CENTERS FOR MEDICARE & MEDICAID SERVICES					ON	1B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409		JILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  07/02/2024	
	PROVIDER OR SUPPLIEF			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	↓ Œ RIATE	(X5) COMPLETION DATE
Bldg	conducted by the Irraccordance with 42  Survey Date: 07/02  Facility Number: 0  Provider Number: AIM Number: 100  At this Emergency Waters of Indianapcompliance with En Requirements for Marticipating Provid 483.73.  The facility has 81 the survey, the cense Quality Review con The requirement at MET as evidenced 403.748(a), 416.5	2/24 200537 155409 267270 Preparedness survey, The olis was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of sus was 67. mpleted on 07/08/24 42 CFR, Subpart 483.73 is NOT by: 4(a), 418.113(a),	E 00	000	July 20, 2024  Preparation or execution of plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and Stalaw. The plan of correction submitted in order to resport the allegation of noncomplicated during the Annual Surv July 2, 2024. Please accepplan of correction as the procredible allegation of complication with Federal Medicare and Medicaid requirements. We respectfully request a desk review.	seement of the set s tte is nd to ance vey on t this ovider's ance	
SS=F Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §460 §483.73(a), §483.	20(a), 486.360(a),					

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

§485.920(a), §486.360(a), §491.12(a),

(X6) DATE

TITLE

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155409			ILDING		COMPL 07/02/	ETED	
	PROVIDER OR SUPPLIER			3895 S I	DDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The [facility] must Federal, State and preparedness required must develop estate comprehensive errogram that meet section. The emer program must include following elem  (a) Emergency Pladevelop and main preparedness plar and updated at least substance or CAH] must comprehensive errogram that meet section, utilizing at [For LTC Facilities Emergency Plandevelop and main preparedness plar and updated at least substance or ESRD Facilies Emergency Plandevelop and main develop and main	uirements. The [facility] ablish and maintain a nergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or up and maintain a inergency preparedness ts the requirements of this in all-hazards approach.  es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually.  Ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],					

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Facility ID: 000537

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CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/02/2024	
	PROVIDER OR SUPPLIE			3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on record refailed to maintain a plans that were revannually in accord. This deficient prace and the Maintenan "Emergency Prepa Waters of Indianar 05/15/23 with the record review from 07/02/24, emergen documentation was recent twelve month plans were dated a which was not with month period. Bas record review, the emergency prepare was not document most recent twelve survey.  These findings were	view and interview, the facility 2 of 2 emergency preparedness riewed and updated at least ance with 42 CFR 483.73(a). tice could affect all occupants.  If the Administrator's version of redness Policy Manual for polis' documentation dated Maintenance Director during an 9:05 a.m. to 12:20 p.m. on cy preparedness program is not reviewed within the most the period. The aforementioned is being reviewed on 05/15/23 and the most recent twelve are don interview at the time of Maintenance Director agreed endness program documentation and as being reviewed within the emonth period at the time of the emonth period at the time of the end of the end of the external period with the external period w	E 00		1 The Administrator/DON/Maintenar Supervisor/designee updated emergency preparedness pro and reviewed the plan with all to meet set standards.  2 All residents and all sta and visitors have the potentia be affected but none were. 3 The Administrator inservithe DON /Maintenance Super on the requirement to update review the emergency preparedness program annua meet set standards. The Administrator inserviced all st on the updated emergency preparedness program. a Maintenance Supervisor/DON/ designee wi work with the Administrator to ensure the emergency preparedness program/plan is updated annually and reviewe meet set standards. If any issues are discovered, they w addressed and resolved immediately. b The Administrator will monitor adherence to the Emergency Preparedness Po Manual and validate the documentation is in place.	the gram I staff  If to viced visor and  ally to aff  iill be ed to	08/10/2024
					4 At least annually to ensi compliance, the Administrator		

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DON/Maintenance

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Supervisor/designee will review the Emergency Preparedness Policy

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	l í	JILDING	ONSTRUCTION	(X3) DATE COMPL 07/02	LETED
	PROVIDER OR SUPPLIER			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Manual and conduct required		(X5) COMPLETION DATE
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2 §418.113(a)(1)-(2 §460.84(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2 §485.625(a)(1)-(2 §491.12(a)(1)-(2), (a) Emergency Plate (a) Emergency Plate (b) Emergency Plate (a) Emergency Plate (b) Emergency Plate (a) Emergency Plate (b) Emergency Plate (b) Emergency Plate (b) Emergency Plate (a) Emergency Plate (b) Emergency Pl	416.54(a)(1)-(2), 418.113(a) )(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) )(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)  Hazards Risk Assessment ), §416.54(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2), §485.68(a)(1)-(2), ), §485.68(a)(1)-(2), ), §486.360(a)(1)-(2), ), §494.62(a)(1)-(2) lan. The [facility] must tain an emergency that must be reviewed, ast every 2 years. The plan			exercises and make changes necessary to meet set standa Those reviews will be docume as appropriate. The Administrator/designee will present the training results at Quality Assurance/ Performan Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliar is maintained.	as ards. ented the nce g. ents	

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must do the following:]

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155409		i '	LDING	NSTRUCTION	(X3) DATE COMPL 07/02/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Me	(1) Be based on a facility-based and assessment, utiliz approach.*  (2) Include strategemergency events assessment.  * [For Hospices at	ind include a documented, community-based risk ing an all-hazards gies for addressing identified by the risk it §418.113(a):] Emergency is must develop and						
	that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategemergency events assessment, incluthe consequences disasters, and other consequences.	gency preparedness plan ewed, and updated at least e plan must do the and include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk adding the management of is of power failures, natural iver emergencies that would 's ability to provide care.						
	develop and main preparedness pla and updated at ledo the following: (1) Be based on a facility-based and assessment, utilizapproach, includir (2) Include strateg	s at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards and missing residents. gies for addressing sidentified by the risk						

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB	NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLE	TED
		155409	B. WING		07/02/2	2024
NAME OF	PROVIDER OR SUPPLIEI	P	STREET	ADDRESS, CITY, STATE, ZIP COD		
				KEYSTONE AVE		
WATER	S OF INDIANAPOL	IS, THE	INDIAN	NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	<b>■</b>	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1 - 3	§483.475(a):] Emergency				
		must develop and maintain				
		eparedness plan that must				
		updated at least every 2				
	years. The plan m	nust do the following:				
	(4) 5					
	1 ' '	and include a documented,				
	1	l community-based risk				
		zing an all-hazards				
	approach, including missing clients.  (2) Include strategies for addressing emergency events identified by the risk assessment.					
		view and interview, the facility	E 0006	1 The Maintenance		08/10/2024
		an emergency preparedness	E 0000	Supervisor, DON and the		06/10/2024
		ased on and includes a		Administrator updated the		
		ty-based and community-based		emergency preparedness plan	that	
		ilizing an all-hazards approach		is based on and includes a	unat	
		ed within the most recent twelve		documented, facility based and		
	month period and (	(2) included strategies for		community based risk		
		ncy events identified by the		assessment, utilizing an all		
	risk assessment in a	accordance with 42 CFR		hazards approach which is		
	483.73(a) (1) and 4	12 CFR 483.73(a) (2). This		reviewed annually and included	1	
	deficient practice c	ould affect all occupants.		strategies for addressing		
				emergency events identified by	the	
	Findings include:			risk assessment in accordance		
				with 42 CFR 483.73 (a) and 42		
		f the Administrator's version		CFR 483.73(a)2 to meet set		
		ce Director's version of		standards.		
		redness Policy Manual for				
	_	polis" documentation dated		2 All residents and all staff		
		Maintenance Director during		and visitors have the potential t	О	
		1 9:05 a.m. to 12:20 p.m. on		be affected but none were.		
		ented facility-based and		3 The Administrator inservice	ced	
		risk assessment reviewed by		the Maintenance		
	-	the most recent twelve month		Supervisor/DON/designee on the	I .	
	1 -	ilable for review. Based on		requirement that the emergency		
	interview at the tim	ne of record review, the	- 1	preparedness plan must include	ea	

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Maintenance Director agreed a documented

facility-based and community-based risk

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facility based and community

based risk assessment, utilizing

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>	COMPL	
		155409	B. W	/ING		07/02/	2024
NAME OF P	ROVIDER OR SUPPLIER						
					KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, ITE		INDIAN	IAPOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		d by the facility within the		TAG		. d	DATE
		month period was not			an all hazards approached an reviewed annually to meet set		
		at the time of the survey.			standards.		
					Starragi do:		
	These findings were	e reviewed with the			The Administrator/Maintenand	ce	
	Maintenance Direct	for during the exit conference.			Supervisor/DON inserviced a	II	
					staff on the updated Emergen	-	
					Preparedness binders located		
					the nurses station and all other	er	
					areas to meet set standards.  The Maintenance		
					Supervisor/DON/Administrato	r/des	
					ignee will ensure the emerger		
					preparedness plan must inclu	-	
					facility based and		
					community-based risk		
					assessment, utilizing an all		
					hazards approached and revie		
					annually to meet set standard	S.	
					The Administrator will monitor	•	
					adherence to the Emergency		
					Preparedness Policy Manual		
					validate the documentation is	in	
					place.		
					4 The Administrator and		
					Maintenance		
					Supervisor/DON/designee wil	I	
					review the Emergency		
					Preparedness Policy Manual	and	
					make changes as necessary t	to	
					meet set standards. Those		
					reviews will be documented a	s	
					appropriate. The		
					Administrator/designee will	41	
					present the training results at		
					Quality Assurance/ Performar Improvement (QA/PI) meeting		
					Results and system compone		
1	l		1		1		Ī

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155409	B. WI	NG		07/02/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS	OF INDIANAPOLI	S, THE			KEYSTONE AVE APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	will be reviewed by the QA/PI		DATE
					Committee with subsequent pl	ans	
					of correction developed and		
					implemented as deemed		
					necessary to ensure complian	ce	
					is maintained.		
E 0013	403.748(b), 416.5	4(h) 418 113(h)					
SS=F	, ,	5(b), 483.475(b), 483.73(b),					
Bldg	484.102(b), 485.6						
	485.727(b), 485.93	20(b), 486.360(b),					
	491.12(b), 494.62	• •					
	·	P Policies and Procedures					
		5.54(b), §418.113(b), 5.84(b), §482.15(b),					
		475(b), §484.102(b),					
	- , , -	625(b), §485.727(b),					
	- , , -	6.360(b), §491.12(b),					
	§494.62(b).						
	(b) Policies and pr	ocedures. [Facilities] must					
	develop and imple						
		cies and procedures, based					
		plan set forth in paragraph					
	. ,	risk assessment at					
		of this section, and the an at paragraph (c) of this					
	-	ies and procedures must					
		ipdated at least every 2					
	years.						
	*IFor LTC facilities	at §483.73(b):] Policies					
	_	he LTC facility must					
	develop and imple	•					
	preparedness poli	cies and procedures, based					
		plan set forth in paragraph					
	, ,	risk assessment at					
		of this section, and the  an at paragraph (c) of this					
	-	ies and procedures must					
	2000011. THE POIL	and procodurou must	1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155409		A. BUILDING B. WING		COMPI 07/02	ETED	
	ROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	*Additional Requir ESRD Facilities:  *[For PACE at §46 procedures. The I develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The polician address management nonmedical emergilimited to: Fire; eqfailure; care-related disasters likely to safety of the partic. The policies and previewed and updates and previewed and updates are preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe reviewed and updates. The polician additional procedures. The polician additional procedures are preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The polician be reviewed and updates. These emenot limited to, fire, failures, care-relate supply interruption likely to occur in the area.	ements for PACE and  50.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not uipment, power, or water de emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be atted at least every 2 years.  Ities at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 regencies include, but are equipment or power ed emergencies, water n, and natural disasters me facility's geographic				
		riew and interview, the facility	E 0013	1 The Maintenance		08/10/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING COMPLETED  B. WING 07/02/2024				ETED	
		PROVIDER OR SUPPLIEF			3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE IAPOLIS, IN 46227		
		SUMMARY (EACH DEFICIENT REGULATORY OF failed to review and preparedness policiprocedures must be annually in accordath This deficient practor of the failed to review of an and the Maintenance of the failed to review of an the Maintenance of Indianape of 15/23 with the failed of the			3895 S	REYSTONE AVE IAPOLIS, IN 46227  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Supervisor/DON/Administrator reviewed and updated the pol and procedures in the emerge plan to meet set standards.  2 All residents and all staff and visitors have the potential be affected but none were.  3 The Administrator in serviced the DON/ Maintenan Supervisor on the requiremen review and update the policies procedures in the emergency annually to meet set standard The Administrator or designed inserviced all staff on the update emergency preparedness program.  a The Administrator/Maintenance Supervisor/designee will ensure view and update the policies procedures in the emergency plans annually to meet set standards.  b The Administrator will	r icies ency  f to  ce t to s and plan s. e ated	(X5) COMPLETION DATE
						monitor adherence to the Emergency Preparedness Pol Manual and validate the documentation is in place.  4 The Administrator and Maintenance Supervisor/designell will review the Emergency Preparedness Policy Manual tensure it includes a letter from their natural gas provider to meset standards. Those reviews be documented as appropriate The Administrator/designee were present the training results at Ouglity Assurance/Performance	gnee to n neet s will e. rill	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	(X2) MULTIPLE CONSTRUCTION (X3) DATI A. BUILDING COMP				
		155409	B. WI	NG		07/02/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					Improvement (QA/PI) meeting Results and system componer will be reviewed by the QA/PI Committee with subsequent pi of correction developed and implemented as deemed necessary to ensure complian is maintained.	nts lans	
E 0029 SS=F Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §466 §483.73(c), §483. §485.68(c), §485. §485.920(c), §486 §494.62(c).	5(c), 483.475(c), 483.73(c), 225(c), 485.68(c), 20(c), 486.360(c),					
	an emergency pre plan that complies local laws and mu	eparedness communication s with Federal, State and ust be reviewed and updated ears [annually for LTC					
	Based on record rev failed to develop ar preparedness comm with Federal, State, reviewed and updat accordance with 42 practice could affect	view and interview, the facility and maintain an emergency nunication plan that complies, and local laws which was ted at least annually in 2 CFR 483.73(c). This deficient et all occupants.	E 00	029	<ol> <li>The Administrator and the DON/Maintenance</li> <li>Supervisor/designee reviewed updated the communications print the emergency plan to meet standards.</li> <li>All residents and all staff and visitors have the potential</li> </ol>	and olan t set	08/10/2024
		f the Administrator's version			be affected but none were.  3 The Administrator inserv the DON/Maintenance	iced	
1	and the Maintenance	ce Director's version of			Supervisor/designee on the		,

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Event ID:

 $XFU021 \qquad {\tt Facility\ ID:} \quad 000537$ 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/02/2024					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
TAG	"Emergency Prepar Waters of Indianap 05/15/23 with the M record review from 07/02/24, documen emergency preparer reviewed by the fact twelve month period Based on interview the Maintenance Difor a complete eme communication pla within the most recont available for reviewed.	edness Policy Manual for oblis" documentation dated Maintenance Director during 9:05 a.m. to 12:20 p.m. on tation for a complete dness communication plan oblity within the most recent d was not available for review. The time of record review, at the time of record review, are tree agreed documentation regency preparedness on reviewed by the facility ent twelve month period was view at the time of the survey.  The reviewed with the tor during the exit conference.	TAG	requirement to ensure to upd the communications plan in the emergency plan annually to reset standards. The Administratinserviced all staff on the upd communication plan.  a DON/Maintenance Supervisor/designee will work the Administrator to ensure to update the communications pin the emergency plan to meet standards. If any issues are discovered, they will be address and resolved immediately.  b The Administrator will monitor adherence to the Emergency Preparedness Polymonic Manual and validate the documentation is in place.  4 At least annually to ensure compliance, the Administrator DON/Maintenance Supervisor/designee will revice Emergency Preparedness Polymonic Manual and conduct required exercises and make changes necessary to meet set standard. Those reviews will be docum as appropriate. The Administrator/designee will present the training results at Quality Assurance/ Performa Improvement (QA/PI) meeting Results and system componed will be reviewed by the QA/PI Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliances maintained	ate ne neet ator ated  K with D Dan et set essed  Dicy  ure r and ew the Dicy  as ards. ented  the nce g. ents  Dolans				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
		155409	B. W.	ING		07/02/	2024
	PROVIDER OR SUPPLIER		<u> </u>	3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0036 SS=F Bldg	403.748(d), 416.54 441.184(d), 482.13 484.102(d), 485.63 485.727(d), 485.93 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §483.8 §485.68(d), §485.9 §485.920(d), §486 §494.62(d).  *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testing that is based on the in paragraph (a) or assessment at paragraph (b) of this section, plan at paragraph training and testing reviewed and update in the emergency plan of this section, risk (a)(1) of this section	4(d), 418.113(d), 5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 5.360(d), §491.12(d), 403.748, ASCs at §416.54, 13, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at 10/FHQs at §491.12:] (d) ng. The [facility] must tain an emergency ning and testing program are emergency plan set forth					

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER  155409	A. BUILDING B. WING	G	COMPLETED 07/02/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE			
	section. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) ocommunication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i).	evacuation drills and training ties at §494.62(d):]						
	dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the communic of this section. The orientation programupdated at every 2 Based on record reversalled to develop an preparedness training was reviewed and use the emergency of the section of the section.	d maintain emergency and testing program that pdated at least annually in CFR 483.73(d). This deficient	E 0036	1 The Administrator and DON/Maintenance Supervisor/designee reviewe updated the training and test program in the emergency preparedness plan to meet s standards.	ting			

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Event ID:

XFU021 Facility ID: 000537

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	LDING	<del></del>	COMPL	ETED	
		155409	B. WIN	NG		07/02/	2024	
			<del>'</del> 1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			KEYSTONE AVE			
WATERS	S OF INDIANAPOLI	S, THE			IAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE	
	Findings include:				2 All residents and all staff			
					and visitors have the potential	to		
Based on review of the Administrator's version				be affected but none were.				
	and the Maintenance Director's version of				3 The Administrator inserv	riced		
		redness Policy Manual for			DON/Maintenance			
	_	olis" documentation dated			Supervisor/designee on the			
		Maintenance Director during			requirement to review and upo			
		9:05 a.m. to 12:20 p.m. on			the training and testing progra			
	·	ty's emergency preparedness			the emergency preparedness	pıan		
		program documentation was			to meet set standards.			
		the most recent twelve month			a DON/Maintenance			
	_	nterview at the time of record			Supervisor/designee will work			
		nance Director agreed the			the Administrator to ensure to			
		y preparedness training and			review and update the training	· I		
		cumentation was not reviewed			testing program in the emerge	-		
	within the most rec	ent twelve month period.			preparedness plan to meet se	τ		
	Th C 1:	1 4			standards. If any issues are			
	_	e reviewed with the			discovered, they will be addre	ssea		
	Maintenance Direct	tor during the exit conference.			and resolved immediately.			
					b The Administrator will			
					monitor adherence to the	lia.		
					Emergency Preparedness Police Manual and validate the	icy		
					documentation is in place.  4 At least annually to ensu	ıro		
					compliance, the Administrator			
					DON/Maintenance	unu		
					Supervisor/designee will revie	w the		
					Emergency Preparedness Pol			
					Manual and conduct required	. ⊃ y		
					exercises and make changes	as		
					necessary to meet set standar			
					Those reviews will be docume			
					as appropriate. The Administr			
					will present the training results			
					the Quality Assurance/			
					Performance Improvement (Q	A/PI)		
					meeting. Results and system	, i		
					components will be reviewed			
					the QA/PI Committee with	- ,		

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		IDENTIFICATION NUMBER  155409	A. BUILDING B. WING	onstruction =-	COMPLETED 07/02/2024
	ROVIDER OR SUPPLIER		3895 \$	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE	
WATERS	OF INDIANAPOLIS	S, THE	INDIA	NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §48 §483.475(d)(2), §48 §485.625(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.93 §491.12, and ESR (2) Testing. The [factorial community of the communi	8.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 844.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d) §494.62(d)(2).  6.54, CORFs at §485.68, 68, 68, 68, 68, 69, 69, 69, 69, 69, 69, 69, 69, 69, 69			
	actual event. (ii) Conduct an add	ditional exercise at least			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION (X3		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155409	B. W	NG		07/02	/2024
		1	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S, THE			APOLIS, IN 46227		
	1	·	ı		, 		075)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		CLSC IDENTIFYING INFORMATION  COSITIENT TO SHOOT THE STATE OF THE STAT		TAG			DATE
		cise under paragraph (d)(2)					
	(i) of this section is conducted, that may include, but is not limited to the following:						
		scale exercise that is					
	' '	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
		ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	/18 113/d\·1					
	-	spices that provide care in					
		e. The hospice must					
	l '	to test the emergency					
		ally. The hospice must do					
	the following:	a,					
		a full-scale exercise that is					
	community based						
		nunity based exercise is not					
	` '	ict an individual facility					
		exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospital is					
	exempt from enga	aging in its next required full					
	scale community-	based exercise or individual					
	-	tional exercise following the					
	onset of the emer	<del>-</del>					
	(ii) Conduct an ac	dditional exercise every 2					
	vears, opposite th	e year the full-scale or					

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Event ID: XFU021 Facility ID: 000537

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	AN OF CORRECTION	IDENTIFICATION NUMBER  155409	l í	JILDING	NSTRUCTION		LETED 2/2024	
	DF PROVIDER OR SUPPLIEI RS OF INDIANAPOLI		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	of this section is of include, but is not (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop ex led by a facilitator discussion using a clinically-relevant set of problem star messages, or pre to challenge an el (3) Testing for hos care directly. The exercises to test to per year. The hos (i) Participate in a that is community (A) When a communicacessible, conductacility-based functional emergency exempt from engatull-scale communicational exercisemergency event (ii) Conduct an authat may include, following:  (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop exercis	ster drill; or lercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan.  spices that provide inpatient hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise hased; or nunity-based exercise is not lect an annual individual ctional exercise; or experiences a natural or lency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is le or a facility based e; or						

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Event ID:

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PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155409	JILDING	NSTRUCTION	COMPL 07/02/	ETED
	PROVIDER OR SUPPLIER		3895 S	DDRESS, CITY, STATE, ZIP COD KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE	INDIAN	APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	statements, direct questions designe emergency plan. (iii) Analyze the h maintain documer exercises, and em	rio, and a set of problem ed messages, or prepared				
	§482.15(d), CAHs (2) Testing. The [F conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community- (A) When a comm accessible, condu facility-based func (B) If the [PRTF, F an actual natural of that requires activ plan, the [facility] i its next required fu or individual, facilif following the onse (ii) Conduct a exercise or and th limited to the follow (A) A second full- community-based facility-based func	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following: an annual full-scale exercise abased; or annual individual, attional exercise; or dospital, CAH] experiences or man-made emergency attion of the emergency attion of the emergency s exempt from engaging in all-scale community based ty-based functional exercise at of the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a				
	(C) A tabletop is led by a facilitate discussion, using	o exercise or workshop that or and includes a group				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	l í	UILDING	NSTRUCTION	(X3) DATE COMPI 07/02		
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE	
	set of problem sta messages, or pre to challenge an e (iii) Analyze t and maintain doc tabletop exercises and revise the [fa needed.	ntements, directed pared questions designed mergency plan. he [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as						
	conduct exercises plan at least annuorganization musi (i) Participate in a that is community (A) When a comn	PACE organization must is to test the emergency rally. The PACE it do the following: an annual full-scale exercise						
	(B) If the PACE e or man-made em- activation of the e is exempt from er full-scale commun facility-based fund onset of the emer							
	2 years opposite of functional exercise of this section is of but is not limited to (A). A second full community-based	-scale exercise that is I or individual, a facility						
	led by a facilitator discussion, using clinically-relevant	ter drill; or ercise or workshop that is and includes a group						

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	OF CORRECTION	IDENTIFICATION NUMBER  155409	r í	ILDING	NSTRUCTION	COMPL 07/02/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
IAU	messages, or prepto challenge an er (iii) Analyze the Pmaintain documer exercises, and em the PACE's emergent exercises, and em the emergency properties of the emergency properties exercises in a that is community. (A) When a community-based functional exercises activation actual natural or not require activation exercises activation actual natural or not require activation actual natural exercises (ii) Conduct an actual natural exercises (iii) Conduct an actual may include, following:  (A) A second full-community-based based functional exercises functional exercises (C) A tabletop exer	pared questions designed mergency plan. PACE's response to and natation of all drills, tabletop mergency events and revise gency plan, as needed.  Is at §483.73(d):]  ty] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: In annual full-scale exercise exercise exercise is not ext an annual individual, etional exercise.  Illity] facility experiences an man-made emergency that in of the emergency plan, the mpt from engaging its next le community-based or based functional exercise ext of the emergency event. In of the emergency event. In other exercise is not limited to the exercise that is or an individual, facility exercise; or the drill; or exercise or workshop that is includes a group an anarrated, emergency scenario, and a tements, directed or eared questions designed		TAG			DATE	
	(iii) Analyze the [l	_TC facility] facility's						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	ETED
		155409	B. WI	NG		07/02/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S THE			APOLIS, IN 46227		
WALLE			_	II V D I/ VI V	711 OLIO, 114 40227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 '	naintain documentation of					
	all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.						
	*IFIOF/IID+ 0	2400 475/-1/1					
	*[For ICF/IIDs at §	• • •					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:	n annual full apple aversion					
	that is community	n annual full-scale exercise					
		nunity-based exercise is not					
	` '	ct an annual individual,					
		ctional exercise; or.					
	-	experiences an actual					
	' '	ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	· ·	nity-based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		ditional annual exercise					
	, ,	but is not limited to the					
	following:						
	_	scale exercise that is					
	community-based						
	_	ctional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is					
		and includes a group					
	discussion, using	• .					
		emergency scenario, and a					
	set of problem sta						
	· · · · · · · · · · · · · · · · · · ·	pared questions designed					
	to challenge an er	·					
		CF/IID's response to and					
	, , ,	ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					

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Event ID:

XFU021 Facility ID:

Facility ID: 000537

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	OF CORRECTION	IDENTIFICATION NUMBER  155409	î ´	JILDING	NSTRUCTION	COMPL 07/02/	ETED
	PROVIDER OR SUPPLIER			3895 S	DDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	exercises to test the least annually. The following:  (i) Participate in a community-based  (A) When a control is not accessible, individual, facility-levery 2 years; or.  (B) If the HH. Inatural or man-man activation of the exempt from engate full-scale community based functional exercises of the emerging of this section is controlled, but is not (A) A second community-based facility-based functional exercises of the exempt from engate facility-based functional exercises of this section is controlled, but is not (B) A mock dinger (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem state messages, or prepto challenge an error (iii) Analyze the Himaintain documer exercises, and error exercises, and error exercises.	e HHA must conduct the emergency plan at the HHA must do the  full-scale exercise that is the or community-based exercise conduct an annual based functional exercise  A experiences an actual ade emergency that requires mergency plan, the HHA is the ging in its next required tity-based or individual, tional exercise following the the gency event.  ditional exercise every 2 the year the full-scale or the under paragraph (d)(2)(i) tonducted, that may limited to the following: full-scale exercise that is or an individual, tional exercise; or saster drill; or to exercise or workshop that or and includes a group a narrated, temergency scenario, and a tements, directed to ared questions designed					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/02/2024			
	PROVIDER OR SUPPLIER S OF INDIANAPOLI		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan. It actual natural or requires activation OPO is exempt for required testing exercises, and emergency (ii) Analyze the Olimaintain document exercises, and emergency (iii) Analyze the Olimaintain document exercises to test to the total exercises to test to the total exercises to test to the total exercises in a sed	e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an if the OPO experiences an anan-made emergency that a of the emergency plan, the om engaging in its next exercise following the onset event. PO's response to and antation of all tabletop aregency events, and revise OPO's] emergency plan, as  3.748]: e RNHCI must conduct the emergency plan. The	E 0039	1 The Administrator and t	he 08/10/2024			
		tercises to test the emergency	E 0033	DON/ Maintenance	00/10/2024			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	<del></del>	COMPLETED	
		155409	B. W			07/02	/2024
		100 100				0.702	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S, THE		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
	plan at least twice p	per year, including			Supervisor/designee conducte	ed a	
	unannounced staff	drills using the emergency			community-based exercise, ar	า	
	procedures. The LT	C facility must do the			individual facility based exercis	se	
	following:				and an actual natural or		
	(i) Participate in an	annual full-scale exercise that			man-made emergency that		
	is community-based				required activation of the		
	1	ity-based exercise is not			emergency plan and documen	ited	
	accessible, conduct	an annual individual,			the results in the Life Safety		
	facility-based funct	ional exercise.			Binder to meet set standards.		
	b. If the LTC facility experiences an actual natural				2 All residents and all staff		
	or man-made emergency that requires activation				and visitors have the potential	to	
		lan, the LTC facility is exempt			be affected but none were.		
		ext required full-scale			3 The Administrator in		
		or individual, facility-based			serviced the DON/ Maintenand	ce	
	-	l exercise for 1 year following			Supervisor/designee on the		
	the onset of the actu	-			requirement to conduct a		
		itional exercise that may			community-based exercise, ar	1	
	1 1	imited to the following:			individual facility-based exercis		
	a. A second full-sca	_			and an actual natural or		
		or an individual, facility-based			man-made emergency that		
	functional exercise.				required activation of the		
	b. A mock disaster				emergency plan and documen	it the	
		ise or workshop that is led by a			results in the Life Safety Binde		
	_	ides a group discussion, using			meet set standards.	,, (0	
		y-relevant emergency scenario,			a DON/Maintenance		
		n statements, directed			Supervisor/designee will work	with	
	_	red questions designed to			the Administrator to ensure to	WILLI	
	challenge an emerg	-			conduct a community-based		
		FC facility's response to and			exercise, an individual		
		ation of all drills, tabletop			facility-based exercise and an		
		gency events, and revise the			actual natural or man-made		
		gency plan, as needed in			emergency that required activation	ation	
	-	CFR 483.73(d)(2). This			of the emergency plan and	ulion	
		ould affect all occupants.			document exercises testing the	۵	
	deficient practice of	oute arreet air occupants.			_	C	
	Findings include:				emergency plan at least twice		
	r manigs meiade:				during the year to meet set standards. If any issues are		
	Događ or marijari - f	the Administrator's version				d	
	based on review of	me Administrator's version			discovered, they will be addres	ssea	İ

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and the Maintenance Director's version of

"Emergency Preparedness Policy Manual for

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and resolved immediately. The Administrator will

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/02/2024		
WATERS	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	05/15/23 with the M record review from 07/02/24, document that is community-be facility-based function recent two year perimensions. The facility actual natural or ma required activation of the most recent two interview at the time Maintenance Direct community-based expect actual natural or ma required activation of the most recent two for review.	olis" documentation dated faintenance Director during 9:05 a.m. to 12:20 p.m. on ation for a full-scale exercise based or an individual, conal exercise within the most od was not available for also did not document any n-made emergency that of the emergency plan within year period. Based on the of record review, the or agreed documentation of a exercise, an individual, ise or documentation of an n-made emergency plan within year period was not available the emergency plan within year period was not available the reviewed with the or during the exit conference.		monitor adherence to the Emergency Preparedness Po Manual and validate the documentation is in place.  4 At least annually to ensicompliance, the Administrator DON/Maintenance Supervisor/designee will reviee Emergency Preparedness Po Manual and conduct required exercises and make changes necessary to meet set standa Those reviews will be docume as appropriate. The Administrator/designee will present the training results at Quality Assurance/ Performar Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliar is maintained.	are or and ew the licy as rds. ented the nce g. ents		
K 0000							
Bldg. 01	Licensure Survey w	00537 155409	K 0000	July 20, 2024  Preparation or execution of the plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of sorth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	ment the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII				COMPLETED 07/02/2024	
		155409	B. WIN	ن 		07/02/	/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S BLANGE CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.=	DATE	
		Code survey, The Waters of			required by Federal and State			
	_	und not in compliance with			law. The plan of correction is			
	Requirements for Pa	-			submitted in order to respond			
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				the allegation of noncompliand			
	-	re and the 2012 Edition of the			cited during the Annual Surve			
		ction Association (NFPA) 101,			July 2, 2024. Please accept the			
	• `	SC), Chapter 19, Existing			plan of correction as the provi			
	Health Care Occupa	ancies and 410 IAC 16.2.			credible allegation of complian	ice		
					with Federal Medicare and			
	•	ity was determined to be of			Medicaid requirements. We			
	• • • •	ruction and fully sprinklered.			respectfully request a desk			
	_	re alarm system with smoke			review.			
	detection in the corridors and in all areas open to the corridor. The facility has battery operated							
		all resident sleeping rooms.						
	of 67 at the time of	apacity of 81 and had a census						
	of 67 at the time of	this visit.						
	All areas where resi	idents have customary access						
		The facility has two detached						
	-	storage and a detached						
		h were each not sprinklered.						
	C	•						
	Quality Review con	npleted on 07/08/24						
K 0100	NFPA 101							
SS=E	General Requirem	nents - Other						
Bldg. 01	General Requirem							
	-	RKS section any LSC						
	Section 18.1 and	19.1 General Requirements						
	that are not addre	ssed by the provided						
	K-tags, but are de	ficient. This information,						
	along with the app	licable Life Safety Code or						
	NFPA standard cit	tation, should be included						
	on Form CMS-256							
		on and interview, the facility	K 010	00	1 The Maintenance		08/10/2024	
		maintain a door closing			Supervisor/designee installed	а		
		1 door sets to the main Dining			coordinator to the entrance to	the		
	-	uipped with an astragal per			main dining room to meet set			
	4.6.12.3. LSC 4.6.1	2.3 requires existing life safety	1		standards.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155409	B. W	ING		07/02/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF INDIANADOLI	0. THE			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	features obvious to	the public if not required by					
	the Code, shall be e	ither maintained or removed.			2 All residents and all staff		
		ice could affect over 20			and visitors have the potential	to	
	-	visitors in the main Dining			be affected but none were.		
	Room.	5			3 The Administrator inserv	riced	
					the Maintenance		
	Findings include:				Supervisor/designee on the		
					requirement to maintain		
	Based on observation	ons with the Maintenance			coordinators for door sets to n	neet	
		our of the facility from 12:50			set standards.	.550	
	_	n 07/02/24, the south door in the	1		a Maintenance Supervisor	.,	
		rving as the entrance to the			designee will ensure to mainta		
		was equipped with an astragal			coordinators for door sets as a		
	but the door set was not provided with a door				part of the facility's weekly	1	
		to ensure the door equipped			Preventive Maintenance Progr	rom	
	-	ways closes last. Each door in			and document those inspectio		
	_	o held in the fully open			results as appropriate. If any		
		mounted magnetic releasing			issues are discovered, they wi		
	-	with fire alarm system			addressed and resolved	II DE	
		n interview at the time of the			immediately. The Maintenanc		
		aintenance Director agreed			Supervisor/designee will revie		
		t to the main Dining Room was			with the Administrator the	vv	
		door closing coordinator to			inspection results.		
		ipped with the astragal always			b The Administrator will		
	closes last.	ipped with the astragar arways			monitor adherence to the		
	010303 1431.				Preventative Maintenance		
	These findings war	e reviewed with the					
	These findings were	for during the exit conference.			schedule and validate the		
	Maintenance Direct	of during the exit conference.			Preventative Maintenance		
	2.1.10(%)				documentation is in place.	:11	
	3.1-19(b)				4 The inspection results w		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
			1		Administrator monthly and the		
					Administrator/designee will		
			1		present the inspection results	at	
					the monthly Quality		
					Assurance/Performance		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed I	эу	

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  155409  B. WING			COMPLETED 07/02/2024	
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
				the QA/PI Committee with subsequent plans of correct developed and implemented deemed necessary to ensur compliance is maintained.	l as
K 0222 SS=D Bldg. 01	be equipped with a requires the use of egress side unless special locking arr. CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times.  18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the Clinical or Secure being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (	king arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1,  LOCKING Sking arrangements for the e patient are used, all of urity Locking requirements addition, the locks must be t fail safely so as to of power to the device; the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/02/2024	
	PROVIDER OR SUPPLIEI S OF INDIANAPOLI		3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	space); and both systems are arrar upon activation.  18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed a systems installed 7.2.1.6.1 shall be assemblies servir contents in buildir an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTE LOCKING ARRAI Access-Controlled installed in accord be permitted.  18.2.2.2.4, 19.2.2 ELEVATOR LOBI LOCKING ARRAI Elevator lobby exaccordance with 7.000 accordance	the sprinkler and detection aged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING S delayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system.  2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall  2.4 BY EXIT ACCESS			
	automatic fire deta approved, superv system.	approved, supervised ection system and an ised automatic sprinkler			
	failed to ensure cor sleeping rooms wer rescue residents in locked. This defici residents in Room	on and interview, the facility ridor doors to 1 of 39 resident re arranged such that staff can remergency if the door was ent practice could two	K 0222	1 The Maintenance Supervisor/designee removed lock from resident sleeping ro H9 and installed a passage do lock that had no tool requirem to open it to meet set standard	om oor ents ds.
	Findings include:			2 All residents and all staf and visitors have the potential	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155409		A. BUILDING B. WING	01	COMPLETED 07/02/2024	
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director during a to p.m. to 2:30 p.m. or resident sleeping Ro handle which could room but required a door handle from the The lock on the doo handle on the corrid in the handle to insee a pin or tool to unlo available for staff to interview at the time Maintenance Direct paper clip to unlock tool to unlock the dofor staff in an emerg locked.	ons with the Maintenance our of the facility from 12:50 in 07/02/24, the corridor door to be on H9 had a lock on the door be unlocked from inside the tool to be inserted into the e corridor side of the door. It was operable. The door for side of the door had a hole ent a pin to unlock the door but ck the door was not readily ounlock the door. Based on e of the observations, the for stated you could insert a the door but agreed a pin or foor was not readily available gency if the door became  The reviewed with the or during the exit conference.		be affected but none were. The Maintenance Supervisor/design inspected all resident room do and found no other negative findings.  3 The Administrator inservithe Maintenance Supervisor/designee/ all staff ensure corridor doors to residn sleeping rooms are arranged that staff can rescue residents an emergency.  a Maintenance Supervisor/designee will ensure corridor doors to resident sleep rooms are arranged such that can rescue residents in an emergency as a part of the facility's Weekly Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/design will review with the Administrator the inspection results.  b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 The inspection results were presented by the Maintenance supervisor/designee to the Administrator monthly and the Administrator monthly and the Administrator results the monthly Quality	gnee cors  viced  to ent such s in  re ping staff  sults are ssed ne gnee tor

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	A. BU	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/02/2024	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE			APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	REGULATORY OF	CLSC IDENTIFY ING INFORMATION		IAU	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.	py n	DATE
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated to by smoke resisting rs in accordance with 8.4.					
	a. Boiler and Fuel b. Laundries (largo c. Repair, Mainter	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMP	LETED
155409 B. WING 07/02	/2024
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  3895 S KEYSTONE AVE	
WATERS OF INDIANAPOLIS, THE INDIANAPOLIS, IN 46227	
	Т
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION  (X4) ID PROVIDER'S PLAN OF CORRECTION  (X4) ID PROVIDER'S PLAN OF CORRECTION  (X5) ACID CORPECTIVE ACTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION  TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION  TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION	COMPLETION
TAG REGULATOR OR ESCIDENTIFIED INFORMATION TAG	DATE
(exceeding 64 gallons)	
f. Combustible Storage Rooms/Spaces	
(over 50 square feet) g. Laboratories (if classified as Severe	
Hazard - see K322)	
1. Based on observation and interview, the facility K 0321 1 The Maintenance	08/10/2024
failed to ensure 2 of over 9 hazardous areas such  Supervisor/designee repaired the	06/10/2024
as combustible storage rooms/spaces (over 50 latching mechanism to ensure it	
square feet) and trash collection rooms (exceeding self closes and latches into the	
64 gallons) were separated from other spaces by frame of the dutch door to the	
smoke resistant partitions and doors. Doors shall kitchen from the main dining room	
be self closing or automatic closing in accordance to meet set standards.	
with 7.2.1.8. This deficient practice could affect  a The Maintenance	
over 20 residents, staff and visitors.  Supervisor/designee installed a	
self closure latching device on the	
Findings include: entry door to the storage room to	
ensure it self closes and latches	
Based on observations with the Maintenance into the frame to meet set	
Director during a tour of the facility from 12:50 standards.	
p.m. to 2:30 p.m. on 07/02/24, the following was	
noted: Supervisor/designee relocated the	
a. the former Dutch door to the kitchen from the popcorn popper to a hazard room	
main Dining Room was equipped with a equipped with a self closing device	
self-closing device and a positive latching device and positive latching door latch to	
on the door handle but the latching mechanism meet set standards.	
failed to protrude into the door frame when tested  2 All residents and all staff	
to self-close and latch into the door frame multiple and visitors have the potential to	
times. The kitchen contained two 32 gallon and  be affected but none were.	
one 20 gallon trash carts.  b. the latching device on the entry door to the  3 The Administrator in serviced the Maintenance	
storage room inside the break room had been Supervisor/designee on the	
removed which caused the door to not latch into	
the door frame when tested to close. The storage hazardous area doors are provided	
room was greater than 50 square feet in size and with a self-closing device to meet	
was used to store combustible boxes and set standards.	
supplies. a Maintenance	
Based on interview at the time of the Supervisor/designee will ensure	
observations, the Maintenance Director agreed that all hazardous area doors are	
the aforementioned two hazardous areas were not provided with a self-closing device	
separated from other spaces by smoke resistant  & latching hardware as a part of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155409	B. W	ING		07/02	/2024
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE		
\MATEDO	C OE INDIANADOL	IS THE					
WATERS	S OF INDIANAPOL	IS, THE		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	partitions and door	S.			the facility's monthly Preventi	ve	
					Maintenance Program and		
	_	re reviewed with the			document those inspection re	sults	
	Maintenance Direc	tor during the exit conference.			as appropriate. If any issues		
	3.1-19(b)				discovered, they will be addre	essed	
					and resolved immediately. The		
					Maintenance Supervisor/design		
		ation and interview, the facility			will review with the Administra	ator	
	_	protection of 1 of 1 hot oil			the inspection results.		
		the Activity room. This			b The Administrator will		
	•	ould affect over 20 residents,			monitor adherence to the		
	staff and visitors in the vicinity of the Activities Room.				Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
	Findings include:				documentation is in place.		
	5 1 1	id d act.			4 The inspection results w		
		ons with the Maintenance			be presented by the Maintena	ince	
	_	our of the facility from 12:50			Supervisor/designee to the		
		n 07/02/24, the Activities Room			Administrator monthly and the	)	
		oil popcorn popper which had			Administrator/designee will	-4	
		op popcorn. The corridor door			present the inspection results	at	
		oom was not equipped with a			the monthly Quality		
		or was not automatic closing.			Assurance/Performance		
		tor agreed the Activities Room			Improvement (QA/PI) meeting Inspection results and system		
		is a hazardous area when a hot			components will be reviewed		
	•	was being utilized in the room.			the QA/PI Committee with	Dy	
	оп ророот роррег	Jenig utilized in the 100m.			subsequent plans of correction	n	
	These findings wer	re reviewed with the			developed and implemented a		
	_	g the exit conference.			deemed necessary to ensure	40	
		g			compliance is maintained.		
	3.1-19(b)				Comprando io maniamo		
K 0225	NEDA 404						
K 0325	NFPA 101	and Dub Diananas (ADLD)					
SS=E		and Rub Dispenser (ABHR)					
Bldg. 01		and Rub Dispenser (ABHR)					
		cted in accordance with					
		conditions are met:					
	* Corridor is at lea						
	iviaximum indivi	dual dispenser capacity is					1

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED	
		155409	B. W	ING		07/02/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> —                                   </u>		
NAME OF 1	PROVIDER OR SUPPLIE	R			KEYSTONE AVE			
WATER	S OF INDIANAPOL	IS THE			IAPOLIS, IN 46227			
WAILIN				INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	0.32 gallons (0.53	3 gallons in suites) of fluid						
	and 18 ounces of							
	* Dispensers sha	I have a minimum of 4-foot						
	horizontal spacing							
		in aggregate of 10 gallons of						
		es aerosol are used in a						
	_	npartment outside a storage						
	cabinet, excluding	g one individual dispenser						
	per room							
	_	gle smoke compartment						
	1 "	llons complies with NFPA						
	30 * Dispensers are not installed within 1 inch of							
	an ignition source							
	1	r carpeted floors are in						
	sprinklered smok							
		exceed 95 percent alcohol						
	-	e dispenser shall comply						
		.2.6(11) or 19.3.2.6(11)						
	1	ted against inappropriate						
	access	42.0ED Davida 402, 440						
		i, 42 CFR Parts 403, 418,						
	460, 482, 483, an	on and interview, the facility	K 0	225	1 The Maintenance		08/10/2024	
		ohol based hand sanitizers	KU	323	1 The Maintenance Supervisor/designee relocated	d tha	08/10/2024	
		over an ignition source in 1 of			alcohol-based hand sanitizer	ı iile		
		FPA 101, in 19.1.1.3 requires all			dispensers away from the ligh	nt.		
		be designed, constructed,			switch inside the Laundry Roc			
		erated to minimize the			meet set standards.	<i>/</i> 111 tO		
	_	emergency requiring the			2 All residents and all staff	f		
		pants. This deficient practice			and visitors have the potential			
		0 residents, staff and visitors in			be affected but none were. T			
	the vicinity of the l				Maintenance Supervisor/design			
		.,			inspected the location of all	,		
	Findings include:				alcohol-based hand sanitizer			
					dispensers and found no othe	:r		
	Based on observati	ons with the Maintenance			negative findings.			
		our of the facility from 12:50			3 The Administrator inserv	/iced		
		n 07/02/24, an alcohol based			the Maintenance			
	_	enser was installed on the wall			Supervisor/designee on the			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/02/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE		
	regulatory of inside the Laundry switch for the room Manufacturer's doc container inside the 70% ethyl alcohol. of the observations, agreed the dispense solution and agreed directly above the l			requirement that alcohol-b hand sanitizers cannot be installed over ignition sour meet set standards.  a Maintenance Supervisor/designee will in all alcohol-based hand san throughout the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensure they are in the proplocations as a part of the facility more ensured that the preventive Maintenance of the Administrator facility. The Maintenance schedule and validate the preventative Maintenance documentation is in place.  4 The inspection result be presented by the Maint Supervisor/designee to the Administrator monthly and Administrator facility and Administrator monthly Quality Assurance/Performance Improvement (QA/PI) meet Inspection results and system components will be review the QA/PI Committee with	ased ces to  aspect initizers inthly to per acility's frogram ection any by will be inance eview  II  as will enance et the II ults at  eting. tem red by		
				subsequent plans of corredeveloped and implement deemed necessary to ensi	ed as		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155409	B. WI	NG		07/02/2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD  3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT	/E	DATE
					compliance is maintained.		
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are really 100 for the National Fire Alarm Records of system and testing are really 100 for the National Fire Alarm Records of system and testing are really 100 for the National Fire Alarm Code of the National Electrical Office Alarm Code of 14.4.5 requires testification accordance with Tally NFPA 72, Table 14. System initiating detested annually. See all inspections, testification provided that including requested in Figure practice could affectivisitors.  Findings include:  Based on review of inspection contractors.	n - Testing and n - Testing and n is tested and maintained n an approved program e requirements of NFPA 70, code, and NFPA 72, n and Signaling Code. n acceptance, maintenance adily available.	K 0:		DEFICIENCY)	out or g neet to	DATE  08/10/2024
	the Maintenance Di	rector during record review			system initiating devices as a p	part	
	from 9:05 a.m. to 12	2:20 p.m. on 07/02/24, an			of the facility's monthly Preven		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/02/2024		
	PROVIDER OR SUPPLIER		•	3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE APOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	system initiating de most recent twelve available for review contained a listing of inspections of initia as 09/18/23. In add alarm system inspections of also indicated it was visual inspections of dated as 09/18/23. of record review, the additional fire alarm documentation with month period was in Maintenance Direct system inspection of to provide 03/18/24 contractor again profinspection of initiat the cover page of the Based on interview	etional testing all fire alarm vices in the facility within the month period was not 7. The 03/18/24 documentation of the results of visual ting devices which was dated lition, the review of the fire etion contractor's "Fire Alarm documentation dated 09/18/24 as a listing of the results of of initiating devices which was Based on interview at the time the Maintenance Director stated in inspection and testing win the most recent twelve toot available for review. The correct contacted the fire alarm contractor during record review testing documentation but the ovided the results of the visual ting devices dated 09/18/24 for the report dated 03/18/24. The time of record review, at the time of record review,			Maintenance Program and document those inspection resas appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/desigwill review with the Administrative inspection results.  b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.  4 The inspection results where the preventative Maintenance documentation is in place.  4 The inspection results where the preventative Maintenance documentation is in place.  4 The inspection results where the preventative Maintenance documentation is in place.  5 The Administrator is in place.  6 The inspection results where the monthly and the Administrator/designee will present the inspection results the monthly Quality Assurance/Performance Improvement (QA/PI) meeting	are ssed e Inee tor  ill nce at	
	of functional testing devices in the facili	rector agreed an itemized list g all fire alarm system initiating ty within the most recent d was not available for review.			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	oy 1	
	_	for during the exit conference.			compliance is maintained.		
	3.1-19(b)						
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA

		IDENTIFICATION NUMBER 155409	A. BU B. WI	JILDING NG	01	COMPL 07/02/		
	NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Protection Systems.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	Records of syster inspection and tes secure location and	n design, maintenance, sting are maintained in a nd readily available. r system last checked						
	c) Water system							
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record interview; the facil sprinkler systems it LSC 9.7.5 requires inspected, tested, awith NFPA 25, Sta Testing, and Maint	non-required or partial er system.  , and NFPA 25 review, observation and ity failed to maintain automatic accordance with NFPA 25. all sprinkler systems shall be and maintained in accordance undard for the Inspection, enance of Water-Based Fire	K 0.	353	1 The facilities licensed sprinkler contractor repaired the sprinkler system per the 8/10/2 inspection documentation and received copy of the completed repair work to meet set standards.	23	08/10/2024	
	Section 4.1.4.1 stat designated represer deficiencies or imp the inspection, test this standard. Corr performed by quali	es the property owner or natative shall correct or repair airments that are found during and maintenance required by sections and repairs shall be fied maintenance personnel or tor. NFPA 25, Section 4.3.1			a The Maintenance Supervisor/designee sealed th holes with a one hour fire rated material in the corridor ceiling outside room H9 and in the cei in the bathroom for resident ro L11 to meet set standards.	d iling		
	tests, and maintena and shall be made a having jurisdiction practice could affect visitors in the facili	all be made for all inspections, nce of the system components available to the authority upon request. This deficient of all residents, staff and ity.			<ul> <li>2 All residents and all staff and visitors have the potential be affected but none were.</li> <li>3 The Administrator inservithe Maintenance</li> <li>Supervisor/designee on the requirement to ensure to maintenance</li> </ul>	to ced		
		the sprinkler system or's "Work Performed"			the sprinkler systems including correcting any deficiencies not and to ensure to maintain the ceiling construction in ceiling			

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155409	B. WI	NG		07/02	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S, THE			IAPOLIS, IN 46227		
	Г		1		, - <del></del>		T
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	documentation date	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
					smoke barriers to meet set		
		for during record review from			standards.		
		o.m. on 07/02/24, the facility's			a Maintenance		
	_	system needs additional			Supervisor/designee will ensu		
	1 -	er Work Required" section of			maintain the sprinkler systems	8	
	_	tion documentation stated			including correcting any		
		ace 1/4" bleed off valve (Gate			deficiencies noted and to ensu	ure	
	· ·	alarm pressure switch &			to maintain the ceiling		
		4" nipple connected to 1/4"			construction in ceiling smoke		
		f into tee during sprinkler			barriers as a part of the facility		
		place 1/4" gate valve on			quarterly Preventive Maintena		
		e." Based on interview at the			Program and document those		
		ew, the Maintenance Director			inspection results as appropri		
		find the quote for sprinkler			If any issues are discovered, t	•	
		greed he was not certain the			will be addressed and resolve		
		pairs were made on or after			immediately. The Maintenand		
		observations with the			Supervisor/designee will revie	W	
		for during a tour of the facility			with the Administrator the		
	_	2:30 p.m. on 07/02/24, the facility			inspection results.		
		dry sprinkler system riser			b The Administrator will		
	located in the maint	enance office.			monitor adherence to the		
					Preventative Maintenance		
	These findings were				schedule and validate the		
	Maintenance Direct	for during the exit conference.			Preventative Maintenance		
					documentation is in place.		
	3.1-19(b)				4 The inspection results w		
					be presented by the Maintena	nce	
		ation and interview, the facility			Supervisor/designee to the		
		ne ceiling construction in 1 of 1			Administrator monthly and the	:	
	_	ers. NFPA 13, 2010 edition,			Administrator/designee will		
		nes a smooth ceiling as a			present the inspection results	at	
		free from significant			the monthly Quality		
		s, or indentations. The ceiling			Assurance/Performance		
	traps hot air and gas	ses around the sprinkler and			Improvement (QA/PI) meeting	١.	
		to operate at a specified			Inspection results and system		
	temperature. Section	on 8.5.4.1.1 states the distance			components will be reviewed	by	
	between the sprinkl	er deflector and the ceiling			the QA/PI Committee with		
	above shall be selec	eted based on the type of			subsequent plans of correction	n	
	sprinkler and the ty	pe of construction. This			developed and implemented a		
	deficient practice could affect over 20 residents.		1		deemed necessary to ensure		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETI  B. WING 07/02/20					
		155409	B. WING			07/02/	2024	
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROUDERIC DI AN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	staff and visitors.				compliance is maintained.			
	Findings include:							
	Based on observation	ons with the Maintenance						
		our of the facility from 12:50						
	p.m. to 2:30 p.m. or	n 07/02/24, four separate holes						
		orridor ceiling outside Room						
	_	the attic above. In addition, a						
		r hole was noted in the ceiling						
		resident Room L11 which						
	•	ove. Based on interview at ervations, the Maintenance						
		thing fixture used to be in						
	_	outside Room H9 and agreed						
		ing at the aforementioned two						
	locations did not ma	_						
	construction.							
	These findings were							
	Maintenance Direct	for during the exit conference.						
	3.1-19(b)							
K 0521	NFPA 101							
SS=E	HVAC							
Bldg. 01	HVAC							
	Heating, ventilatio	n, and air conditioning shall						
		nd shall be installed in						
	accordance with the	he manufacturer's						
	specifications.	0.0						
	18.5.2.1, 19.5.2.1,	, 9.2 view, observation and	17.0	501	4 The facility's licensed		00/10/2024	
		ty failed to ensure all fire	K 0:	521	1 The facility's licensed contractor inspected the three	fire	08/10/2024	
		lity were inspected and			dampers and received copies			
	_	maintenance within the most			the inspection to file in the	٠,		
		iod in accordance with NFPA			facilities life safety binder to m	eet		
		quires heating, ventilating and			set standards.			
	air conditioning (HV	VAC) ductwork and related			2 All residents and all staff	and		
	equipment shall be	in accordance with NFPA 90A,			visitors have the potential to b	е		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155409	B. W			07/02	
				_	<u> </u>		-
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					KEYSTONE AVE		
WATERS	S OF INDIANAPOLI	S, THE		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Standard for the Ins	stallation of Air-Conditioning			affected but none were.		
	and Ventilating Sys	stems. NFPA 90A, 2012			3 The Administrator inservi	ced	
	Edition, Section 5.4	4.8.1 states fire dampers shall be			the Maintenance		
	maintained in accor	dance with NFPA 80, Standard			Supervisor/designee on the		
	for Fire Doors and	Other Opening Protectives.			requirement to test all fire		
	NFPA 80, 2010 Ed	ition, Section 19.4.1 states each			dampers to meet set standard	S.	
	damper shall be tes	ted and inspected 1 year after			a Maintenance		
	installation. The te	st and inspection frequency			Supervisor/designee will inspe	ect	
	shall be every 4 year	ars. If the damper is equipped			and test all fire dampers as		
	with a fusible link,	the link shall be removed for			required as a part of the facilit	y's	
	testing to ensure ful	Il closure and lock-in-place if			Preventive Maintenance Prog	ram	
	so equipped. The d	lamper shall not be blocked			and document those inspectio	n	
	from closure in any way. All inspections and				results as appropriate. If any		
	testing shall be doc	umented, indicating the			issues are discovered, they wi	ill be	
		damper, date of inspection,			addressed and resolved		
	_	and deficiencies discovered.			immediately. The Maintenand		
	The documentation	shall have a space to indicate			Supervisor/designee will revie	W	
	when and how the	deficiencies were corrected.			with the Administrator the		
		es full unobstructed access to			inspection results.		
		ll be verified and corrected as			b The Administrator will		
	_	cient practice could affect all			monitor adherence to the		
	residents, staff and	visitors.			Preventative Maintenance		
					schedule and validate the		
	Findings include:				Preventative Maintenance		
					documentation is in place.		
		the fire damper inspection			4 The inspection results wil		
		Camper Inspection Checklist"			presented by the Maintenance	•	
		ed June 2023 with the			Supervisor/designee to the		
		tor during record review from			Administrator monthly and the		
		o.m. on 07/02/24, a total of 115			Administrator/designee will		
	_	facility were inspected and			present the inspection results	at	
		ost recent four year period.			the monthly Quality		
		ons with the Maintenance			Assurance/Performance		
		our of the facility from 12:50			Improvement (QA/PI) meeting		
		n 07/02/24, the fire damper			Inspection results and system		
		or had affixed inspection			components will be reviewed I	by	
		per locations throughout the			the QA/PI Committee with		
		dated June 2023 to most all fire			subsequent plans of correction		
	-	xcept three fire damper			developed and implemented a	ıs	
	locations. Each of	the three fire damper locations			deemed necessary to insure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLE			ETED		
		155409	B. WING 07/02			07/02/	2024
				CTDEET A	DDDFGG CITY CTATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WATERS		C THE			KEYSTONE AVE		
WATERS	OF INDIANAPOLIS	5, I П E		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	had an affixed inspe	ection sticker which was dated			compliance is maintained.		
	06/19/24. The three	e fire damper locations were in					
	the corridor ceiling	outside Room H10, at the					
	entrance to the Faith	n Hall and outside the					
	Administrator's offic	ce. The three fire damper					
	locations could not	be identified on the					
	contractor's June 20	23 inspection documentation.					
	Based on interview	at the time of the					
	observations, the M	aintenance Director agreed it					
	could not be ensured	d the aforementioned three					
	fire damper location	as were inspected and tested					
	within the most rece	ent four year period.					
	These findings were	e reviewed with the					
	Maintenance Direct	or during the exit conference.					
	3.1-19(b)						
K 0761							
SS=E							
Bldg. 01							
		riew, observation and	K 0'	761	1 The Maintenance		08/10/2024
		ty failed to ensure annual			Supervisor/designee conducte		
		ng of all fire door assemblies			the annual inspection for the fi	re	
	•	accordance of LSC 19.1.1.4.1.1.			door inspections including the		
		enings in dividing fire barriers			doors to oxygen storage and		
		.1 shall be permitted only in			transfilling rooms and docume	nted	
		be protected by approved			the inspection results on the		
	_	or assemblies. (See also Section			Annual Door Inspections log to	)	
		penings required to have a fire			meet set standards.		
		Table 8.3.4.2 shall be			2 All residents and all staff		
		ed, listed, labeled fire door			and visitors have the potential	to	
		window assemblies and their			be affected but none were.		
		ware, including all frames,			3 The Administrator/corpor		
	closing devices, and	<b>.</b>			Property Manager inserviced t		
		requirements of NFPA 80,			Maintenance Supervisor/desig		
		oors and Other Opening			on the requirement that annua		
	-	as otherwise specified in this			testing and inspections of the	fire	
		2.1 states fire door assemblies			door assemblies including the		
	shall be inspected an	nd tested not less than			doors to oxygen storage and		

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Event ID:

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	T OF REPUGENCE	•	(XA) > (X X ======	NOTE NAME OF THE OWNER	OMB NO. 0938-039		
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
		155409	B. WING		07/02/2024		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE			
WATERS	OF INDIANAPOLI	S, THE	INDIAN	IAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	annually, and a writ	tten record of the inspection		transfilling rooms must be			
	shall be signed and	kept for inspection by the		conducted to ensure proper			
		2.4.1 states fire door assemblies		operation and documented on	the		
	shall be visually ins	spected from both sides to		Annual Door Inspections log to	1		
	assess the overall co	ondition of door assembly.		meet set standards.			
				a Maintenance			
	NFPA 80, 5.2.4.2 st	tates as a minimum, the		Supervisor/designee will condu	uct		
	following items sha	ll be verified:		the annual inspection of fire do	or		
	(1) No open holes o	or breaks exist in surfaces of		assemblies including the doors			
	either the door or fr	ame.		oxygen storage and transfilling			
	(2) Glazing, vision	light frames, and glazing beads		rooms to ensure proper operat	ion		
	are intact and secur	ely fastened in place, if so		and document the inspection			
	equipped.			results on the Annual Door			
		, hinges, hardware, and		Inspection log as a part of the			
	noncombustible thre	eshold are secured, aligned,		facility's Preventive Maintenan	ce		
		er with no visible signs of		Program and document those			
	damage.	C		inspection results as appropria	te.		
	(4) No parts are mis	ssing or broken.		If any issues are discovered, the			
	-	do not exceed clearances		will be addressed and resolved	-		
	listed in 4.8.4 and 6			immediately. The Maintenance			
		device is operational; that is,		Supervisor/designee will review			
		pletely closes when operated		with the Administrator the			
	from the full open p			inspection results.			
		is installed, the inactive leaf		b The Administrator will			
	closes before the ac			monitor adherence to the			
	(8) Latching hardwa	are operates and secures the		Preventative Maintenance			
	door when it is in th	-		schedule and validate the			
		vare items that interfere or		Preventative Maintenance			
		re not installed on the door or		documentation is in place.			
	frame.			4 The inspection results wi	ıı İ		
	(10) No field modif	ications to the door assembly		be presented by the Maintenar			
	1 1	ed that void the label.		Supervisor/designee to the			
	_	edge seals, where required, are		Administrator monthly and the			
		their presence and integrity.		Administrator/designee will			
		ice could affect over 20		present the inspection results a	at		
	_	visitors in the vicinity of the		the monthly Quality			
	oxygen storage and			Assurance/Performance			
	Jan Storage und	<del>0</del> - > <del></del>		Improvement (QA/PI) meeting.			
	Findings include:			Inspection results and system			
	i manigo metade.			components will be reviewed b	av.		
	I		I	I combonente will be reviewed r	'Y		

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		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY  COMPLETED			
		155409	B. WING			07/02/2024		
NAME OF PROVIDER OR SUPPLIER  WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	REGULATORY OR  Based on review of Inspection" docume the Maintenance Di from 9:05 a.m. to 12 door inspections for doors to oxygen sto Based on interview Maintenance Direct and test doors to ox rooms and agreed dinspection and testin transfilling rooms with month period was non observations with during a tour of the p.m. on 07/02/24, the storage and transfill Dining Room was e resistance rating lab the door. The oxyger oom contained four nine 'E' type oxyger.	entation dated 11/21/23 with rector during record review 2:20 p.m. on 07/02/24, annual fire of the facility did not include rage and transfilling rooms. The time of the review, the or stated he did not inspect tygen storage and transfilling ocumentation of annual region of annual region of the oxygen storage and within the most recent twelve of available for review. Based the Maintenance Director facility from 12:50 p.m. to 2:30 recorridor door to the oxygen ring room across from the main quipped with a 90-minute fire real affixed to the hinge side of ren storage and transfilling reliquid oxygen containers and recylinders.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	n	(X5) COMPLETION DATE	

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