PRINTED:

06/01/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days 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.

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | r í | ILDING | NSTRUCTION | CON | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|-------------------|---|--|-----|--------------|---|------|---|--|
| NAME OF | PROVIDER OR SUPPLIE | ĒR | | | DDRESS, CITY, STATE, ZIP COD | E | | |
| ALPHA | HOME - A WATER | S COMMUNITY | | | OLD SPRING RD APOLIS, IN 46222 | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF | D BE | (X5) COMPLETIO | |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | The [LTC facility implement emerg systems based of forth in paragrap §482.15(e)(1), §4 (1) Emergency gene generator must b with the location Health Care Faci Tentative Interim 12-3, TIA 12-4, T Safety Code (NF Interim Amendm 12-3, and TIA 12 | nd standby power systems. and the CAH] must gency and standby power on the emergency plan set h (a) of this section. 483.73(e)(1), §485.625(e) erator location. The be located in accordance requirements found in the ilities Code (NFPA 99 and Amendments TIA 12-2, TIA TA 12-5, and TIA 12-6), Life PA 101 and Tentative ents TIA 12-1, TIA 12-2, TIA -4), and NFPA 110, when a built or when an existing ing is renovated. | | | | | | |
| | Emergency gene The [hospital, CA implement the er inspection, testin requirements fou | 33.73(e)(2), §485.625(e)(2) erator inspection and testing. AH and LTC facility] must mergency power system g, and [maintenance] und in the Health Care NFPA 110, and Life Safety | | | | | | |
| | Emergency gene and LTC facilities fuel source to po must have a plan emergency powe | 33.73(e)(3), §485.625(e)(3) erator fuel. [Hospitals, CAHs s] that maintain an onsite wer emergency generators n for how it will keep er systems operational gency, unless it evacuates. | | | | | | |
| | §483.73(g), and | : §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in | | | | | | |

| | R MEDICARE & MEDI NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | IULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|---------|--------------------------------------|--------------------------------|--------|-------------|---|-----------|-----------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | î î | UILDING | | COMPI | |
| | | 155717 | | VING | | 05/12 | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | ER | | 2640 C | OLD SPRING RD | | |
| ALPHA | HOME - A WATER | S COMMUNITY | | INDIAN | APOLIS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTIO | DN | (X5) |
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| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | approved for incorporation | | | | | |
| | | he Director of the Office of | | | | | |
| | - | ster in accordance with 5 | | | | | |
| | | id 1 CFR part 51. You may | | | | | |
| | | al from the sources listed | | | | | |
| | - | inspect a copy at the CMS | | | | | |
| | | burce Center, 7500 Security | | | | | |
| | | nore, MD or at the National | | | | | |
| | | cords Administration | | | | | |
| | · · · | rmation on the availability of | | | | | |
| | | IARA, call 202-741-6030, or | | | | | |
| | go to: | <i>"</i> ,,, | | | | | |
| | | /es.gov/federal_register/cod | | | | | |
| | | ulations/ibr_locations.html. | | | | | |
| | | this edition of the Code are | | | | | |
| | | reference, CMS will publish | | | | | |
| | | e Federal Register to | | | | | |
| | announce the ch | - | | | | | |
| | | Protection Association, 1 | | | | | |
| | Batterymarch Pa | | | | | | |
| | 1.617.770.3000. | 69, www.nfpa.org, | | | | | |
| | (i) NFPA 99, Hea | alth Care Facilities Code, | | | | | |
| | 2012 edition, iss | ued August 11, 2011. | | | | | |
| | (ii) Technical inte | erim amendment (TIA) 12-2 | | | | | |
| | to NFPA 99, issu | ied August 11, 2011. | | | | | |
| | (iii) TIA 12-3 to N | IFPA 99, issued August 9, | | | | | |
| | 2012. | | | | | | |
| | (iv) TIA 12-4 to N 2013. | IFPA 99, issued March 7, | | | | | |
| | | FPA 99, issued August 1, | | | | | |
| | 2013. (vi) TIA 12-6 to N | IFPA 99, issued March 3, | | | | | |
| | 2014. | ite Catatu Cada 2012 | | | | | |
| | | Life Safety Code, 2012 | | | | | |
| | edition, issued A | C | | | | | |
| | | NFPA 101, issued August | | | | | |
| | 11, 2011. | IEDA 101 jacuard Oatakar | | | | | |
| | (IX) TIA 12-2 to N 30, 2012. | IFPA 101, issued October | | | | | |
| | 1 | | | | 1 | | 1 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MUL A. BUIL B. WINC | | СОМ | 'e survey pleted 2/2022 |
|---------|---|--|--------------------------------|--|--|--------------------------------------|
| | PROVIDER OR SUPPLIE | | : | STREET ADDRESS, CITY, STATE, ZI 2640 COLD SPRING RD INDIANAPOLIS, IN 46222 | P CODE | |
| (X4) ID | SUMMARY S | SUMMARY STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PR | REFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T | N SHOULD BE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG DEFICIENCY | | DATE |
| | (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to N 22, 2013. (xiii) NFPA 110, S and Standby Pow including TIAs to 2009 Based on record re facility failed to im power system inspe maintenance requin Care Facilities Coo Code in accordance This deficient prace occupants. Findings include: Based on review of Monthly Test Log" recent twelve mont Administrator duria a.m. to 12:05 p.m. testing documentat fuel fired emergend month period of Se December 2021 wa Review of "Emergy Inspection Checkli most recent twelve weekly emergency documentation for emergency generat 04/18/22 was also is Based on interview the Administrator se former Maintenance | FPA 101, issued October FPA 101, issued October Standard for Emergency ver Systems, 2010 edition, chapter 7, issued August 6, view and interview, the aplement the emergency ection, testing and rements found in the Health de, NFPA 110, and Life Safety e with 42 CFR 483.73(e)(2). tice could affect all f "Emergency Generators - ' documentation for the most | E 004 | | ent of the mplement the ystem nd ements found facilities code, Safety Code 42 CFR et set E ACTIONS 2 the ted the visor/designee that the deness Policy e weekly load testing of erator to meet NITH AFFECTED : all staff and tential to be ere. The Emergency y Manual. | 06/03/2022 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V9S721

Facility ID: 000376

If continuation sheet Page 4 of 37

| AND PLAN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | A. BUILDING CO | | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|-----------------------------------|--|---|-------------------------------|---|---|--|
| | PROVIDER OR SUPPLIE | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE COLD SPRING RD NAPOLIS, IN 46222 | | |
| ALPHA (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE REGULATORY O emergency generat documentation for within the most rea not available for rea | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) tor testing and inspection • the aforementioned periods cent twelve month period was eview. | INDIAN ID PREFIX TAG | APOLIS, IN 46222 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) the Administrator to review the Emergency Preparedness Policy Manual and ensure weekly testir and monthly load testing of the emergency generator is conducted and recorded in the Emergency Preparedness Manu to meet set standards. If any issues are discovered, they will b addressed and resolved immediately. B) The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: A) The results will be presented the Maintenance Supervisor/designee to the Administrator at least annually a the Administrator will present the results at the Quality Assurance/Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plar | ng lal loo loo loo loo loo loo loo loo loo | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000376

2022.

constitutes our credible

allegation of compliance with all regulatory requirements. Our date of compliance is June 3,

If continuation sheet

Page 5 of 37

PRINTED:

06/01/2022

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | ì í | LDING IG | 01 | сом 05/ | te survey Mpleted 12/2022 |
|--------------------------|--|---|------|---------------------|--|--|---------------------------------|
| | PROVIDER OR SUPPLIE | | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| | HOME - A WATER | | | | NAPOLIS, IN 46222 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | Р | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| < 0000 | | , | | | | | |
| Bldg. 01 | Licensure Survey State Department of 42 CFR 483.90(a). Survey Date: 05/1 Facility Number: Provider Number: AIM Number: 100 At this Life Safety Waters Communit with Requirements Medicare/Medicai Life Safety from F National Fire Proto 101, Life Safety C Existing Health Ca 16.2. This one story faci Type V (111) cons The facility has a f wired smoke detect open to the corrido rooms. The facilit a census of 54 at th All areas where re- were sprinkled and services were sprin storage shed. | 2/22 000376 155717 | K 00 | 00 | : Preparation and/or exe of this plan of correction general, or this corrective action in particular, does constitute an admission agreement by this facility facts alleged or conclusie forth in this statement of deficiencies. The plan of correction and specific corrective actions are pre and/or executed in comp with state and federal law This plan of correction constitutes a written alleg of substantial compliance Federal Medicare and Me requirements. | in e not or of the ons set epared liance vs. gation e with | |

Facility ID: 000376

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Page 6 of 37

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 B. WING 155717 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) K 0100 **NFPA 101** SS=E General Requirements - Other Bldg. 01 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility K 0100 **K100**– It is the intent of the facility 06/03/2022 failed to maintain latching hardware on 1 of 3 to ensure to maintain latching sets of smoke barrier doors per LSC Section hardware on smoke barrier doors 4.6.12.3. LSC Section 4.6.12.3 requires existing per LSC Section 4.6.12.3 to meet life safety features obvious to the public if not set standards. **CORRECTIVE ACTIONS** required by the Code, shall be either maintained 1. or removed. This deficient practice could affect TAKEN: over 20 residents, staff and visitors in the a. The Maintenance vicinity of the smoke barrier door set for the 100 Supervisor/designee will repair Hall. the latching mechanism at the top of the west door in the corridor Findings include: door set at the entrance to the 100 hall so that it latches fully into the Based on observations with the Administrator door frame to meet set standards. The Administrator will verify the and the Maintenance Director during a tour of the facility from 12:30 p.m. to 2:10 p.m. on repair when completed . 05/12/22, the latching mechanism at the top of 2. ALL OTHERS WITH the west door in the corridor door set at the POTENTIAL TO BE AFFECTED: entrance to the 100 Hall failed to protrude into a. All residents and all staff the latching plate on the door frame when tested and visitors have the potential to to close multiple times. Each door in the door be affected but none were. The Maintenance Supervisor/designee set was equipped with an affixed fire resistance rating (FRR) label stating the door was rated at inspected all smoke barrier doors throughout the facility and found 90 minutes FRR. Based on interview at the time of the observations, the Administrator agreed the no other negative findings. latching hardware for the west door in the smoke 3. **MEASURES TO** barrier door set at the entrance to the 100 Hall PREVENT REOCCURRENCE: failed to latch into the door frame when tested to a. On May 25, 2022 the close multiple times. Administrator educated the Maintenance Supervisor/designee

V9S721 Facility

Facility ID: 000376

If continuation sheet

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06/01/2022

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | 01 | COMPI | date survey completed 95/12/2022 | |
|-------------------|-------------------------------------|--|---|--|---|--|--|
| | PROVIDER OR SUPPLIE | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE COLD SPRING RD NAPOLIS, IN 46222 | | | |
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| | during the exit cor 3.1-19(b) | eviewed with the Administrator ference. | | on the requirement that late hardware on smoke barrier must be maintained in good working condition to meet s standards. b. Maintenance Supervisor/designee will ins all smoke barrier doors thro the facility monthly to ensur are maintained and in good working condition as a part facility's Preventive Mainter Program and document tho inspection results as appropriate. If any issues discovered, they will be add and resolved immediately. Maintenance Supervisor/de will review with the Adminis the inspection results. c. The Administrator wil monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance | doors d et spect oughout e they of the nance se are dressed The esignee trator | | |
| | | | | 4. MONITORING CORRECTIVE ACTION : a. The inspection result be presented by the Mainter Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mod Quality Assurance/Perform Improvement (QA/PI) meet Inspection results and syste components will be reviewed the QA/PI Committee with subsequent plans of correct | nance the onthly ance ing. em ed by | | |

| | R MEDICARE & MEDI NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE (| CONSTRUCTION | (X3) DATE | IB NO. 0938-0391 | |
|----------|---|--|-----------------|---|-----------|------------------|--|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPL | | |
| ANDILAN | I OF CORRECTION | 155717 | B. WING | <u>01</u> | | /12/2022 | |
| | | 1957 17 | D. WING | | 03/12/ | 12022 | |
| NAME OF | PROVIDER OR SUPPLI | ER | | FADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | COLD SPRING RD | | | |
| ALPHA I | HOME - A WATER | S COMMUNITY | INDIA | NAPOLIS, IN 46222 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
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| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY | | DATE | |
| | | | | developed and implemented a | s | | |
| | | | | deemed necessary to ensure | | | |
| | | | | compliance is maintained. | | | |
| | | | | This plan of correction | | | |
| | | | | constitutes our credible | | | |
| | | | | allegation of compliance with | | | |
| | | | | regulatory requirements. Ou | | | |
| | | | | date of compliance is June 3 | , | | |
| | | | | 2022. | | | |
| K 0211 | NFPA 101 | | | | | | |
| SS=E | Means of Egress | - General | | | | | |
| Bldg. 01 | Means of Egress | | | | | | |
| 0 | | vays, corridors, exit | | | | | |
| | | locations, and accesses are | | | | | |
| | in accordance w | ith Chapter 7, and the | | | | | |
| | means of egress | is continuously maintained | | | | | |
| | free of all obstrue | ctions to full use in case of | | | | | |
| | | ss modified by 18/19.2.2 | | | | | |
| | through 18/19.2. | | | | | | |
| | 18.2.1, 19.2.1, 7 | | | | | | |
| | | tion and interview, the facility | K 0211 | K211 – It is the intent of the | | 06/03/202 | |
| | | of 6 means of egress were | | facility to ensure to provide me | | | |
| | - | ntained free of all obstructions | | of egress continuously maintai | ned | | |
| | - | full instant use in the case of | | free of all obstructions or | in | | |
| | | gency. This deficient practice 20 residents, staff and visitors | | impediments to full instant use the case of fire or other | III) | | |
| | | the facility from the 400 Hall. | | emergency to meet set standa | rde | | |
| | If ficeding to exit | the facility from the 400 fran. | | 1. CORRECTIVE ACTION | | | |
| | Findings include: | | | TAKEN: | 0 | | |
| | 1 mangs mereaet | | | a. On May 12, 2022 the | | | |
| | Based on observat | tions with the Administrator | | Maintenance Supervisor/desig | nee | | |
| | and the Maintenar | nce Director during a tour of | | removed the wooden recycling | | | |
| | | 2:30 p.m. to 2:10 p.m. on | | container from the wall in the | | | |
| | | en recycling container was | | corridor outside of Director of | | | |
| | stored up against | he wall in the corridor outside | | Nursing's office in the 400 hall | to | | |
| | the Director of Nu | rsing's (DON) Office in the | | meet set standards. The | | | |
| | | ntainer protruded two feet into | | Administrator verified the remo | oval | | |
| | | of the corridor. Based on | | on May 12, 2022 . | | | |
| | interview at the time | ne of the observations, the | | 2. ALL OTHERS WITH | | 1 | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|--------------------------|---|---|---|---|--|--|
| NAME OF | PROVIDER OR SUPPLIE | 3R | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ALPHA I | HOME - A WATER | S COMMUNITY | INDIAN | NAPOLIS, IN 46222 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES 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 APPROPRI. DEFICIENCY) | (X5) COMPLET DATE | |
| | Administrator state stored in the hallw not continuously n obstructions or im the case of fire or o | ed the container is normally ray and agreed the 400 Hall was naintained free of all pediments to full instant use in other emergency. | | POTENTIAL TO BE AFFECT a. All residents and all sta and visitors have the potential be affected but none were. Of May 12, 2022 the Maintenan Supervisor/designee inspected corridor means of egress and found no other negative findir 3. MEASURES TO PREVENT REOCCURRENCE a. On May 24th and 25th Administrator educated the Maintenance Supervisor/desi and other staff on the requirement that the Corridor meet set standards. b. Maintenance Supervisor/designee will insp all corridor means of egress throughout the facility weekly obstructions as a part of the facility's Preventive Maintena Program and document those inspection results as appropriate. If any issues ar discovered, they will be addre and resolved immediately. Th Maintenance Supervisor/desi will review with the Administra the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results of the inspection results of the preventative Maintenance schedule and validate the preventative Maintenance documentation is in place. | ED: aff l to Dn ce ed all ngs. E: the gnee s to ect for nce e essed he gnee ator | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION 01 | COM | te survey Ipleted 12/2022 |
|--------------------------|--|--|---|---|--|---------------------------------|
| | PROVIDER OR SUPPLIE | | 2640 0 | [°] address, city, state, zip COLD SPRING RD NAPOLIS, IN 46222 | P CODE | |
| (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY) Supervisor/designee Administrator monthl | T SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| K 0222 | NFPA 101 | | | Administrator month Administrator will pre- inspection results at Quality Assurance/Pe Improvement (QA/PI Inspection results an components will be re- the QA/PI Committee subsequent plans of developed and imple deemed necessary to compliance is mainta This plan of correctional constitutes our credo allegation of compliance date of compliance is 2022. | sent the the monthly erformance) meeting. d system eviewed by e with correction mented as o ensure ained. ion dible ance with all ents. Our | |
| SS=E Bldg. 01 | not be equipped requires the use egress side unlet special locking a CLINICAL NEED LOCKING Where special lo clinical security r used, only one lo permitted on eac be made for the by: remote contro locks or keys car other such reliab staff at all times. | ed means of egress shall with a latch or a lock that of a tool or key from the ss using one of the following rrangements: DS OR SECURITY THREAT cking arrangements for the needs of the patient are ocking device shall be th door and provisions shall rapid removal of occupants of of locks; keying of all rried by staff at all times; or le means available to the 2.2.2.6, 19.2.2.2.5.1, | | | | |

| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CON | STRUCTION | (X3) DA | TE SURVEY |
|----------|---------------------|---|----------------------|---------|---|----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155717 | A. BUILDI B. WING | NG | 01 | | MPLETED 12/2022 |
| | | | ST | REET AD | DRESS, CITY, STATE, ZIP C | CODE | |
| NAME OF | PROVIDER OR SUPPLIE | ER | 26 | 640 COI | LD SPRING RD | | |
| ALPHA | HOME - A WATER | S COMMUNITY | | | POLIS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF COR | RECTION | (X5) |
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| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | TA | .G | DEFICIENCY) | | DATE |
| | 19.2.2.2.6 | | | | | | |
| | SPECIAL NEED | S LOCKING | | | | | |
| | ARRANGEMEN | TS | | | | | |
| | | cking arrangements for the | | | | | |
| | - | he patient are used, all of | | | | | |
| | | curity Locking requirements | | | | | |
| | - | addition, the locks must be | | | | | |
| | | nat fail safely so as to | | | | | |
| | | s of power to the device; the | | | | | |
| | | ted by a supervised | | | | | |
| | | ler system and the locked | | | | | |
| | | ed by a complete smoke | | | | | |
| | | (or is constantly monitored | | | | | |
| | | cation within the locked | | | | | |
| | | the sprinkler and detection | | | | | |
| | - | nged to unlock the doors | | | | | |
| | upon activation. | | | | | | |
| | 18.2.2.2.5.2, 19.2 | | | | | | |
| | DELAYED-EGRI | | | | | | |
| | ARRANGEMEN | | | | | | |
| | | delayed-egress locking | | | | | |
| | | l in accordance with | | | | | |
| | | e permitted on door | | | | | |
| | | ng low and ordinary hazard ngs protected throughout by | | | | | |
| | | · · · · | | | | | |
| | | pervised automatic fire or an approved, supervised | | | | | |
| | automatic sprink | | | | | | |
| | 18.2.2.2.4, 19.2.2 | - | | | | | |
| | | ROLLED EGRESS | | | | | |
| | LOCKING ARRA | | | | | | |
| | | ed Egress Door assemblies | | | | | |
| | | dance with 7.2.1.6.2 shall | | | | | |
| | be permitted. | | | | | | |
| | 18.2.2.2.4, 19.2.2 | 2.2.4 | | | | | |
| | | BBY EXIT ACCESS | | | | | |
| | LOCKING ARRA | | | | | | |
| | | kit access door locking in | | | | | |
| | - | 7.2.1.6.3 shall be permitted | | | | | |
| | | ies in buildings protected | | | | | |
| | 1 | J 1 | | | | | |

| | ENT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE A. BUILDING B. WING | construction <u>01</u> | COMP | e survey leted 2/2022 |
|--------------------------|--|---|---|--|---|-----------------------------|
| | PROVIDER OR SUPPLIE | | 2640 | T ADDRESS, CITY, STATE, ZIP CODE COLD SPRING RD ANAPOLIS, IN 46222 | | |
| | - | | | | | • |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | IATE | (X5) COMPLETION DATE |
| | automatic fire de approved, superv system. 18.2.2.2.4, 19.2.2 Based on observat failed to ensure the 7 exits were readil without a clinical of security measures. means of egress sh latch or lock that r key from the egres permitted by LSC arrangements shall with 19.2.2.5.2. affect over 20 resid needing to exit the Findings include: Based on observat and the Maintenan the facility from 11 05/12/22, the main short hallway by th Hall and the exit do marked as a facilit each exit door was egress lock. Each entering a four dig exit door but the c interview at the tin Administrator stat be a secure wing fa agreed the code wa aforementioned th | ion and interview, the facility e means of egress through 3 of y accessible for residents diagnosis requiring specialized Doors within a required nall not be equipped with a equires the use of a tool or ss side unless otherwise 19.2.2.2.4. Door-locking I be permitted in accordance This deficient practice could dents, staff and visitors if facility. ions with the Administrator ce Director during a tour of 2:30 p.m. to 2:10 p.m. on n entrance, the exit door in the he entrance door set to the 100 oor in the 300 Hall were each y exit with an exit sign and s not equipped with a delayed exit door could be opened by it code into a keypad at the ode was not posted. Based on ne of the observations, the ed only the 200 Hall needs to for Alzheimer's residents and as not posted at the ree exit doors. | K 0222 | K222– It is the intent of the fit to ensure means of egress through exits are readily accessible for residents with clinical diagnosis requiring specialized security measure meet set standards. 1. CORRECTIVE ACTIO TAKEN: a. The Maintenance Supervisor/designee will poinformation to obtain the cod needed to release the exit do the short hallway by the entr door set to the 100 hall and the exit door in the 300 hall to m set standards. The Administ will verify the posting of the codes. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all st and visitors have the potentiable affected but none were. Maintenance Supervisor/designed will inspect all doors to the m of egress to ensure they wer readily available for use and information posted to obtain and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCT | but a es to NS st es bor in ance he eet rator TED: aff al to The ignee leans e codes | 06/03/2022 |

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Event ID:

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Facility ID: 000376

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|---------------|-------------------------------------|--|---|---|---|--|
| NAME OF I | PROVIDER OR SUPPLIE | ĒR | STREET | | | |
| ALPHA H | HOME - A WATER | S COMMUNITY | | COLD SPRING RD NAPOLIS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | | (X5) | |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE COMPLETI DATE | |
| | | , | | Maintenance Supervisor/desig | | |
| | 3.1-19(b) | | | on the requirement that doors | | |
| | | | | must have information posted how to obtain codes near the | on | |
| | | | | doors to meet set standards. | | |
| | | | | b. Maintenance | | |
| | | | | Supervisor/designee will inspe | ect | |
| | | | | all means of egress throughou | | |
| | | | | facility weekly to ensure codes | | |
| | | | | remain posted for all doors wh | ich | |
| | | | | require codes for use as a par | t of | |
| | | | | the facility's Preventive | | |
| | | | | Maintenance Program and | | |
| | | | | document those inspection res | | |
| | | | | as appropriate. If any issues | | |
| | | | | discovered, they will be addres | | |
| | | | | and resolved immediately. Th Maintenance Supervisor/desig | | |
| | | | | will review with the Administra | | |
| | | | | the inspection results. | | |
| | | | | c. The Administrator will | | |
| | | | | monitor adherence to the | | |
| | | | | Preventative Maintenance | | |
| | | | | schedule and validate the | | |
| | | | | Preventative Maintenance | | |
| | | | | documentation is in place. | | |
| | | | | 4. MONITORING | | |
| | | | | CORRECTIVE ACTION: | | |
| | | | | a. The inspection results w | | |
| | | | | be presented by the Maintenal | nce | |
| | | | | Supervisor/designee to the Administrator monthly and the | | |
| | | | | Administrator monthly and the Administrator will present the | | |
| | | | | inspection results at the month | nlv | |
| | | | | Quality Assurance/Performance | • | |
| | | | | Improvement (QA/PI) meeting | | |
| | | | | Inspection results and system | | |
| | | | | components will be reviewed b | ру | |
| | | | | the QA/PI Committee with | | |
| | | | | subsequent plans of correctior | ו ו | |

| | R MEDICARE & MEDIC | X1) PROVIDER/SUPPLIER/CLIA | | TIPLE CONSTRU | ICTION | 3) DATE SU | NO. 0938-0391 |
|------------------|---------------------|---------------------------------|----------|---------------|---|------------|---------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILI | | | COMPLE | |
| | or condenion | 155717 | B. WING | 01 | | 05/12/2 | |
| | | 1337 17 | | | | 00/12/2 | 022 |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | SS, CITY, STATE, ZIP CODE | | |
| | | | | 2640 COLD S | | | |
| ALPHA F | HOME - A WATERS | S COMMUNITY | 1 | NDIANAPOL | IS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | CRO | ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE | | COMPLETIO |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | Т | TAG | DEFICIENCY) | | DATE |
| | | | | | eloped and implemented as | | |
| | | | | | med necessary to ensure | | |
| | | | | | pliance is maintained. | | |
| | | | | | plan of correction | | |
| | | | | | stitutes our credible | | |
| | | | | | gation of compliance with a | | |
| | | | | - | latory requirements. Our | | |
| | | | | 2022 | of compliance is June 3, | | |
| | | | | 2022 | 2. | | |
| < 0331 | NFPA 101 | | | | | | |
| SS=E | Interior Wall and | Ceiling Finish | | | | | |
| Bldg. 01 | Interior Wall and | - | | | | | |
| 0 | 2012 EXISTING | 5 | | | | | |
| | Interior wall and | ceiling finishes, including | | | | | |
| | | surfaces of buildings such | | | | | |
| | as fixed or moval | ble walls, partitions, | | | | | |
| | columns, and have | e a flame spread rating of | | | | | |
| | Class A or Class | B. The reduction in class of | | | | | |
| | interior finish for | a sprinkler system as | | | | | |
| | prescribed in 10.2 | 2.8.1 is permitted. | | | | | |
| | 10.2, 19.3.3.1, 19 | | | | | | |
| | Indicate flame sp | read rating(s). | | | | | |
| | | on and interview, the facility | V 022 | 1 1 1 1 1 2 2 | 1 – It is the intent of the | | 00000000 |
| | | of 4 smoke compartments | K 033 | - | ity to ensure smoke | | 06/03/202 |
| | | a complete interior finish | | | partments are provided with | a | |
| | - | d rating of Class A or Class B | | | plete interior finish with a | ä | |
| | | cility. LSC 10.2.3.4 states | | | e spread rating of Class A o | r l | |
| | • | o be tested in accordance with | | | s B for a sprinklered facility | | |
| | · · | ard Test Method for Surface | | | t set standards. | - | |
| | | istics of Building Materials or | | 1. | CORRECTIVE ACTIONS | | |
| | | ndard for Test for Surface | | ТАК | | | |
| | | istics of Building Materials | | a. | Fire-resistant material has | | |
| | | the following classes in | | beer | n ordered and the | | |
| | | eir flame spread and smoke | | | ntenance man will apply to th | ne | |
| | development. | • | | | nate on the corridor walls | | |
| | - | r Wall and Ceiling Finish. | | | er the handrails to the floor ir | n | |
| | | ; smoke development 0-450. | | | 200 hall and documented on | | |
| | - | ial classified at 25 or less on | | | lame spread logs to meet se | | |

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

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) the flame spread test scale and 450 or less on the standards. The smoke test scale. Any element thereof, when so Administrator/designee verify tested, shall not continue to propagate fire. when this is complete. ALL OTHERS WITH (b) Class B Interior Wall and Ceiling Finish. 2. POTENTIAL TO BE AFFECTED: Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 a. All residents and all staff but not more than 75 on the flame spread test and visitors have the potential to be affected but none were. scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. 3. **MEASURES TO** PREVENT REOCCURRENCE: Flame spread 76-200; smoke development 0-450. Includes any material classified at more a. On May 25, 2022 the than 75 but not more than 200 on the flame Administrator/designee educated spread test scale and 450 or less on the smoke the Maintenance Supervisor/designee on the test scale. LSC Table A.10.2 permits the following test requirement that smoke methods for textile wall coverings: compartment interior finishes ASTM E 84, Standard Test Method for Surface throughout the facility must have a flame spread rating of Class A or Burning Characteristics of Building Materials; ANSI/UL 723, Standard for Test for Surface Class B and documented in the Burning Characteristics of Building Materials; flame spread logs to meet set NFPA 286 standards. NFPA 265, Method B Maintenance b. This deficient practice could affect over 10 Supervisor/designee will inspect residents, staff and visitors in the 200 Hall. all interior finishes in the smoke compartments throughout the Findings include: facility to ensure they have a flame spread rating of Class A or Based on observations with the Administrator B as a part of the facility's and the Maintenance Director during a tour of Preventive Maintenance Program the facility from 12:30 p.m. to 2:10 p.m. on and document those inspection 05/12/22, a brown colored laminate was affixed results as appropriate. If any to the corridor walls under the handrails to the issues are discovered, they will be floor in the 200 Hall. The laminate appeared to addressed and resolved be the same material as the flooring installed in immediately. The Maintenance the 100 Hall. Based on interview at the time of Supervisor/designee will review with the Administrator the the observations, the Administrator stated the laminate had not been treated with flame inspection results. retardant material and agreed flame spread rating The Administrator will C. documentation for the laminate affixed to the monitor adherence to the wall in the 200 Hall was not available for review Preventative Maintenance

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V9S721 Facility

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06/01/2022

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|----------------------------|--|---|---|---|---|---------------------------|
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODI | 2 | |
| ALPHA I | HOME - A WATER | S COMMUNITY | | NAPOLIS, IN 46222 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | ION D BE OPRIATE | (X5) COMPLETIO DATE |
| mo | at the time of the s | · · · · · · · · · · · · · · · · · · · | | schedule and validate the Preventative Maintenance | | |
| | This finding was r during the exit cor 3.1-19(b) | eviewed with the Administrator ference. | | documentation is in place 4. MONITORING CORRECTIVE ACTION: a. The inspection results be presented by the Main | Its will | |
| | | | | Supervisor/designee to th Administrator monthly and Administrator will present inspection results at the m Quality Assurance/Perform Improvement (QA/PI) mee Inspection results and sys components will be review the QA/PI Committee with subsequent plans of correct developed and implement deemed necessary to ens compliance is maintained. This plan of correction constitutes our credible allegation of compliance regulatory requirements date of compliance is Ju 2022. | e the the nonthly nance eting. tem ved by ection ed as ure with all Our | |
| < 0351 SS=E Bldg. 01 | by construction ty throughout by an sprinkler system 13, Standard for Systems. In Type I and II c protection measu | | | | | |

| | T OF HEALTH AND HU R MEDICARE & MEDIC | | | | | | RM APPROVED |
|---------|--|--|--------|-----------|--|--|-------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE C | ONSTRUCTION | (X3) DATE | |
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | JILDING | 01 | COMPL | LETED |
| | | 155717 | B. W. | ING | <u></u> | 05/12 | /2022 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | COLD SPRING RD | | |
| ALPHA I | HOME - A WATERS | S COMMUNITY | | | NAPOLIS, IN 46222 | | |
| X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | 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 APPROPRI | IATE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| IAG | areas where state prohibit sprinklers In hospitals, sprin clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, Based on observati failed to maintain t 1 ceiling smoke ba NFPA 13, Standard Sprinkler Systems. Section 6.2.7.1 stat other devices used around a sprinkler listed for use arour practice could affect visitors. Findings include: Based on observati and the Maintenan- the facility from 12 05/12/22, the follor sprinkler locations a. 100 Hall Cart Sta b. 100 Hall Janitor c. 100 Hall oxygen d. closet in Room 2 f. both sprinklers in room across from t Based on interview observations, the A | e or local regulations be added a sprinkler severage rowers f the closet does not exceed a sprinkler coverage covers and as required by NFPA 13, allation of Sprinkler c, 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) on and interview, the facility the ceiling construction in 1 of rriers in accordance with d for the Installation of NFPA 13, 2010 edition, res plates, escutcheons, or to cover the annular space shall be metallic, or shall be id a sprinkler. This deficient et over 20 residents, staff and ons with the Administrator ce Director during a tour of cons with the Administrator ce Director during a tour of cons with the Administrator ce Director during a tour of conserved the annular space shall be metallic, or shall be d a sprinkler. This deficient et over 20 residents, staff and ons with the Administrator ce Director during a tour of conserved the annular space staff and ons with the Administrator ce Director during a tour of consect. storage and transfilling room. 109. 206. n the Housekeeping Supply he Activities Room. | К 0 | | K351– It is the intent of the fatto ensure to maintain the ceil construction in ceiling smoke barriers in accordance with N 13 to meet set standards. CORRECTIVE ACTION TAKEN: The Maintenance Supervisor/designee will instate scutcheon rings at the follow ceiling mounted sprinkler locations: a) 100 hall cart stor room b) 100 hall janitors closs 100 hall oxygen storage and transfilling room d) closet in r 109 e) closet in room 206 f) the sprinklers in the housekeeping supply room across from the activities room to meet set standards. The Administrator verify when work completed in the standards. The Administrator verify when work completed in | ing IFPA NS all the ving rage et c) ooom ooth ng r ED : aff al to | 06/03/2022 |

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Facility ID: 000376

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| STATEMENT OF DEFICIENCIE ND PLAN OF CORRECTION | 5 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED 05/12/2022 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPP | LIER | | ADDRESS, CITY, STATE, ZIP CODE | |
| ALPHA HOME - A WATE | RS COMMUNITY | INDIAN | NAPOLIS, IN 46222 | |
| PREFIX (EACH DEFIC | Y STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETIC |
| locations was n | OR LSC IDENTIFYING INFORMATION) issing its escutcheon. s reviewed with the Administrator onference. | TAG | Administrator educated the Maintenance Supervisor/desig on the requirement that ceiling mounted sprinklers must have escutcheon ring to meet set standards. b. Maintenance Supervisor/designee will inspe- all sprinklers monthly to ensur escutcheon rings are present part of the facility's Preventive Maintenance Program and document those inspection re- as appropriate. If any issues discovered, they will be addre and resolved immediately. Th Maintenance Supervisor/desig will review with the Administra- the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results v be presented by the Maintena Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting | vill vill vill hly ce |

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| | R MEDICARE & MEDI NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | 1B NO. 0938-0391 SURVEY |
|--------------------------|---|----------------------------------|--------|------------|--|-----------|----------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | ì í | JILDING | 01 | COMP | |
| | | 155717 | B. WI | | 01 | | /2022 |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | OLD SPRING RD | | |
| | HOME - A WATER | | | | IAPOLIS, IN 46222 | | |
| | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP | RIATE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | deemed necessary to ensur | e | |
| | | | | | compliance is maintained. | | |
| | | | | | This plan of correction | | |
| | | | | | constitutes our credible | ith all | |
| | | | | | allegation of compliance w regulatory requirements. | | |
| | | | | | date of compliance is June | | |
| | | | | | 2022. | З, | |
| | | | | | | | |
| 0353 | NFPA 101 | | | | | | |
| SS=E | Sprinkler System | - Maintenance and Testing | | | | | |
| Bldg. 01 Sp Au are | Sprinkler System | - Maintenance and Testing | | | | | |
| | Automatic sprink | ler and standpipe systems | | | | | |
| | are inspected, te | sted, and maintained in | | | | | |
| | accordance with | NFPA 25, Standard for the | | | | | |
| | Inspection, Testi | ng, and Maintaining of | | | | | |
| | Water-based Fire | e Protection Systems. | | | | | |
| | Records of syste | m design, maintenance, | | | | | |
| | inspection and te | sting are maintained in a | | | | | |
| | | nd readily available. | | | | | |
| | a) Date sprinkle | r system last checked | | | | | |
| | b) Who provide | d system test | | | | | |
| | c) Water system | n supply source | | | | | |
| | Provide in REMA | RKS information on | | | | | |
| | coverage for any | non-required or partial | | | | | |
| | automatic sprink | | | | | | |
| | 9.7.5, 9.7.7, 9.7.8 | | | | | | |
| | | ion and interview, the facility | K 0 | 353 | K353 – It is the intent of the | | 06/03/202 |
| | | the ceiling construction in 1 of | | | facility to maintain the ceiling | | |
| | | oms. NFPA 13, 2010 edition, | | | construction of storage room | ns to | |
| | | fines a smooth ceiling as a | | | meet set standards. | | |
| | | free from significant | | | | | |
| | | os, or indentations. The | | | 1.CORRECTIVE ACTIONS | 5 | |
| | | r and gases around the | | | TAKEN: | | |
| | | e the sprinkler to operate at a | | | 1.The Maintenance | | |
| | | ure. Section 8.5.4.1.1 states | | | Supervisor/designee will ins | | |
| | I the distance betwe | en the sprinkler deflector and | 1 | | three suspended ceiling tiles | 5 | 1 |

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 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) the ceiling above shall be selected based on the missing in the ceiling in the type of sprinkler and the type of construction. storage room by the entrance door to the Alzheimer's wing in the This deficient practice could affect over 10 200 hall to meet set standards. residents, staff, and visitors in the vicinity of the storage room by the entrance door to the The Administrator will verify when Alzheimer's wing in the 200 Hall. work is completed. 2.ALL OTHERS WITH Findings include: POTENTIAL TO BE AFFECTED: 1.All residents and all staff Based on observations with the Administrator and visitors have the potential to and the Maintenance Director during a tour of be affected but none were. the facility from 12:30 p.m. to 2:10 p.m. on **3.MEASURES TO PREVENT** 05/12/22, three suspended ceiling tiles were REOCCURRENCE: missing in the ceiling in the storage room by the 1.On May 25, 2022the entrance door to the Alzheimer's wing in the 200 Administrator educated the Hall. HVAC room by the Workroom by the main Maintenance Supervisor/designee lobby. The room was equipped with one pendant on the requirement that the ceiling must be maintained to meet set sprinkler installed on the suspended ceiling. Based on interview at the time of the standards. observations, the Administrator agreed there 2.Maintenance Supervisor/designee will ensure were missing ceiling tiles in the aforementioned the ceiling is checked monthly as room. a part of the facility's Preventive This finding was reviewed with the Administrator Maintenance Program and document those inspection results during the exit conference. as appropriate. If any issues are 3.1-19(b) discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the **Preventative Maintenance** documentation is in place. 4.MONITORING CORRECTIVE ACTION: 1.The inspection results will

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PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTI A. BUILDI B. WING | ple construction ng <u>01</u> | COM | te survey Ipleted 1 2/2022 |
|----------------------------|---|---|------------------------------------|--|--|---|
| | PROVIDER OR SUPPLIE | | 26 | REET ADDRESS, CITY, STATE, ZI 440 COLD SPRING RD DIANAPOLIS, IN 46222 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREI TA | PROVIDER'S PLAN OF FIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI | M SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| K 0363 SS=E Bldg. 01 | NFPA 101 Corridor - Doors Corridor - Doors | | | Administrator month Administrator will pro- inspection results at Quality Assurance/F Improvement (QA/P Inspection results ar components will be the QA/PI Committe subsequent plans of developed and imple deemed necessary compliance is maint This plan of correct constitutes our cree allegation of compli- regulatory requirem date of compliance 2022. | ally and the esent the the monthly Performance I) meeting. Ind system reviewed by the with f correction emented as to ensure ained. tion dible liance with all nents. Our | |
| Bidg. 01 | Doors protecting than required en- openings, exits, o the passage of s inch solid-bonder material capable 20 minutes. Door compartments ar passage of smok to rooms contain combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or cor | corridor openings in other closures of vertical or hazardous areas resist moke and are made of 1 3/4 d core wood or other of resisting fire for at least rs in fully sprinklered smoke e only required to resist the e. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain nbustible material. en bottom of door and floor | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | A. BUII B. WIN | LDING G | DNSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|--------------------------|--|--|-------------------|--------------------|--|--|---------------------------|
| | ROVIDER OR SUPPLIE | | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE OLD SPRING RD APOLIS, IN 46222 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ιΤΕ | (X5) COMPLETIC DATE |
| | doors complying if provided with a the door closed w applied. There is closing of the door release when the are permitted. Not unlimited height a meeting 19.3.6.3 frames shall be la other materials in unless the smoke sprinklered. Fixed are allowed per 8 compartments th area or fire resist window assembli 19.3.6.3, 42 CFR 483, and 485 Show in REMAR fire protection rat devices, etc. Based on observat failed to ensure 6 no impediment to door frame and wo smoke. This defice 10 residents, staff Room 204. Findings include: Based on observat and the Maintenan the facility from 11 05/12/22, the follo a. the east door in | d fire window assemblies 8.3. In sprinklered ere are no restrictions in ance of glass or frames in ies. 8 Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing ion and interview, the facility of over 40 corridor doors had closing and latching into the build resist the passage of ient practice could affect over and visitors in the vicinity or ions with the Administrator ice Director during a tour of 2:30 p.m. to 2:10 p.m. on | К 030 | 63 | K363 – It is the intent of the facility to ensure corridor door have no impediments to closir and latching into the door fran and would resist the passage smoke to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On May 12, 2022 the Maintenance Supervisor/desig a) removed the portable meal cart from the kitchen door set the main dining room b) repa the latching mechanism in the east door so that the door lato fully into the frame. Maintena | ng of S gnee tray in ired s shes | 06/03/20 |

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

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED |
|-------------------|---|---|--------------------------------|--|-------------------------------|
| | | 155717 | B. WING | | 05/12/2022 |
| | PROVIDER OR SUPPLIE | | 2640 0 | ADDRESS, CITY, STATE, ZIP CODE COLD SPRING RD NAPOLIS, IN 46222 | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | DATE |
| | position with a por door was equipped latch the door into failed to latch into close multiple time diameter hole was in the west door in resist the passage of room was open to b. one of two screw door frame for the was missing which loose and did not a into the door frame c. the corridor doo into the door frame multiple times. d. a towel was stuf mechanism hole in frame for the corri- prevented the door frame when tested e. a latching plate of the latching plate of the latching and la when tested to close Based on interview observations, the A aforementioned co impediment to close frame or would no | table meal tray cart. The east I with a latching mechanism to the door frame but the door the door frame when tested to es. In addition, a one inch in noted below the door handle the door set which would not of smoke. The main dining the corridor. vs for the latching plate on the corridor door to Room 204 in caused the latching plate to be illow the corridor door to latch e. r for Room 306 failed to latch e when tested to close fed into the latching in the latching plate on the door dor door to Room 310 which from latching into the door to close. was screwed into and on top of on the door frame for the e Clean Utility room by the ch prevented the door from atching into the door from atching into the door frame se multiple times. v at the time of the Administrator agreed the rridor doors had an sing and latching into the door t resist the passage of smoke. | | Supervisor/designee will reparation hole with a 1 hour fire rated material below the door hand the west door in the door set meet set standards. b. On May 13, 2022 the Maintenance Supervisor/desi secured the latching plate on door frame for the corridor do to room 204 to meet set standards. The Administrator verified the work on May 13, 2022 the Maintenance Supervisor/desi repaired the latching mechan on the corridor door to room 3 so the door latches fully into t frame to meet set standards. Administrator verified the towel that was s into the latching mechanism h in the latching plate on the do frame for the corridor door to room 310 to meet set standard the work on May 12, 2022 . e. On May 13, 2022 the Maintenance Supervisor/desi repoved the towel that was s into the latching mechanism h in the latching plate on the do frame for the corridor door to room 310 to meet set standard the work on May 12, 2022 . e. On May 13, 2022 the Maintenance Supervisor/desi repaired the latching plate on the do frame for the corridor door to room 310 to meet set standard the work on May 12, 2022 . e. On May 13, 2022 the Maintenance Supervisor/desi repaired the latching plate on the do frame for the corridor door to room 310 to meet set standard the work on May 13, 2022 the Maintenance Supervisor/desi repaired the latching plate on door frame for the corridor door to room 310 to meet set standard the work on May 13, 2022 the Maintenance Supervisor/desi repaired the latching plate on door frame for the corridor door to to to the clean utility room by the laundry room so the door self closes and fully latches into the frame to meet set standards. Administrator verified the work May 13, 2022 . | ir the le in to gnee the or |

| | MEDICARE & MEDI | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLE CO | NSTRUCTION | | MB NO. 0938-0 E SURVEY |
|------------|--------------------|--------------------------------|---------|----------------------------|--|--------|---------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | Ê Ź | LDING | <u>01</u> | . , | PLETED |
| | | 155717 | B. WIN | | 01 | | 2/2022 |
| | | 100717 | | | | 00/1 | |
| NAME OF PI | ROVIDER OR SUPPLIE | CR . | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | OLD SPRING RD | | |
| ALPHA H | OME - A WATER | S COMMUNITY | | INDIAN | APOLIS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | IATE | COMPLETI |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | 2. ALL OTHERS WITH | | |
| | | | | | POTENTIAL TO BE AFFECT | | |
| | | | | | a. All residents and all sta | | |
| | | | | | and visitors have the potentia | | |
| | | | | be affected but none were. | | | |
| | | | | | Maintenance Supervisor/des inspected all corridor doors for | - | |
| | | | | | impediments, failing latching | | |
| | | | | | mechanisms, and gaps and f | ound | |
| | | | | | no other negative findings. | ound | |
| | | | | | 3. MEASURES TO | | |
| | | | | | PREVENT REOCCURRENC | E: | |
| | | | | | a. On May 25, 2022 the | | |
| | | | | | Administrator educated the | | |
| | | | | | Maintenance Supervisor/des | - | |
| | | | | | and staff on the requirement | that | |
| | | | | | corridor doors may not have | | |
| | | | | | impediments to closing, the | | |
| | | | | | latching mechanism latches i | | |
| | | | | | the frame, and the doors are of gaps to resist the passage | | |
| | | | | | smoke to meet set standards | | |
| | | | | | b. Maintenance | • | |
| | | | | | Supervisor/designee will insp | ect | |
| | | | | | all corridor doors throughout | | |
| | | | | | facility monthly to ensure the | | |
| | | | | | latching mechanisms work | | |
| | | | | | properly, impediments to clos | sing | |
| | | | | | are not in place, and the doo | | |
| | | | | | have no gaps which would al | | |
| | | | | | the passage of smoke as a p | art of | |
| | | | | | the facility's Preventive | | |
| | | | | | Maintenance Program and | | |
| | | | | | document those inspection re as appropriate. If any issues | | |
| | | | | | discovered, they will be addr | | |
| | | | | | and resolved immediately. T | | |
| | | | | | Maintenance Supervisor/des | | |
| | | | | | will review with the Administr | - | |
| | | | | | the inspection results. | | 1 |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|--------------------------|-------------------------------------|---|---|--|---|--|
| NAME OF 1 | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ALPHA H | HOME - A WATERS | S COMMUNITY | INDIA | NAPOLIS, IN 46222 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES 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 | |
| | | | | c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results w be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting Inspection results and system components will be reviewed I the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with regulatory requirements. Ou date of compliance is May 27 2022. | nce | |

Facility ID: 000376

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| | NT OF DEFICIENCIES I OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717 | | JILDING ING | onstruction 01 | со 05 | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|----------------------------|--|---|-----|---------------------|--|---|---|--|
| | PROVIDER OR SUPPLIE | | | 2640 C | ADDRESS, CITY, STATE, ZIP COD COLD SPRING RD NAPOLIS, IN 46222 | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| K 0372 SS=D Bldg. 01 | Barrie Subdivision of Bu Barrier Construct 2012 EXISTING Smoke barriers s 1/2-hour fire resis Smoke barriers s terminate at an a are not required ducted HVAC sy sprinkler system compartments ac 19.3.7.3, 8.6.7.10 Describe any me system in REMA Based on observat failed to ensure op smoke barriers wa resistance rating o 19.3.7.3 refers to S states penetrations and similar items to floor/ceiling assen barrier, or through ceiling smoke barri system or material transfer of smoke. also constructed as penetrations shall with the requirement the spread of fire f fire resistance of to This deficient praces staff and visitors in Findings include: | shall be constructed to a stance rating per 8.5. shall be permitted to trium wall. Smoke dampers in duct penetrations in fully stems where an approved is installed for smoke djacent to the smoke barrier. 1) chanical smoke control RKS. ion and interview, the facility enings through 1 of 1 ceiling s protected to maintain the fire f the smoke barrier. LSC Section 8.5. Section 8.5.6.2 for cables, conduits, pipes hat pass through a ably constructed as a smoke the ceiling membrane of a ier shall be protected by a capable of resisting the Where a smoke barrier is a fire barrier, the be protected in accordance ents of Section 8.3.5 to limit for a time period equal to the ne assembly and Section 8.5.6. | К 0 | 372 | K372 – It is the intent of t facility to ensure opening through ceiling smoke ba protected to maintain the resistance rating of the sr barrier to meet set standa 1. CORRECTIVE ACT TAKEN: a. The Maintenance Supervisor/designee will hole in the ceiling of the r in the kitchen next to the escutcheon for the sprink room with a one hour fire material to meet set stand The Administrator will ver the repair is completed. 2. ALL OTHERS WIT POTENTIAL TO BE AFFT a. All residents and al and visitors have the pote be affected but none were May 25, 2022 the Mainten | s rriers are fire moke ards. FIONS repair the estroom ler in the rated dards. ify when H ECTED: I staff ential to e. On | 06/03/202 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155717 | A. BUILDING B. WING | <u>01</u> | COMPLETED 05/12/2022 | |
|-------------------------------------|--|--|------------------------|--|---|--|
| | PROVIDER OR SUPPLII | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE COLD SPRING RD NAPOLIS, IN 46222 | | |
| ALPHA H (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE REGULATORY C and the Maintenar the facility from 1 05/12/22, a one in ceiling of the restr escutcheon for the layer of 5/8ths inc the ceiling constru- interview at the tin Administrator agr kitchen restroom of the room. | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) nee Director during a tour of 2:30 p.m. to 2:10 p.m. on ch hole was noted in the room in the kitchen next to the e sprinkler in the room. One h thick drywall was noted as action for the room. Based on ne of the observations, the eed there was a hole in the ceiling next to the sprinkler for | | APOLIS, IN 46222 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Supervisor/designee inspected smoke barrier walls & ceilings throughout the facility for penetrations and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. On May 25, 2022 the Administrator educated the Maintenance Supervisor/design on the requirement that smoke barrier walls & ceilings must be free of penetrations and voids to meet set standards. b. Maintenance Supervisor/designee will inspect all smoke barrier walls & ceiling throughout the facility monthly fr penetrations and voids as a par of the facility's Preventive Maintenance Program and document those inspection result as appropriate. If any issues a discovered, they will be address and resolved immediately. The Maintenance Supervisor/design will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING | ee b t s or t t s or t t ults re sed ee | |
| | | | | a. The inspection results wil be presented by the Maintenand Supervisor/designee to the Administrator monthly and the | | |

| STATEMEN | T OF DEFICIENCIES | CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA | | TIPLE CONSTRU | CTION | | IB NO. 0938-039 E SURVEY |
|-----------|----------------------|---|----------|---------------|---|--------------|------------------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | <u> </u> | LETED |
| | | 155717 | B. WING | 01 | | 05/12 | 2/2022 |
| | | | S | TREET ADDRES | S, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIE | ĸ | 2 | 2640 COLD S | PRING RD | | |
| ALPHA H | OME - A WATER | S COMMUNITY | 11 | NDIANAPOL | IS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | I | D | PROVIDER'S PLAN OF CORRECTIO |)N | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PRI | EFIX (EA | ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROI | BE PRIATE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | T | 'AG | DEFICIENCY) | | DATE |
| | | | | | inistrator will present th | | |
| | | | | | ection results at the mo | • | |
| | | | | | ity Assurance/Perform | | |
| | | | | | ovement (QA/PI) meet | | |
| | | | | | ection results and syste conents will be reviewe | | |
| | | | | | A/PI Committee with | Juby | |
| | | | | | equent plans of correc | tion | |
| | | | | | loped and implemente | | |
| | | | | | ned necessary to ensu | | |
| | | | | com | pliance is maintained. | | |
| | | | | This | plan of correction | | |
| | | | | | titutes our credible | | |
| | | | | - | ation of compliance v | | |
| | | | | - | latory requirements. | | |
| | | | | date 2022 | of compliance is Jun | е 3, | |
| | | | | | | | |
| < 0712 | NFPA 101 | | | | | | |
| SS=F | Fire Drills | | | | | | |
| Bldg. 01 | Fire Drills | the transmission of a fire | | | | | |
| | | simulation of emergency | | | | | |
| | • | re drills are held at | | | | | |
| | | expected times under | | | | | |
| | | s, at least quarterly on each | | | | | |
| | | familiar with procedures | | | | | |
| | and is aware that | drills are part of established | | | | | |
| | | rills are conducted between | | | | | |
| | 9:00 PM and 6:0 | - | | | | | |
| | | ay be used instead of | | | | | |
| | audible alarms. | | | | | | |
| | 19.7.1.4 through | | | | | | 0.000 |
| | | view and interview, the | K 0712 | ~ | 2 – It is the intent of the | | 06/03/202 |
| | on the: | ocument quarterly fire drills | | | ty to ensure to conduct terly fire drills on each | | |
| | | f 4 calendar quarters. | | | terly fire drills on each r varied conditions to r | | |
| | b. second shift for | | | | tandards. | 1001 | |
| | c. third shift for 2 | | | 1. | CORRECTIVE ACTI | ONS | |
| | | 1.6 requires drills to be | | ТАК | | | |

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 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) On May 25, 2022 the conducted quarterly on each shift under varied a. conditions. This deficient practice affects all Administrator educated the residents, staff and visitors. Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected Findings include: times under varying conditions at least quarterly on each shift and Based on review of "Fire Drill Report" documented to meet set documentation with the Administrator during record review from 9:30 a.m. to 12:05 p.m. on standards. ALL OTHERS WITH 05/12/22, documentation of a first shift fire drill 2 or staff training documentation on fire drill POTENTIAL TO BE AFFECTED: All residents and all staff procedures on the first shift in the fourth quarter a. (October, November, December) 2021 and in the and visitors have the potential to be affected but none were. first quarter (January, February, March) 2022 was not available for review. Documentation of a 3 **MEASURES TO** second shift fire drill or staff training PREVENT REOCCURRENCE: documentation on fire drill procedures on the Maintenance a. Supervisor/designee will ensure second shift in the second quarter (April, May, June) 2021, in the third quarter (July, August, fire drills are conducted at September) 2021 and in the fourth quarter 2021 unexpected times under varying was also not available for review. In addition, conditions at least quarterly on documentation of a third shift fire drill or staff each shift and documented on the Fire Drill Report and that training documentation on fire drill procedures on the third shift during the second quarter 2021 documentation be retained in the and the third quarter 2021 was also not available facility's Life Safety Binder as a part of the facility's Preventive for review. Based on interview at the time of record review, the Administrator stated the Maintenance Program and facility operates three shifts per day and agreed document those inspection results documentation of fire drills or staff training on as appropriate. If any issues are fire drill procedures for the aforementioned discovered, they will be addressed shifts and calendar quarters within the most and resolved immediately. The recent twelve month period was not available for Maintenance Supervisor/designee will review with the Administrator review. the inspection results. This finding was reviewed with the Administrator h The Administrator will monitor adherence to the during the exit conference. Preventative Maintenance schedule and validate the 3.1-19(b) Preventative Maintenance documentation is in place.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VS

V9S721 Facility ID

Facility ID: 000376

If continuation sheet

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| | NT OF DEFICIENCIES | CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | TPLE CONSTRUCTION | | OMB NO. 0938-0391 TE SURVEY |
|---|---|---|-----------|--|--------------|--------------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155717 | | IDENTIFICATION NUMBER: | A. BUILD | DING <u>01</u> | COM | PLETED |
| | | B. WING | | 05/1 | 2/2022 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | TREET ADDRESS, CITY, STATE, ZIP CO | DDE | |
| ALPHA I | HOME - A WATER | S COMMUNITY | | 640 COLD SPRING RD NDIANAPOLIS, IN 46222 | | |
| (X4) ID | 1 | STATEMENT OF DEFICIENCIES | | D | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PROVIDER'S PLAN OF CORE EFIX (EACH CORRECTIVE ACTION SH | OULD BE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | Т | AG CROSS-REFERENCED TO THE AI DEFICIENCY) | PROPRIATE | DATE |
| | | | | 4. MONITORING | | |
| | | | | a. The inspection re | | |
| | | | | be presented by the Ma | | |
| | | | | Supervisor/designee to | | |
| | | | | Administrator monthly a | | |
| | | | | Administrator will prese | nt the | |
| | | | | inspection results at the | • | |
| | | | | Quality Assurance/Perf | | |
| | | | | Improvement (QA/PI) n | 0 | |
| | | | | Inspection results and s | - | |
| | | | | components will be rev the QA/PI Committee w | • | |
| | | | | subsequent plans of co | | |
| | | | | developed and impleme | | |
| | | | | deemed necessary to e | | |
| | | | | compliance is maintain | | |
| | | | | This plan of correction | ı | |
| | | | | constitutes our credib | | |
| | | | | allegation of complian | | |
| | | | | regulatory requirement | | |
| | | | | date of compliance is 2022. | June 3, | |
| | | | | | | |
| C 0911 | NFPA 101 | | | | | |
| SS=F | Electrical System | is - Other | | | | |
| Bldg. 01 | Electrical System | | | | | |
| | | RKS section any NFPA 99 | | | | |
| | | cal Systems requirements | | | | |
| | | essed by the provided | | | | |
| | - | leficient. This information, plicable Life Safety Code or | | | | |
| | | itation, should be included | | | | |
| | on Form CMS-25 | | | | | |
| | Chapter 6 (NFPA | | | | | |
| | | vation and interview, the | K 0911 | K911 - It is the intent of | the facility | 06/03/202 |
| | | entify protected branch | | to ensure to identify pro | | |
| | | electrical panels at the | | branch circuits for elect | | |
| | emergency generat | tor transfer switch location in | | panels at the emergend | »y | |

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

STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) accordance with NFPA 70. NFPA 99, Health generator transfer switch location Care Facilities Code, 2012 Edition, Section are in accordance with NFPA 70 6.3.2.1 states electrical installation shall be in and to ensure access and working space is maintained in enclosures accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 210.5(A) housing electrical apparatus in states the grounded conductor of a branch circuit electrical rooms to meet set shall be identified in accordance with Article standards. 200.6. This deficient practice could affect all 1. CORRECTIVE ACTIONS TAKEN: residents, staff and visitors. The Maintenance a. Findings include: Supervisor/designee will identify the circuits in the electrical panel Based on observations with the Administrator identified as NDPE1 at the automatic transfer switch location and the Maintenance Director during a tour of in the 100 hall electrical room to the facility from 12:30 p.m. to 2:10 p.m. on 05/12/22, overcurrent devices in the electrical meet set standards. panel identified as "NDPE1" at the automatic b. On May 27, 2022 the transfer switch location in the 100 Hall Maintenance Supervisor/designee Electrical Room did not identify circuits removed the one mattress and protected by the overcurrent devices. Based on several boxes that were stored on interview at the time of the observations, the the floor up against the wall Administrator agreed overcurrent devices for the mounted electrical panel identified as I-T-E Switchboard in the 100 panel did not identify the circuits protected by the device. hall electrical room to meet set standards ALL OTHERS WITH This finding was reviewed with the Administrator 2. during the exit conference. POTENTAL TO BE AFFECTED: All residents and all staff a. 3.1-19(b) and visitors have the potential to be affected but none were. 2. Based on observation and interview, the 3. **MEASURES TO** facility failed to ensure access and working PREVENT REOCCURRENCE: space was maintained in enclosures housing On May 24 and May 25 the a. Administrator educated the electrical apparatus in 1 of 1 electrical rooms in the 100 Hall. NFPA 99, Health Care Facilities Maintenance Supervisor/designee Code, 2012 Edition, Section 6.3.2.1 states and staff on the requirement that electrical installation shall be in accordance with electrical panels must be identified and access to electrical boxes NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working must be maintained to meet set space for equipment operating at 600 volts, standards.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) nominal, or less and likely to require b. Maintenance examination, adjustment, servicing, or Supervisor/designee will inspect all electrical panels throughout the maintenance while energized shall comply with facility monthly to ensure they are the dimensions of 110.26(A)(1), (2) and (3). identified properly and there are Distances shall be measured from the live parts if such parts are exposed or from the enclosure no impediments to accessing the front or opening if such are enclosed. Article panels as a part of the facility's Preventive Maintenance Program 110.26(B) states the working space required by this section shall not be used for storage. This and document those inspection deficient practice could affect all residents, staff results as appropriate. If any and visitors. issues are discovered, they will be addressed and resolved Findings include: immediately. The Maintenance Supervisor/designee will review with the Administrator the Based on observations with the Administrator and the Maintenance Director during a tour of inspection results. the facility from 12:30 p.m. to 2:10 p.m. on c. The Administrator will monitor adherence to the 05/12/22, one mattress and several boxes were stored on the floor up against the wall mounted Preventative Maintenance electrical panel identified as "I-T-E Switchboard" schedule and validate the in the 100 Hall electrical room. Based on **Preventative Maintenance** interview at the time of the observations, the documentation is in place. 4 MONITORING Administrator Director agreed access and working space was not maintained in front of the CORRECTIVE ACTION: wall mounted electrical panel at the The inspection results will a. aforementioned location. be presented by the Maintenance Supervisor/designee to the This finding was reviewed with the Administrator Administrator monthly and the during the exit conference. Administrator will present the inspection results at the monthly 3.1-19(b) Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: V9S721 Facility ID: 000376 If continuation sheet Page 33 of 37

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | MULTIPLE C BUILDING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
|---|--|--|---------|------------------------|---|---|------------|
| | | 155717 | B. WING | | <u>.</u> | | |
| NAME OF 1 | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP | CODE | |
| ALPHA H | IOME - A WATERS | S COMMUNITY | | | COLD SPRING RD NAPOLIS, IN 46222 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH | | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | constitutes our cred allegation of compli- regulatory requirem date of compliance i 2022. | ance with all ents. Our | |
| < 0918 SS=F Bldg. 01 | Electrical System System Maintena The generator of source and assoc of supplying serv 10-second criterio monthly test, a pr annually confirm safety and critica and testing of the switches are perf NFPA 110. Generator sets an exercised under I year in 20-40 day once every 36 mc hours. Scheduled include a comple automatic or mar loads, and are co personnel. Mainte energy power sou accordance with circuit breakers a a program for per components is es manufacturer req of maintenance a and readily availa and circuits are n | s - Essential Electric Syste s - Essential Electric ince and Testing rother alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance generator and transfer ormed in accordance with re inspected weekly, oad 30 minutes 12 times a r intervals, and exercised onths for 4 continuous I test under load conditions te simulated cold start and nual transfer of all EES inducted by competent enance and testing of stored urces (Type 3 EES) are in NFPA 111. Main and feeder re inspected annually, and riodically exercising the stablished according to uirements. Written records ind testing are maintained able. EES electrical panels marked, readily identifiable, in normal power circuits. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155717 B. WING 05/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME - A WATERS COMMUNITY INDIANAPOLIS, IN 46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 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) K 0918 K918 – It is the intent of the 06/03/2022 1. Based on record review, observation and interview; the facility failed to document facility to ensure to document emergency generator monthly load testing for 4 emergency generator monthly months of the most recent 12 month period to load testing for the most recent 12 meet the requirements of NFPA 110, 2010 month period to meet the Edition, the Standard for Emergency and Standby requirements of NFPA 110, 2010 Powers Systems, Chapter 8.4.2. Section 8.4.2 edition. the standard for emergency and standby powers states diesel generator sets in service shall be exercised at least once monthly, for a minimum systems, chapter 8.4.2 and to of 30 minutes, using one of the following ensure a written record of weekly methods: inspections for the emergency (1) Loading that maintains the minimum exhaust generator is maintained of the gas temperatures as recommended by the most recent 52 week period to manufacturer meet set standards. (2) Under operating temperature conditions and 1. CORRECTIVE ACTIONS TAKEN at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. a. On May 25, 2022the Section 8.4.2.3 states diesel-powered EPS Administrator educated the Maintenance Supervisor/designee installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the on the requirement that monthly available EPSS (Emergency Power Supply load testing of the emergency System) load and shall be exercised annually with generator must be completed and documentation retained in the supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous Emergency Preparedness Binder minutes and at not less than 75 percent of the to meet set standards. EPS nameplate kW rating for 1 continuous hour b. On May 25, 2022 the for a total test duration of not less than 1.5 Administrator educated the continuous hours. This deficient practice could Maintenance Supervisor/designee affect all residents, staff and visitors. on the requirement that weekly testing of the emergency Findings include: generator must be completed and documentation retained in the Based on review of "Emergency Generators -Emergency Preparedness Binder to meet set standards. Monthly Test Log" documentation for the most recent twelve month period with the The facility uses LP gas as C. Administrator during record review from 9:30 its fuel source for the generator,

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| ENTERS FOR | R MEDICARE & MEDIC | - | | | | OM | B NO. 0938-0391 |
|---|--|--------------------------------|---------------------------|-----------|--|-----------|-----------------|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLE CC | ONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUIL | DING | <u>01</u> | COMPL | ETED | |
| | | 155717 | B. WINC | ĩ | | 05/12/ | 2022 |
| | | | | STREET 4 | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ł | | | OLD SPRING RD | | |
| ALPHA HOME - A WATERS COMMUNITY | | | | | APOLIS, IN 46222 | | |
| ALFIIAT | | | | | AF0EI3, IN 40222 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PR | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| | a.m. to 12:05 p.m. o | on 05/12/22, monthly load | | | not diesel. | | |
| | testing documentati | on for the facility's diesel | | | 2. ALL OTHERS WITH | | |
| | fuel fired emergenc | y generator for the four | POTENTIAL TO BE AFFECTED: | | | | |
| | month period of Se | ptember 2021 through | | | a. All residents and all staff | | |
| | December 2021 wa | s not available for review. | | | and visitors have the potential to be affected but none were. The | | |
| | Based on interview | at the time of record review, | | | | | |
| | the Administrator s | tated she had to fire the | | | facility has only one emergene | су | |
| | former Maintenance | e Director in December | | | generator. | | |
| | 2021, he may have | taken Life Safety Code | | | 3. MEASURES TO | | |
| | records with him an | nd agreed monthly load testing | | | PREVENT REOCCURRENCE | : | |
| | documentation for the aforementioned four | | | | a. Maintenance | | |
| | month period in 202 | 21 was not available for | | | Supervisor/designee will inspe | ect | |
| | review. Based on observations with the Administrator and the Maintenance Director | | | | and test the emergency gener | rator | |
| | | | | | weekly testing and monthly lo | ad | |
| | during a tour of the | facility from 12:30 p.m. to | | | testing as required and retain | | |
| | 2:10 p.m. on 05/12/22, the facility has one diesel fired emergency generator located outside | | | | documentation of those tests | and | |
| | | | | | inspections in the facility's | | |
| | of the building on the | he south side of the property. | | | Emergency Preparedness Bir | lder | |
| | | | | | as a part of the facility's | | |
| | This finding was re | viewed with the Administrator | | | Preventive Maintenance Prog | ram | |
| | during the exit conf | erence. | | | and document those inspection | n | |
| | | | | | results as appropriate. If any | | |
| | 3.1-19(b) | | | | issues are discovered, they w | ill be | |
| | | | | | addressed and resolved | | |
| | 2. Based on observa | ation, record review and | | | immediately. The Maintenand | e | |
| | interview; the facili | ty failed to ensure a written | | | Supervisor/designee will revie | W | |
| | record of weekly in | spections for the emergency | | | with the Administrator the | | |
| | generator set was m | aintained for 49 weeks of the | | | inspection results. | | |
| | most recent 52 week | k period. This deficient | | | b. The Administrator will | | |
| | practice could affect | t all residents, staff and | | | monitor adherence to the | | |
| | visitors. | | | | Preventative Maintenance | | |
| | | | | | schedule and validate the | | |
| | Findings include: | | | | Preventative Maintenance | | |
| | | | | | documentation is in place. | | |
| | Based on review of | "Emergency Generators - | | | 4. MONITORING | | |
| | | Checklist" documentation for | | | CORRECTIVE ACTION: | | |
| | | lve month period with the | | | a. The inspection results v | vill | |
| | | ng record review from 9:30 | | | be presented by the Maintena | | |
| | | on 05/12/22, weekly | | | Supervisor/designee to the | | |
| | - | or inspection documentation | | | Administrator monthly and the | ; | |

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| | F OF HEALTH AND HU! R MEDICARE & MEDIC | | | | FORM APPROVED OMB NO. 0938-0391 |
|---|--|--|--------|---|---|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155717 | | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 05/12/2022 | |
| | | | 2640 C | ADDRESS, CITY, STATE, ZIP CODE OLD SPRING RD JAPOLIS, IN 46222 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | (X5) COMPLETION |
| TAG | for the facility's die generator after 04/1 was not available for at the time of record stated she had to fir Director in Decemb Life Safety Code re weekly emergency documentation prio facility's diesel fuel was not available for observations with th Maintenance Direct facility from 12:30 05/12/22, the facilit emergency generator building on the sour | LSC IDENTIFYING INFORMATION) sel fuel fired emergency 2/21 but before 04/18/22 or review. Based on interview d review, the Administrator e the former Maintenance er 2021, he may have taken cords with him and agreed generator inspection r to 04/18/22 for the fired emergency generator or review. Based on the Administrator and the or during a tour of the p.m. to 2:10 p.m. on y has one diesel fired or located outside of the h side of the property. | TAG | Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wit regulatory requirements. Ou date of compliance is June 3 2022. | ce g. by n as h all ur |

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