled "Sprinkler Head" This finding was reviewed with the Corporate Support personnel and the Maintenance Director II. The facility will identify at the exit conference. other residents that may potentially be affected by the 2. Based on observation and interview, the facility deficient practice. failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. All staff and residents have the NFPA 25, Standard for the Inspection, Testing, potential to be affected by this and Maintenance of Water-Based Fire Protection deficient practice. 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 III. The facility will put into sprinklers that have been operated or damaged in place the following systematic any way can be promptly replaced. The sprinklers changes to ensure that the shall correspond to the types and temperature deficient practice does not ratings of the sprinklers on the property. The recur. sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at The Maintenance Supervisor has no time exceed 100 degrees Fahrenheit. A special been re educated on what to look sprinkler wrench shall be provided and kept in the for in regards to the sprinkler cabinet to be used in the removal and installation system. of sprinklers. This deficient practice could affect all residents and staff in the facility. IV The facility will monitor Findings include: the corrective action by implementing the following Based on observations during a tour of the facility measures. with the Maintenance Director on 08/15/22 at 1:45 p.m., there was a spare sprinkler cabinet at the CarDon Corporate facilities will basement riser, located in dry storage room, with audit these area as part of the two of eight spare sprinklers lying loose in the annual CQR. cabinet. Based on interview at the time of the observation, the Maintenance Director confirmed V. Plan of Correction

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the spare sprinkler cabinet had two sprinklers

lying loose in the cabinet.

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completion date.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/15/2022
	PROVIDER OR SUPPLIER		3525 E	CADDRESS, CITY, STATE, ZIP COD E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	_	viewed with the Corporate and the Maintenance Director ee.		Plan of Completion date is Aug 31st, 2022.	gust
K 0374 SS=E Bldg. 02	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that r Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of provides a minimu for swinging or ho 19.3.7.6, 19.3.7.8, Based on observatio failed to ensure 1 of would restrict the m 20 minutes. LSC, S doors in smoke barr Section 8.5.4. LSC in smoke barriers to only the minimum of operation which is of the movement of sm	esists fire for 20 minutes. The plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening arm clear width of 32 inches rizontal doors.	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 of fire doors had the approved between them. The Maintena Supervisor has reworked this sof fire doors so they close properly.	y set gap nce

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	02	COMPL	ETED
		155196	B. W	ING		08/15/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
	Г		1		· 		(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		on on 08/15/22 between 1:25	1	IAU	Observation 2- The communit	.,	DATE
		during a tour of the facility with			failed to ensure that the set of	•	
	1 ^ ^	ort personnel and the			doors in rehab by resident roo		
	Maintenance Director, the set of smoke barrier				1138 functioned correctly. The		
		hall near room 1138 did not			Maintenance Supervisor has	C	
	close completely when tested several times. There				reworked this set of fire doors	and	
		gap between the doors when			they are close properly.	GIIG	
		st. Based on interview during			and sides properly.		
		tion, the Corporate Support			II. The facility will identify		
		e set of smoke barrier doors			other residents that may		
	did not close compl				potentially be affected by the)	
	_				deficient practice.		
	This finding was re-	viewed with the Corporate			-		
	Support personnel a	and Maintenance Director			All staff and residents in the		
	during the exit conf	erence.			community have the potential	to	
					be affected by this deficient		
	3.1-19(b)				practice.		
					III. The facility will put into		
					place the following systemat	ic	
					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 T	FLS	
					task labeled "Door Inspection"		
						-	
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
			1		measures.		
					CarDon Corporate Facilities		
					inspects these doors annually		
					during the door audit.		

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DEPARTMEN'	Γ OF HEALTH AND HU	JMAN SERVICES				FOI	RM APPROVED	
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	LETED	
		155196	B. WI	NG _		08/15/	/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					HANNA AVE			
ALTENH	EIM HEALTH & LI	VING COMMUNITY		INDIAN	NAPOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
					V. Plan of Correction			
					completion date.			
					Diam of Commission data is A.	4		
				30th, 2022.	Plan of Completion date is August			
					30(11, 2022.			
K 0711	NFPA 101							
SS=F	Evacuation and F	Relocation Plan						
Bldg. 02	Evacuation and F							
	There is a writter	plan for the protection of all						
		heir evacuation in the event						
	of an emergency							
	Employees are p	eriodically instructed and						
		th their duties under the plan,						
	and a copy of the	plan is readily available						
	with telephone of	perator or with security. The						
	plan addresses t	he 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	3, 19.7.1.1 through 19.7.1.3,						
	19.7.2.1.2, 19.7.2	2.2, 19.7.2.3						
		eview, observation, and	K 0'	711	K 711		09/02/2022	
		lity failed to provide a written						
	^	d all components in 1 of 1			I. The corrective actions to	be		
	_	LSC 19.7.2.2 requires a written			accomplished for those			
		ncy fire safety plan that shall			residents found to have been			
	provide for the fol	lowing:			affected by the deficient			
	(1) Use of alarms				practice.			

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evacuation

(2) Transmission of alarm to fire department (3) Emergency phone call to fire department

(4) Response to alarms

(9) Extinguishment of fire

(6) Evacuation of immediate area

(7) Evacuation of smoke compartment

(8) Preparation of floors and building for

Section 19.2.3.4(4) Projections into the required

(5) Isolation of fire

Event ID:

RZD621

Facility ID: 000103

If continuation sheet

Observation 1- The community

communities written safety plan

equipment in the corridors. The

include what to do with wheeled

equipment during an emergency.

emergency plan has been updated

included a policy for wheeled

in a few different sections to

failed to ensure that the

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	02	COMPL	LETED
		155196	B. WING	·		08/15	/2022
		<u> </u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	R			HANNA AVE		
ALTENH	HEIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE		ID	I		(V5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
TAG		nitted for wheeled equipment,		IAG			DATE
	1	the following conditions are			These policies are for review onsite.		
	met:	the following conditions are			onsite.		
		uipment does not reduce the					
		corridor width to less than 60			II The feeility will identify		
	inches.	corridor width to less than oo			II. The facility will identify other residents that may		
		occupancy fire safety plan and			potentially be affected by the		
		ddress the relocation of the			deficient practice.	,	
		t during a fire or similar			deficient practice.		
	emergency.	during a fire of similar			All staff and residents in the		
(c)The wheeled equipment is limited to the following:				community have the potential	to		
				be affected by this deficient	io		
	i. Equipment in use and carts in use				practice.		
		ncy equipment not in use			practice.		
	_	transport equipment					
		tice could affect all occupants.			III. The facility will put into		
	This deficient pract	nee could affect an occupants.			place the following systemat	io	
	Findings include:				changes to ensure that the	ic	
	i manigs metade.				deficient practice does not		
	Based on records re	eview of with the Corporate			recur.		
		and the Maintenance Director			Todai.		
		/22, the written fire safety plan			The Maintenance Supervisor v	will	
	1 -	relocation of wheeled			include the wheeled cart policy		
		fire or similar emergency.			and procedure during his new	′	
		on with the Corporate Support			employee training.		
		Maintenance Director during a					
	*	from 1:25 p.m. to 4:35 p.m.,			IV The facility will monitor		
	1	d-carts were in the corridors			the corrective action by		
	1 -	ding. Based on interview at			implementing the following		
		review and observations, the			measures.		
		tor acknowledged there was					
		uipment in the halls and the			CarDon Corporate Facilities w	ill	
		personnel stated the written			ensure that the community is		
		not address the relocation of			aware of this policy during thei	ir	
		t during a fire or similar			annual CQR.		
	emergency.						
					V. Plan of Correction		
	This finding was re	eviewed with the Corporate			completion date.		

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during the exit conference.

Support personnel and the Maintenance Director

Event ID:

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If continuation sheet

Plan of Completion date is August

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155196	B. W	NG		08/15/	2022
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	Ł		3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	2.1.10(1)				30th, 2022.		
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 02	Fire Drills						
3		the transmission of a fire					
		simulation of emergency fire					
	_	ills are held at expected					
	and unexpected ti	mes under varying					
	conditions, at least quarterly on each shift.						
		r with procedures and is					
		re part of established					
		ills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	10.7.4.7					
	19.7.1.4 through 1	view and interview, the facility	K 0	710	K 712		09/02/2022
		re drills or documented	KU	/12	K / IZ		09/02/2022
		on each shift for 3 of 4			I. The corrective actions to b	ne	
		1.6 states drills shall be			accomplished for those	,	
	-	on each shift to familiarize			residents found to have been	ก	
	facility personnel (r	nurses, interns, maintenance			affected by the deficient		
	engineers, and adm	inistrative staff) with the			practice.		
		ncy action required under					
		QSO-20-31 1135 temporary			Observation 1- The communit		
		of a physical fire drill, a			failed to ensure that the Fire D	rills	
		tion training program related			were conducted during each		
	-	lan, which considers current			month and compliant with CM	S	
		is acceptable. The training will			standards for frequency.		
		including existing, new or			Observation 2- The communit	-	
		es, on their current duties, life nd the fire protection devices			failed to document the Fire Dr for multiple activations. The		
		ea. This deficient practice			Maintenance Supervisor has b		
	affects all occupant	-			re educated from CarDon	,0011	
					Corporate Facilities on the tim	ina	
	Findings include:				and frequency of these drills.	פ	
	Based on record rev	view with the Maintenance			II. The facility will identify		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	î í	JILDING	onstruction 02	(X3) DATE SURVEY COMPLETED 08/15/2022	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	p.m., the following	22 between 10:25 a.m. and 1:25 quarters and shifts were tion of a completed fire drill or ation training:			other residents that may potentially be affected by the deficient practice.	e	
	a) First, Second, Th 2022 b) Third Shift of th c) First, Second an Quarter of 2021.) First, Second, Third shist of the First Quarter of 022) 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 rills were not available for review at the time of			All staff and residents in the community have the potential to be affected by this deficient practice.		
	Director, he confirm drills were not avail the survey.				III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.	tic	
	at the exit conferen 3.1-19(b) 3.1-51(c)	ce.			There is a monthly TELS task the Maintenance Supervisor t 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 a the Fire Drill Logs for accurac during their annual CQR.	l l	
					V. Plan of Correction completion date.		
					Plan of Completion date is Au 28th, 2022.	ıgust	
K 0741 SS=F	NFPA 101 Smoking Regulati	ions					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	
		155196	B. W	ING		08/15/	2022
	ROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 02	shall include not lead provisions: (1) Smoking shall ward, or compartnt liquids, combustibused or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care of smoking is prohibited prominently placed secondary signs with smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the pasupervision. (5) Ashtrays of notes and devices into which shall be readily avismoking is permitted.	ns shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are d at all major entrances, with language that prohibits be required. It in the sclassified as not be prohibited. In the state of 18.7.4(3) shall not attent is under direct incombustible material and be provided in all areas permitted. In swith self-closing cover a ashtrays can be emptied ailable to all areas where ted.					00/02/2022
		on, records review, and ty failed enforce 1 of 1	K 0	/41	K 741		09/02/2022
		es. This deficient practice			I. The corrective actions to b	ne	
	could affect all staff	-			accomplished for those		
	Findings include:				residents found to have been affected by the deficient practice.		
		on during a tour of the facility					
	-	:35 p.m.mwith the Corporate			Observation 1- The community	У	
	Support personnel a	nd the Maintenance Director	1		failed to enforce the campus		

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE COMPI 08/15	
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CO E HANNA AVE NAPOLIS, IN 46237	DD -	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE	(X5) COMPLETION DATE
	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 Residence smoking on a bench out 1200 wing emergency expenses have been remarked residents made aware to the Altenheim is a smoke frocampus. II. The facility will idented other residents that may potentially be affected deficient practice. All staff and residents in Hall have the potential to affected by this deficient put.	tside of the exit. The moved and hat the ee entify by the note 1200 o be t practice.	
				place the following systemanges to ensure that deficient practice does recur. There is a new monthly created for the Maintena Supervisor or designee campus to ensure the spolicy is being enforced TELS task labeled "Can Smoking Inspection". IV The facility will monthly the corrective action by implementing the following measures. CarDon Corporate Facil Administrator will walk the	t the a not TELS task ance to walk the moking . See npus onitor y wing	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			0	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155196	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>02</u>	COMI	E SURVEY PLETED 5/2022
	PROVIDER OR SUPPLIEF		352	EET ADDRESS, CITY, STATE, ZIF 5 E HANNA AVE IJANAPOLIS, IN 46237	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO TH	SHOULD BE	(X5) COMPLETION DATE
				campus frequently to smoking is not taking V. Plan of Correction	g place.	
				Plan of Completion of 28th, 2022.	late is August	
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenal The generator or source and assoc of supplying serving 10-second criterion monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or mani- loads, and are col personnel. Mainte energy power sou accordance with N circuit breakers ar program for period	other alternate power iated equipment is capable ce within 10 seconds. If the on is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with e inspected weekly, oad 30 minutes 12 times a intervals, and exercised onths for 4 continuous hours. order load conditions include				

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manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		NSTRUCTION (X3)		3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		02	COMPLETED		
		155196	B. WING			08/15/2022		
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE			
ALTFNH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237				
					I		T	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX			PREFIX		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG			TAG		DEFICIENCE		DATE	
	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		K 0918		K 918		09/02/2022	
	failed to document emergency generator monthly							
	load testing for 6 months of the most recent				I. The corrective actions to be			
	12-month period to meet the requirements of				accomplished for those			
	NFPA 110, 2010 Edition, the Standard for				residents found to have been			
		ndby Powers Systems, Chapter			affected by the deficient			
		2 states diesel generator sets in			practice.			
		reised at least once monthly,						
		0 minutes, using one of the			Observation 1- The communit	•		
	following methods:				failed to ensure that the Gene			
		nintains the minimum exhaust			had the proper monthly load to			
		recommended by the	ļ		completed. The Maintenance			
	manufacturer				Supervisor has contacted			
		g temperature conditions and at cent of the EPS (Emergency			Cummins Crosspoint Generat to re educate him on how to	ors		
	_	neplate kW rating. Section				at		
	* * * * *	-powered EPS installations that			operate the generator and whe	al		
		-			documentation is needed.			
	do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS				II. The facility will identify			
	(Emergency Power Supply System) load and shall				other residents that may potentially be affected by the			
	be exercised annually with supplemental loads at							
		cent of the EPS nameplate kW			deficient practice.			
	_	uous minutes and at not less						
	than 75 percent of the EPS nameplate kW rating				All staff and residents in the			
	for 1 continuous hour for a total test duration of				community have the potential to			
	not less than 1.5 continuous hours. This deficient				be affected by this deficient			
	_	et all residents, staff and			practice.			
	visitors.							
	TP: 11: 1: 1: 1							
	Findings include:				III. The facility will put into			
Decedes assisting of Direct County TELC Level 1				place the following systemat	tic			
Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators:				changes to ensure that the				
	Documentation "Er	neigency Power Generators:			deficient practice does not			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CON A. BUILDING		onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED		
155196		155196	B. WING			08/15/2022		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 3525 E HANNA AVE INDIANAPOLIS, IN 46237					
TAG RETORD Test Content of the management of the				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) recur. There is a current weekly TEL task for the Maintenance Supervisor to test and inspect 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 at the documents for the generated during their annual CQR. V. Plan of Correction completion date. Plan of Completion date is Au 30th, 2022.	S the ".	(X5) COMPLETION DATE	

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