STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	11/04/2021

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/04/21 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Emergency Preparedness survey, Altenheim Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 87 certified beds. At the time of the survey, the census was 77. Quality Review completed on 11/08/21	E 0000	November 11, 2021 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: TX4U21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on Nov 4, 2021. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance. We allege substantial compliance on November 10,2021. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-788-4261 Sincerely,	

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

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			Rex Buckley, HFA Administrator Altenheim Health and Living Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting. **E- 004** **I. The corrective actions to be accomplished for those residents found to have been**	

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			affected by the deficient practice. Observation 1- The Community failed to ensure that the Emergency Preparedness Program has been reviewed annually. The Administrator, Director of Nursing, and Maintenance Supervisor has reviewed the EP Program. See attached sign off sheet. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 006** **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 All Hazards Risk Assessment was reviewed or revised in the last 12 months. See attached current risk assessment dated November 7th, 2021. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic**	

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			changes to ensure that the deficient practice does not recur. There is currently a TELS Task in place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and Risk Assessment during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 013** **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 Policies and Procedures have been reviewed after the current All	

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			Hazards Risk Assessment was reviewed or updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. This task discusses reviewing the Policies and Procedures based on those findings. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and the Policies and Procedures during their annual CQR. **V. Plan of Correction**	

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			completion date. Plan of Completion date is November 11, 2021. **E- 020** **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 Emergency Preparedness Program had been reviewed and updated with the creation of an in-house dialysis center. See attached documents titled “Tab 8 E-20 Evacuation and Relocation” showing these revisions. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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			Future training within the community will include the dialysis provider and their onsite staff. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 029** **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 Communication Plan as Part of the EPP was reviewed and updated. **II. The facility will identify other residents that may potentially be affected by the**	

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			deficient practice. All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 036** **I. The corrective actions to be accomplished for those**	

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			residents found to have been affected by the deficient practice. Observation 1- The Community failed to ensure that the Training and Testing Documentation as Part of the EPP was reviewed and updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR.	

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			V. Plan of Correction completion date. Plan of Completion date is November 11, 2021. **K- 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the door latching system was functioning correctly to the door that entered the dialysis treatment area. See attached picture labeled "Altenheim Davita Door Latch" showing this door has been repaired. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the**	

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			deficient practice does not recur. There is currently a monthly TELS Task in place to inspect all doors to the corridors to ensure they are latching correctly. See attached task labeled “Door Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all corridor doors to ensure they latch their annual door inspection. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **K- 372** **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 all penetrations were properly fire caulked. The oxygen room and	

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			Dialysis bio med room had penetrations that were sealed up. See attached pictures showing these 2 areas. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to inspect the entire community every 6 months looking for areas that need fire blocked. See attached Task Labeled “Fire Blocking Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the community looking for improper fire blocking their annual CQR. **V. Plan of Correction completion date.**	

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			Plan of Completion date is November 11, 2021. **K-914** **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 new hospital grade outlets in the dialysis treatment area had been inspected upon installation. Glenn Smith with CarDon Corporate has inspected these outlets. His findings were then added to the Annual Receptacle testing that we do. See attached new updated reports showing these inspections. These receptacles will be inspected annually moving forward. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice **III. The facility will put into place the following systematic**	

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			changes to ensure that the deficient practice does not recur. There is currently a TELS Task in place to have their annual electrical receptacle inspection during the month of February. See attached task labeled “receptacle inspection task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities completes the annual electrical receptacle testing during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 9, 2021.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a),			

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	§485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19 with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 10/08/19 which was not within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities agreed the emergency program documentation was not dated as being reviewed within the most recent twelve month period. This finding was reviewed with the Plant Operations Director during the exit conference.	E 0004	/p> **E- 004** **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 Emergency Preparedness Program has been reviewed annually. The Administrator, Director of Nursing, and Maintenance Supervisor has reviewed the EP Program. See attached sign off sheet. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program	11/11/2021

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			annually during the month of January. See attached TELS Task labeled "EP Preparedness Review Task". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed,			

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ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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	and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing			

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	emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include:	E 0006	**E- 006** **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 All Hazards Risk Assessment was reviewed or revised in the last 12 months. See attached current risk assessment dated November 7th, 2021. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this	11/11/2021

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	Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19 with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. In addition, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was also not available for review. EID was not included in the current emergency preparedness risk assessment for the facility. Based on interview at the time of record review, the Corporate Director of Facilities agreed the emergency preparedness program risk assessment documentation was not reviewed within the most recent twelve month period and the documentation did not address emerging infectious diseases as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Plant Operations Director during the exit conference.		deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and Risk Assessment during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 1/4 Conduct and document facility-based and	

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			community-based risk assessment using an All-Hazards approach (HVA) Regulatory Maintenance Recurrence: Every 12 Months Next Due: This month Change Assigned To: NobodyCategory:Emergency Preparedness Drills and Exercises¿ ResourcesTELS - Emergency Preparedness ETag Overview TELS - Emergency Preparedness Self Assessment TELS - Hazard and Vulnerability Assessment Tool Instructions Facilities are now required to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both types of risk assessments. Examples to consider may include natural disasters prevalent in your	

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			facility's geographic region such as wildfires, tornados, flooding, etc. All Hazards Continuity of Operations Plan (COOP):Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result Related TagsE0006Maintain and Annual EP Updates ¿ ¿ ¿ **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 2/4 interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel. Risk Assessment: The term risk assessment describes a process you will use to assess and document potential hazards that are likely to impact your geographical region, community, facility and patient population. A risk assessment will identify gaps and challenges that should be considered and addressed in developing the emergency	

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			preparedness program. A risk assessment is meant to be comprehensive, and may include a variety of methods to assess and document potential hazards and their impacts. The healthcare industry has also referred to risk assessments as a Hazard Vulnerability Assessments or Analysis (HVA) as a type of risk assessment commonly used in the healthcare industry. All Hazards Approach: An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to your location and your facility considering the types of hazards most likely to occur in your area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures your facility will have the capacity to address a broad range of related emergencies. TELS has a tool to help you conduct your own HVA located above in the 'Resources' section of the screen. Once completed, please attach your final copy to the task using Document Upload. This will allow you to easily access your previously saved copy if you need to review or edit in the future. The word community is not	

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			defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its local community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the requirement is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency. **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 3/4 You may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in combination with conducting your own facility-based assessment. If this approach is used, you are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure	

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			that the your emergency plan is in alignment. When developing an emergency preparedness plan, you need to consider the following: Identification of all business functions essential to your facility's operations that should be continued during an emergency Identification of all risks or emergencies that your facility may reasonably expect to confront Identification of all contingencies for which your facility should plan Consideration of your facility's location Assessment of the extent to which natural or man-made emergencies may cause your facility to cease or limit operations Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency For Long Term Care facilities, written plans and the procedures are required to also include missing residents (elopement) within their emergency plans You must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include	

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			Developing a staffing strategy if staff shortages were identified during the risk assessment Developing a surge capacity strategy if the you have identified your facility would likely be requested to accept additional patients during an emergency. You will also want to consider evacuation plans. For example, if your facility is in a large metropolitan city **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 4/4 you would want to plan to utilize the support of other large community facilities as alternate care sites for your residents if your facility needs to be evacuated. You are also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive your residents. Survey Procedures Be prepared for the Surveyor to ask to see the written documentation of your facility's risk assessments and associated strategies The Surveyor will also interview your leadership and senior staff and ask which hazards (e.g.natural, man-made, facility, geographic) were included in the	

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			your facility's risk assessment, why they were included and how the risk assessment was conducted The Surveyor will also verify the risk-assessment is based on an all-hazards approach specific to the geographic location of your facility and encompasses potential hazards. CMS S&C 17-29-ALL, Appendix Z **Support**	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

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	section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19 with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 10/08/19 which was not within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities agreed policies and procedures based on a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Plant Operations Director during the exit conference.	E 0013	**E- 013** **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 Policies and Procedures have been reviewed after the current All Hazards Risk Assessment was reviewed or updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in	11/11/2021

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			place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. This task discusses reviewing the Policies and Procedures based on those findings. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and the Policies and Procedures during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 1/4 Conduct and document facility-based and community-based risk assessment using an All-Hazards approach (HVA) Regulatory Maintenance	

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			Recurrence: Every 12 Months Next Due: This month Change Assigned To: NobodyCategory:Emergency Preparedness Drills and Exercises¿ ResourcesTELS - Emergency Preparedness ETag Overview TELS - Emergency Preparedness Self Assessment TELS - Hazard and Vulnerability Assessment Tool Instructions Facilities are now required to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Facilities must document both types of risk assessments. Examples to consider may include natural disasters prevalent in your facility's geographic region such as wildfires, tornados, flooding, etc. All Hazards Continuity of Operations Plan (COOP):Develop a continuity of operations	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result Related TagsE0006Maintain and Annual EP Updates ¿ ¿ ¿ **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 2/4 interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel. Risk Assessment: The term risk assessment describes a process you will use to assess and document potential hazards that are likely to impact your geographical region, community, facility and patient population. A risk assessment will identify gaps and challenges that should be considered and addressed in developing the emergency preparedness program. A risk assessment is meant to be comprehensive, and may include a variety of methods to assess and document potential hazards and their impacts. The healthcare	

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	155196	A. BUILDING -- B. WING	11/04/2021

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			industry has also referred to risk assessments as a Hazard Vulnerability Assessments or Analysis (HVA) as a type of risk assessment commonly used in the healthcare industry. All Hazards Approach: An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to your location and your facility considering the types of hazards most likely to occur in your area. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures your facility will have the capacity to address a broad range of related emergencies. TELS has a tool to help you conduct your own HVA located above in the 'Resources' section of the screen. Once completed, please attach your final copy to the task using Document Upload. This will allow you to easily access your previously saved copy if you need to review or edit in the future. The word community is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its local community for emergency planning purposes. However, the	

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			term could mean entities within a state or multi-state region. The goal of the requirement is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency. **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 3/4 You may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in combination with conducting your own facility-based assessment. If this approach is used, you are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the your emergency plan is in alignment. When developing an emergency preparedness plan, you need to consider the following: Identification of all business	

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			functions essential to your facility's operations that should be continued during an emergency Identification of all risks or emergencies that your facility may reasonably expect to confront Identification of all contingencies for which your facility should plan Consideration of your facility's location Assessment of the extent to which natural or man-made emergencies may cause your facility to cease or limit operations Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency For Long Term Care facilities, written plans and the procedures are required to also include missing residents (elopement) within their emergency plans You must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include Developing a staffing strategy if staff shortages were identified during the risk assessment Developing a surge capacity strategy if the you have identified your facility would likely be	

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			requested to accept additional patients during an emergency. You will also want to consider evacuation plans. For example, if your facility is in a large metropolitan city **Support** 11/11/21, 12:20 PM TELS https://www.tels.net/TELS/Tasks/Admin/3569224 4/4 you would want to plan to utilize the support of other large community facilities as alternate care sites for your residents if your facility needs to be evacuated. You are also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive your residents. Survey Procedures Be prepared for the Surveyor to ask to see the written documentation of your facility's risk assessments and associated strategies The Surveyor will also interview your leadership and senior staff and ask which hazards (e.g.natural, man-made, facility, geographic) were included in the your facility's risk assessment, why they were included and how the risk assessment was conducted The Surveyor will also verify the risk-assessment is based on an	

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			all-hazards approach specific to the geographic location of your facility and encompasses potential hazards. CMS S&C 17-29-ALL, Appendix Z **Support** ="" p="">	
E 0020 SS=E Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and			

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	alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication	E 0020	**E- 020** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	11/11/2021

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	with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect six patients in the new dialysis treatment room. Findings include: Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19 with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, the facility's Emergency Preparedness Program documentation did not include consideration of dialysis treatment patients during an emergency. This finding was reviewed with the Plant Operations Director during the exit conference.		Observation 1- The Community failed to ensure that the Emergency Preparedness Program had been reviewed and updated with the creation of an in-house dialysis center. See attached documents titled “Tab 8 E-20 Evacuation and Relocation” showing these revisions. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Future training within the community will include the dialysis provider and their onsite staff. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR.	

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			V. Plan of Correction completion date. Plan of Completion date is November 11, 2021. /p>	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19	E 0029	**E- 029** **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 Communication Plan as Part of the EPP was reviewed and	11/11/2021

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	with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 10/08/19 which was not within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities agreed the emergency preparedness program communication plan documentation was not reviewed by the facility within the most recent twelve month period. This finding was reviewed with the Plant Operations Director during the exit conference.		updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. /p>	

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop			

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	and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility	E 0036	**E- 036**	11/11/2021

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	failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Disaster Preparedness Manual" dated 10/08/19 with the Corporate Director of Facilities and the Plant Operations Director during record review from 10:40 a.m. to 12:00 p.m. on 11/04/21, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities agreed the emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. This finding was reviewed with the Plant Operations Director during the exit conference.		**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 Training and Testing Documentation as Part of the EPP was reviewed and updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021.	
K 0000 Bldg. 01	A Life Safety Code Preoccupancy survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The portion of the facility surveyed was the remodeling of the chapel into a storage room which contains an oxygen storage room and a closet and the conversion of a staff training room, employee toilet room, offices and an oxygen storage room into a 6-bay dialysis treatment room and nurse area in Building 01. Survey Date: 11/04/21 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code and Preoccupancy survey, Altenheim Health and Living Community was found not in compliance with Requirements for Participation in Medicare, 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,	K 0000	November 11, 2021 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: TX4U21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on Nov 4, 2021. This letter is to inform you that the plan of correction attached is to serve as Altenheim Health & Living Community credible allegation of compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Existing Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. 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 77 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/08/21		We allege substantial compliance on November 10,2021. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-788-4261 Sincerely, Rex Buckley, HFA Administrator Altenheim Health and Living Submission of this plan of correction in no way constitutes an admission by Altenheim Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment	

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			Committee meeting. **E- 004** **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 Emergency Preparedness Program has been reviewed annually. The Administrator, Director of Nursing, and Maintenance Supervisor has reviewed the EP Program. See attached sign off sheet. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not**	

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			recur. There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 006** **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 All Hazards Risk Assessment was reviewed or revised in the last 12 months. See attached current risk assessment dated November 7th, 2021.	

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			II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and Risk Assessment during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021.	

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			E- 013 **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 Policies and Procedures have been reviewed after the current All Hazards Risk Assessment was reviewed or updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the All Hazards Risk Assessment annually during the month of January. See attached TELS Task labeled “Risk Assessment Review Task”. This task discusses reviewing the Policies and Procedures based on	

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			those findings. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program and the Policies and Procedures during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 020** **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 Emergency Preparedness Program had been reviewed and updated with the creation of an in-house dialysis center. See attached documents titled “Tab 8 E-20 Evacuation and Relocation” showing these revisions. **II. The facility will identify other residents that may**	

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			potentially be affected by the deficient practice. All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Future training within the community will include the dialysis provider and their onsite staff. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **E- 029** **I. The corrective actions to be accomplished for those**	

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			residents found to have been affected by the deficient practice. Observation 1- The Community failed to ensure that the Communication Plan as Part of the EPP was reviewed and updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program annually during the month of January. See attached TELS Task labeled “EP Preparedness Review Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR.	

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			V. Plan of Correction completion date. Plan of Completion date is November 11, 2021. **E- 036** **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 Training and Testing Documentation as Part of the EPP was reviewed and updated. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to review the EP Program	

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			annually during the month of January. See attached TELS Task labeled "EP Preparedness Review Task". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the EP Program during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **K- 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the door latching system was functioning correctly to the door that entered the dialysis treatment area. See attached picture labeled "Altenheim Davita Door Latch" showing this door has been repaired.	

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			II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a monthly TELS Task in place to inspect all doors to the corridors to ensure they are latching correctly. See attached task labeled “Door Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all corridor doors to ensure they latch their annual door inspection. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021.	

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			K- 372 **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 all penetrations were properly fire caulked. The oxygen room and Dialysis bio med room had penetrations that were sealed up. See attached pictures showing these 2 areas. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to inspect the entire community every 6 months looking for areas that need fire blocked. See attached Task Labeled “Fire Blocking Task”	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will audit the community looking for improper fire blocking their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 11, 2021. **K-914** **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 new hospital grade outlets in the dialysis treatment area had been inspected upon installation. Glenn Smith with CarDon Corporate has inspected these outlets. His findings were then added to the Annual Receptacle testing that we do. See attached new updated reports showing these inspections. These receptacles will be inspected annually moving forward.	

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			II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents in the dialysis treatment area have the potential to be affected by this deficient practice **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently a TELS Task in place to have their annual electrical receptacle inspection during the month of February. See attached task labeled “receptacle inspection task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities completes the annual electrical receptacle testing during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is November 9, 2021.	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 1 dialysis treatment rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 6 residents, staff and visitors in the vicinity of the new dialysis treatment room. Findings include: Based on observations with the Corporate Director of Facilities during a tour of the facility from 10:15 a.m. to 10:40 a.m. on 11/04/21, the latching plate was missing on the door frame for the corridor door to the new dialysis treatment room which caused the door to not latch into the door frame and resist the passage of smoke when tested to close multiple times. Based on interview at the time of the observations, the Corporate Director of Facilities stated a latching plate was supposed to be installed on the door frame by tomorrow but agreed the corridor door to the new dialysis treatment room had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Plant Operations Director during the exit conference. 3.1-19(b)	K 0363		11/11/2021
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

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	Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 3 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect 6 patients and staff in the new dialysis treatment room. Findings include: Based on observations with the Corporate Director of Facilities during a tour of the facility from 10:15 a.m. to 10:40 a.m. on 11/04/21, the annular space surrounding electrical conduits which penetrated the suspended ceiling in two separate holes above the wall mounted electrical	K 0372		11/11/2021

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	panel in the Bio-Med storage room inside the new dialysis treatment room was not firestopped. Based on interview at the time of the observations, the Corporate Director of Facilities agreed the aforementioned two openings in the suspended ceiling of the Bio-Med storage room inside the new dialysis treatment room were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Plant Operations Director during the exit conference. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	11/04/2021

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

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	containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation and interview, the facility failed to ensure hospital-grade receptacles testing documentation after initial installation was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect 6 patients in the new dialysis treatment room. Findings include: Based on observations with the Corporate Director of Facilities during a tour of the facility from 10:15 a.m. to 10:40 a.m. on 11/04/21, wall mounted hospital-grade receptacles were installed in outlet boxes near each of the six bays for dialysis treatment in the new dialysis treatment room. Based on interview at the time of the observations, the Corporate Director of Facilities stated the new dialysis treatment room has 6	K 0914	*Electrical Receptacle Deficiency Log* **Receptacle** **Inspection Deficiency** **Documentation 05.17.2021** **Room #** **Device ID or Location** **Physical Integrity** **Ground Continuity** **Polarity Check** **Ground Retention; no less than 4oz.** **Repaired Date** **Pass/Fail** **Pass/Fail** **Pass/Fail** **Pass/Fail** 1071A All Room Recept. Pass Pass Pass Pass 1071B All Room Recept. Pass Pass Pass Pass 1072A All Room Recept. Pass Pass Pass Pass	11/11/2021

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	patient treatment areas, the hospital-grade receptacles were newly installed in the room and stated an itemized listing of the inspection and testing of the newly installed hospital-grade electrical outlet receptacles in the new dialysis treatment room was not available for review. This finding was reviewed with the Plant Operations Director during the exit conference. 3.1-19(b)		1072B All Room Recept. Pass Pass Pass Pass 1073A All Room Recept. Pass Pass Pass Pass 1073B All Room Recept. Pass Pass Pass Pass 1074A All Room Recept. Pass Pass Pass Pass Pass 1074B All Room Recept. Pass Pass Pass Pass 1075A All Room Recept. Pass Pass Pass Pass 1075B All Room Recept. Pass Pass	

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			Pass Pass 1076A All Room Recept. Pass Pass Pass Pass 1076B All Room Recept. Pass Pass Pass Pass 1077A All Room Recept. Pass Pass Pass Pass 1077B All Room Recept. Pass Pass Pass Pass 1078A All Room Recept. Pass Pass Pass Pass 1078B All Room Recept. Pass Pass Pass Pass 1079A All Room Recept.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			Pass Pass Pass Pass 1079B All Room Recept. Pass Pass Pass Pass 1080A All Room Recept. Pass Pass Pass Pass 1080B All Room Recept. Pass Pass Pass Pass 1081A All Room Recept. Pass Pass Pass Pass 1081B All Room Recept. Pass Pass Pass Pass 1082A All Room Recept. Pass Pass Pass Pass	

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			1082B All Room Recept. Pass Pass Pass Pass 1083A All Room Recept. Pass Pass Pass Pass 1083B All Room Recept. Pass Pass Pass Pass 1085A All Room Recept. Pass Pass Pass Pass *Electrical Receptacle Deficiency Log* **Receptacle Inspection Deficiency Documentation** **05.17.2021** **Room #** **Device ID or Location** **Physical Integrity** **Ground Continuity** **Polarity Check** **Ground Retention; no less than 4oz.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	11/04/2021

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			Repaired Date **Pass/Fail** **Pass/Fail** **Pass/Fail** **Pass/Fail** 1085B All Room Recept. Pass Pass Pass Pass 1086A All Room Recept. Pass Pass Pass Pass 1086B All Room Recept. Pass Pass Pass Pass 1087A All Room Recept. Pass Pass Pass Pass 1087B All Room Recept. Pass Pass Pass Pass 1088A All Room Recept. Pass Pass Pass	

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			Pass 1088B All Room Recept. Pass Pass Pass Pass 1089A All Room Recept. Pass Pass Pass Pass 1089B All Room Recept. Pass Pass Pass Pass 1090A All Room Recept. Pass Pass Pass Pass 1090B All Room Recept. Pass Pass Pass Pass 1091A All Room Recept. Pass Pass Pass Pass 1091B All Room Recept. Pass	

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			Pass Pass Pass 1092A All Room Recept. Pass Pass Pass Pass 1092B All Room Recept. Pass Pass Pass Pass 1093A All Room Recept. Pass Pass Pass Pass 1093B All Room Recept. Pass Pass Pass Pass 1094A All Room Recept. Pass Pass Pass Pass 1094B All Room Recept. Pass Pass Pass Pass 1095A	

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			All Room Recept. Pass Pass Pass Pass 1095B All Room Recept. Pass Pass Pass Pass 1096A All Room Recept. Pass Pass Pass Pass 1096B All Room Recept. Pass Pass Pass Pass 1097A All Room Recept. Pass Pass Pass Pass 1097B All Room Recept. Pass Pass Pass Pass 1098A All Room Recept. Pass Pass Pass	

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			Pass 1098B All Room Recept. Pass Pass Pass Pass *Electrical Receptacle Deficiency Log* **Receptacle** **Inspection Deficiency Documentation 05.17.2021** **Room #** **Device ID or Location** **Physical Integrity** **Ground Continuity** **Polarity Check** **Ground Retention; no less than 4oz.** **Repaired Date** **Pass/Fail** **Pass/Fail** **Pass/Fail** **Pass/Fail** 1099A All Room Recept. Pass Pass Pass Pass 1099B All Room Recept. Pass	