		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155196	B. W	ING		08/26/	/2016
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	•	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	State Licensure included a State Survey.  This visit include Complaint IN00 Complaint IN00 Unsubstantiated Survey dates: A 25, and 26, 2016 Facility number Provider number AIM number: 1 Census bed type SNF: 21 SNF/NF: 47 Residential: 46 Total: 114 Census payor ty Medicare: 21 Medicaid: 30 Other: 17 Total: 68	2205017 - due to lack of evidence.  August 18, 19, 22, 23, 24, 6.  : 000103 r: 155194 00290000 e:	F 00	000	This plan of correction is to serve Altenheim Family FirstSenior Living' credible allegation of compliance. Submission of this plan ofcorrection does not constitute an admission by Altenheim Family First SeniorLiving or its management company that the allegations contained in the surveyreport are a true and accurate portrayal of the provision of nursing care andother services in this facility. Nor does this submission constitute an agreementor admission of the survey allegations. We would like to respectfully requestpaper compliance for Altenheim Family. First Senior Living's Recertification and State Licensure Survey and Residential Licensure Survey.	e	
	i nese deficienc	ies reflect State findings					

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

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155196	B. WI	NG		08/26/	2016
	ROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID PROVIDER'S		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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	16.2-3.1.	by 14466 on September					
F 0246 SS=D Bldg. 00	NEEDS/PREFERIA resident has the services in the fact accommodations of preferences, exces afety of the indivision would be endanged. Based on record interview, the fact resident was awallocation to ensur resident needed that assistance. (Resident #10's clareviewed on 8/24 Diagnoses include to, contracture of contracture is still joints that restrict On 8/19/16 at 1:10	right to reside and receive illity with reasonable of individual needs and pt when the health or dual or other residents ared.  review, observation, and cility failed to ensure a are of the call light cord e it was available if the co contact staff for ident #10).  :  tinical record was 4/16 at 1:00 p.m. led, but were not limited	F 02	246	Altenheim Family First Senior Livingwould like to respectfully request a face-to-face Informa Dispute Resolution of F246. Thebasis of the findings was ir reference to resident #10 being unable to reachher call light ar was unaware of the call light location on three occurrences.During each of the three occurrences resident wa lying in bed and call lightwas clipped to resident's pillow and within resident's reach. Altenhe FamilyFirst Senior Living's Accommodation of Needs Poli states "Staff shall arrangetoiletries and personal items so that they are in easy reach of the resident". The facil did follow the policy and ensur	l g g nd e s s e im	09/16/2016

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Event ID:

M31611 Facility ID: 000103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155196	B. W	ING		08/26/2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			HANNA AVE	
	EIM HEALTH & LI\	/ING COMMUNITY			IAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		sed halfway. Resident			withinreach. Resident #10 ha	
	#10 indicated sh	ne was unable to open the			BIMS of 11 out of 15. Altenhe	
	3 fingers outwar	rd all the way.			Family First SeniorLiving wou	
	[	,			like to respectfully request the F246 be removed from the 23	
	The Opertoric N	Ainimum Data Sat (MDS)			1. What corrective Actions	
	· · · · ·	Minimum Data Set (MDS)			be accomplished for those	WIII
	Assessment dated 7/29/16, assessed				residents found to have bee	an
	Resident #10 as	scoring a 11 out of 15 on			affected bythe deficient	711
	the Brief Intervi	ew for Mental Status			practice? Call light is placed	
	(BIMs) assessm	ent (11 out of 15,			within resident #10's reach a	nd
	indicated moder	,			view while resident is in room	
		ate cognitive			How will other residents ha	
	impairment).				the potential to be affected	_
					the same deficient practice	-
	On 8/19/16 at 9:	:56 a.m., Resident #10			identified and what correcti	
	was observed ly	ring in bed. The call light			action will be taken? All	
	1	to the left side of the			residents residing in the Skille	ed
	_	sked to demonstrate use			Nursing Facility have the pote	
					to be affected by thealleged	
		Resident #10 responded,			deficient practice. Director of	
	"I can't reach it.	••			Nursing/Designee will do a	
					random audit of 10 rooms da	-
	On 8/23/16 at 3	:00 p.m., Resident #10			ensure resident call light was	sin
	was observed ly	ring in bed. The call light			resident view and resident	
		he bottom left corner of			isaware of location. 3. What	
		When asked where the			measures will be put into pl	
					or what systematic changes	<b>'</b>
	"	cated, Resident #10			will be made to ensure that thedeficient practice does n	not
	ındıcated, " I do	n't know where it is."			occur? Director of	iot
					Nursing/Designee will do ran-	dom
	On 8/24/16 at 1	0:46 a.m., Resident #10			audit of 10 rooms daily to ens	
	was observed ly	ring in bed. The call light			resident call lights are in	
		he top right corner of the			resident's view and resident's	s are
					aware of location. Facility sta	ff will
	1 ^	hen asked to turn the call			be educated by Director of	
		nt #10 indicated, "I don't			Nursing/Designee by Septem	
	know where it is	s."			16, 2016 on ensuring resider	
					call lights are within resident	
	During an interv	view on 8/24/16 at 11:58			and residents are aware of ca	all

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED					
		155196	B. WI	NG		08/26/	2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	indicated Reside how to use the calcindicated that du hand contracture pinned to the froor blanket."  On 8/24/26 at 1:: Nursing (DON) in October, 2009 Accommodation it was the policy facility. The pol shall arrange toil	ractical Nurse (LPN) #3 nt #10 cognitively knows all light. LPN #3 e to Resident #10's left , the call light is usually nt of Resident #10's shirt  80 p.m., the Director of provided a policy revised , titled "Quality of Life - of Needs" and indicated currently used by the icy indicated, "Staff etries and personal items in easy reach of the			light location. 4. How will the corrective actions be monitored to ensure the deficient practice will not rec and what quality assurance program. Daily Call Light aud will be completed weekly X 4,monthly x 2, the quarterly the after until compliance is 100%. The results of these audits will reviewed by the Quality Assurance Committee weekly until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	ur, its ere be		
F 0250 SS=D Bldg. 00	SOCIAL SERVICE The facility must p social services to a highest practicable psychosocial well- Based on observ interview, the fac Social Service for resident's need for	IEDICALLY RELATED  rovide medically-related attain or maintain the ephysical, mental, and being of each resident. action, record review, and cility failed to ensure ollowed through on a per dentures for 1 of 2 ed for dental services.	F 02	250	1. What correctiveActions will be accomplished for those residents found to have been affected bythe deficient practice? Resident #76 receiv dentures on 7/12/16. 2. How wotherresidents having the potential to be affected by the	ed vill	09/16/2016	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	NG		08/26/	2016
				GED DEET A	DDDEGG CUTY GTATE JUD GODE		
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	Findings include	· ·			same deficient practice		
					byidentified and what		
	The clinical reco	ord of Resident #76 was			corrective action will be take	n?	
					All residentsresiding in the Ski	lled	
	reviewed on 8/23/16 at 10:24 a.m.				Nursing Facility requesting		
	Diagnoses for th	e resident included, but			dentures have the potentialto		
	were not limited	to, dysphagia (difficulty			affected by the alleged deficien	nt	
	swallowing).				practice. Social Services Director/Designee will do a ho	1100	
	J				wide audit of resident's record		
	A care plan crea	ted 7/15/15, and deemed			ensure timely follow up for der		
	_	irector of Nursing			needs by September 16, 2016		
	1	· ·			What measures will be put in		
	, , , , , , , , , , , , , , , , , , ,	d Resident #76 had			place or what systematic		
	consented to rec	eive dental services from			changes will be made to		
	the facility denta	al provider. The goal			ensure that the deficient		
	was, "Resident v	vill have ancillary			practice does not occur? Soo	cial	
	services needs m	net." Approaches			Services Director/Designee wi	II	
		l to consult as needed."			do a house wideaudit of		
	-				resident's records to ensure		
		onsible were Nursing and			timely follow up for dental need		
	Social Services.				bySeptember 16, 2016. Social		
					Services staff will be educated	-	
	Review of a den	tal exam summary, dated			the SocialServices Consultant	•	
	11/2/15, indicate	ed Resident #76 did not			September 16, 2016 on timely follow up to resident's dental		
	have any teeth y	would like dentures, and			needs.		
	1	dentures would be taken			IDT will review all Dental Servi	ices	
		dentures would be taken			recommendations for each		
	at the next visit.				resident on the next business	day	
					to ensure timely follow up is	,	
	A dental exam s	ummary dated 12/23/15			completed for resident's denta	I	
	indicated, "Toot	h Notespt [patient] seen			needs		
	11-2-15Impres	ssions after [payor			Social Services		
	source] approval				Director/Designee will		
	approvui				complete Dental Services CQI		
	A 14.1	1.1.1.6/0/16			Audit to verify timely follow up on residents' dental needs		
	A dental exam summary, dated 6/2/16,				weekly x 4, monthly x 2, and		
		ssions for dentures were			quarterly thereafter		
	taken on that day	y.			4. How will thecorrective		
					actions be monitored to ensu	ıre	

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` ´			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155196	B. WI	ING		08/26/	2016
ALTENHEIM		ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
A dir R A dir	A Denture Delivindicated the dental care dental provider, a Director of Nursion, indicated, be denture case a denture case a denture case and the scheduling mpressions were converted and the scheduling mpressions were converted and abricated June 2 duly 12, 2016"  An undated communicated June 2 duly 12, 2016"  An undated communicated, "During Administrator of a denture determined [Resignal down of denture deceive a denture case of denture denture denture of dental provider and lower denture deceive a denture denture of dental provider and lower denture deceive a denture denture of dental provider and lower denture denture denture of dental provider and lower denture denture denture of dental provider and lower denture denture of dental	ery Form, dated 7/12/16, attures were delivered to munication from the received from the ing on 8/23/16 at 2:00 l'On November 2, 2015 started for [Resident ras submitted to [payor mber 3 2015 and the on was approved on 15. The case manager sible for this case did not g team know that e needed to move fabrication process; that til May 5 2016. The e received into our lab on the dentures were 27 2016 and delivered on munication from the received from the Acting a 8/23/16 at 2:15, and an examination on thist, [name of dentist] ident #76] has a need for, it from complete upper res. The resident didn't e delivery until 7/12/16. provider] takes full ne length of time took to		IAG	the deficient practice will notrecur, and what quality assurance program. Social Services Director/Designee wi complete Dental Services CQI Audit to verify timely follow up residents' dental needs weekly 4, monthly x 2, and quarterly thereafter The results of these audits will be reviewed weekly 4,monthly x 2, then quarterly thereafter by the Quality Assurance Committee untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is bel 100%.	on / x x	DATE

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155196	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2016
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	fabricate dentures for the resident. Poor communication between our Utilization and Scheduling departments resulted in the resident not being scheduled for impressions until May 2016. This is why the resident case took seven months to complete"  On 8/26/16, the DON indicated Social Services should have been tracking Resident #76's need for dentures as determined on 11/2/15, and followed up on the progress toward obtaining the dentures so that he would have received them prior to July 12, 2016 (8 months after initial determination of his need for dentures).  3.1-34(a)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155196	B. WING			08/26/	2016
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	appropriate participrofessionals.  A registered nurse the assessment is Each individual with the assessment maccuracy of that pure Under Medicare a who willfully and k material and false assessment is subpenalty of not more assessment; or are and knowingly carectify a material are sident assessment.  Clinical disagreem material and false Based on record the facility failed Data Set (MDS) accurately for a weight loss (Respectiving an anticomment (Resident #14).  Findings included 1. The clinical residents are sident assessment.	assessment with the lipation of health  e must sign and certify that a completed.  The completes a portion of must sign and certify the lortion of the assessment.  Ind Medicaid, an individual convenience of the season of the estatement in a resident object to a civil money re than \$1,000 for each individual who willfully uses another individual to land false statement in a lent is subject to a civil not more than \$5,000 for lent does not constitute a lestatement.  The entity of the ensure Minimum and the ensure Minimum and the ensure Minimum are coded to the ensure Minimum and the ensure medication is and a resident in a lent is and a resident with significant and a resident medication in the ensure medication i	F 02	278	What correctiveactions will be accomplished for those residents found to have been affected by the deficient practice? Resident #46 and Resident #17 had a corrected MDS submitted during the sumprocess.  How will other residentshaving the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to	vey ing y ee	09/16/2016
			1		affected by the same alleged		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		08/26/	2016
				CTD DET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	8					
A1 TENII		UNIO COMMANIATIV			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Diagnoses for th	e resident included, but			deficient practice. All Current		
	were not limited to, gastroesophageal				residents will have their most		
		nd congestive heart			recent MDS reviewed for		
	failure.	ia congestive near			accuracy of weight loss and	D0	
	lanure.				anticoagulant coding by the M	סט	
					Personnel by September 16, 2016. What measures will be		
	A recapitulated physician order for				put into place or what systen		
	August, 2016, w	ith an original order date			changes will be made to		
	of 1/5/16, indica	ted Resident #146 was to			ensure that the deficient		
	receive a regular	diet with no added salt,			practice does not recur?		
	_	No order for a weight			Education will be provided to		
	_	s found in the resident's			MDS Personnel regarding corr	rect	
		s found in the resident's			coding of the MDS for weight I		
	record.				and anticoagulant coding by M	1DS	
					Consultant/Designee by		
	A review of Res	ident #46's weights			September 16, 2016. MDS		
	indicated:				Coordinator/Designee will aud		
					accuracy of anticoagulant cod	ing	
	2/3/16 weight =	223 lbs (pounds)			and weight loss coding daily	4la a	
	2/3/10 Weight =	223 los (pounds)			Monday through Friday, using		
	-,-,-				MDS accuracy audit tool on th assessment prior to any MDS	ا ا	
		204 lbs This was a			being submitted. How will the		
	significant weigl	ht loss in 3 months of			corrective actions be		
	8.5%.				monitored to ensure the		
					deficient practice will not rec	ur l	
	An Interdisciplir	nary Team (IDT) note			and what quality assurance		
	•	idicated Resident #46's			program will be put into plac	e?	
	· ·				Daily MDS accuracy audits for		
	current weight w				anticoagulant coding and weig	ıht	
	documentation to	o indicate the resident			loss coding will be completed		
	was on a weight	loss regimen.			weekly x 4, monthly x 2, and the		
					quarterly thereafter until 100%		
	An IDT note dat	ed 5/25/16 indicated the			compliance is met. The results		
					these audits will be reviewed by	•	
	resident's current weight was 200.6 lbs.				the Quality Assurance Commit weekly x 4, monthly times 2, a		
	This was a significant weight loss of 10%				quarterly thereafter until	iiu	
	in 3-4 months. No documentation to				compliance is at 100%.		
	indicate the resid	dent was on a weight loss			Frequency and duration of		
	regimen.				reviews will be increased as		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	OO	(X3) DATE COMPL		
ANDILAN	or connection	155196	B. W		00	08/26/	
		100100			DDDDGG GYMY GM MD GYD GODD	00/20/	2010
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
PREFIX TAG	A quarterly Min assessment, date back period betw was coded "0" w #46 had not lost month, or 10% On 8/22/16 at 4: Nursing indicate Dietician had co the 6/15/16, MD incorrectly at a 1 physician-preser regimen. The cobeen 2, "Yes, no prescribed weigh The 6/15/16 MI #6 verifying acc verifying assessing 2. The clinical resident #14 was at 11:01 a.m. Dower not limited abnormal heartb	imum Data Set(MDS) ad 6/15/16, with a look eveen 6/9/16 and 6/15/16, which indicated Resident "5% or more in the last in the last 6 months."  26 p.m., the Director of ad the Registered ded the K0300 section of as on Weight Loss I, Yes on ribed weight loss orrect coding should have at on a physician int-loss regimen."  DS was signed by LPN uracy, and RN #7 ment completion.  Peccord review for as completed on 8/22/16 aiagnoses included, but to, atrial fibrillation (an eat).  S assessment Section ted on 3/19/16, assessed		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
	anticoagulant me	edication.					
	A review of the	Medication					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		155196	B. W	ING		08/26	/2016
NAME OF F	PROVIDER OR SUPPLIEF	?	-		ADDRESS, CITY, STATE, ZIP CODE		
AI TENH	FIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	0210, 114 10201		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Administration 1	Record (MAR) dated					
	3/13/16 through	3/19/16, for Resident					
	#14 for 7 days p	rior to the Annual MDS					
	assessment, indicated Resident #14						
	received warfari	n (an anticoagulant					
	medication) dail	y from 3/13/16 through					
	3/19/16.						
		view on 8/24/16 at 10:59					
	·	Coordinator indicated the					
		ted 3/19/16 for Resident					
		ncorrectly. The MDS					
		•					
	7 days during th	e assessment period.					
	The 3/19/16, An	nual MDS assessment					
	was signed by L	PN #4 verifying					
	accuracy, and R	N #5 verifying					
	assessment com	pletion.					
	Th. D. 11 / A	and the state of t					
	*	*					
	· · · · · · · · · · · · · · · · · · ·	0 \					
		•					
	_	-					
		-					
	100k-back period	J					
	3.1-31(d)						
	Coordinator indishould have indireceived an antic 7 days during the The 3/19/16, An was signed by L accuracy, and R assessment company The Resident As Comprehensive 3.0, copy right 2 "N0410E, An Record the number anticoagulant metals assessment company in the second secon	icated Section N0410E icated that Resident #14 coagulant medication for e assessment period.  mual MDS assessment PN #4 verifying N #5 verifying pletion.  ssessment Instrument User Manual, Version 2009, page 477 indicated, aticoagulant (warfarin): ber of days an edication was received by my time during the 7-day					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/26/2016				ETED		
	PROVIDER OR SUPPLIEI	R VING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F 0279 SS=D Bldg. 00	PLANS A facility must use assessment to de the resident's con The facility must of care plan for each measurable object meet a resident's mental and psychidentified in the control of the care plan must that are to be furned the resident's high mental, and psychiat would otherw §483.25 but are not resident's exercise including the right §483.10(b)(4). Based on intervity facility failed to resident assessed incontinence for reviewed for uring (Resident #111)  Findings included 08/22/2016 2:44 review, indicated included but not weakness, difficity failed to resident #111)	e the results of the velop, review and revise aprehensive plan of care.  develop a comprehensive a resident that includes stives and timetables to medical, nursing, and osocial needs that are comprehensive assessment.  st describe the services stished to attain or maintain nest practicable physical, mosocial well-being as 83.25; and any services itse be required under ot provided due to the e of rights under §483.10, at to refuse treatment under the wand record review the develop a Care Plan for a divith urinary 1 of 3 residents mary incontinence.	F 027	79	F279 – DevelopComprehensive Care Plan What corrective actionswill be accomplished for those resident found to have been affected by thedeficient practice? Resident #111 MDS record was reviewed and urinaryincontinence care plan was initiated during the survey process. How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action will be taken. All residents have the potential to be affected by the same alleged deficient practice.	2	09/16/2016	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	r í	JILDING	DNSTRUCTION  00	(X3) DATE COMPL <b>08/26</b> /	ETED
	ROVIDER OR SUPPLIER		•	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	STIMMARY S	FATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		CY 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
	chronic obstructi	ve pulmonary disease.			All Current residents will have their		
	Medications incl	uded, but not limited to			mostrecent MDS reviewed for		
	metroprolol tartr	ate.			accuracy of urinary incontinence an	d	
	-				care planinitiated as indicated.		
	Point Of Care Hi	istory indicated			What measures will beput into		
	incontinent episo				place or what systemic changes will be made to ensure that	II.	
	•				thedeficient practice does not		
	8/20/2016 at 12:				recur? Education will be provided to		
	8/17/2016 at 9:39				MDSpersonnel regarding	,	
	7/27/2016 at 10:	10 a.m.,			comprehensive care plan needed for	nr	
	7/26/2016 at 3:29	9 p.m.,			urinary incontinence bythe MDS	·•	
	7/19/2016 at 3:39	9 p.m.,			Consultant/Designee by September		
	7/16/16 at 2:01	a.m. and 9:34 a.m.,			16, 2016.		
	7/9/2016 at 1:33	· · · · · · · · · · · · · · · · · · ·			MDS coordinator/designee will aud	it	
	7/5/2016 at 10:14	•			accuracy of urinaryincontinence car		
		-			plan initiation with comprehensive		
	7/3/2016 at 12:04	*			assessments with the MDS		
	6/21/2016 at 2:4				accuracyaudit tool by September 16	5,	
	5/24/16 at 1:16 a	· · · · · · · · · · · · · · · · · · ·			2016.		
	5/15/2016 at 2:2'	7 p.m.			How will the correctiveactions will		
					be monitored to ensure the		
	Resident #111's	clinical record lacked			deficient practice will not recur and		
	documentation o	f a care plan to address			whatquality assurance program wi	II	
	incontinence.	1			be put into place?		
					Daily MDS accuracy audits for		
	8/22/2016 at 2:00	0 p.m., Director Of			urinary incontinence and initiatinga		
					comprehensive urinary incontinenc		
	_	d she would look for			care plan will be completed weekly 4,monthly x 2, and then quarterly	^	
	•	ontinence for Resident			thereafter, until 100% compliance is	5	
	#111.				met.	•	
					The results of these audits will be		
	8/23/2016 at 10:	30 a.m., Director Of			reviewed by the QualityAssurance		
	Nursing indicate	d she continues to look			Committee weekly x 4, monthly		
	for care plan for				times 2, and quarterly thereafter		
	Resident #111.				untilcompliance is at 100%.		
	resident // 111.				Frequency and duration of reviews		
	0/04/0016 + 0.1	O a ma Dimantan OC			will be increased asneeded, if		
	8/24/2016 at 9:10	0 a.m., Director Of			compliance is below 100%.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/26/2016	
	ROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	care plan for inco #111. 8/24/2016 at 11:: Nursing indicate	d she is going to look for continence for Resident  30 a.m., Director Of d an incontinence care eloped and one would be			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, F BLADDER Based on the resident sessessment, the faresident who enterindwelling cathete the resident's clinic that catheterization resident who is increceives appropriate to prevent urinary restore as much in possible. Based on observent interview, the facturinary catheter were maintained urinary tract infectobserved for care	dent's comprehensive acility must ensure that a rest the facility without an rest is not catheterized unless cal condition demonstrates in was necessary; and a continent of bladder attended the treatment and services tract infections and to formal bladder function as action, record review, and callity failed to ensure drainage bags and tubing in a manner to prevent attended to the formal bladder function for 2 of 2 residents are of urinary catheter definitions. (Residents #38)	F 0315	1. What correctiveActions wibe accomplished for those residents found to have beer affected bythe deficient practice? Resident #38's Catheter Tubing is not touchin the floor. Resident #155's Catheter Tubing is positioned allow free flow. 2. How will otherresidents having the potential to be affected by the same deficient practice byidentified and what	g to

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ΈD
		155196	B. WI	ING		08/26/20	016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			HANNA AVE		
AI TENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
	1				T		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	0	DATE
		's clinical record was			corrective action will be take All residents residing in the	en?	
	reviewed on 8/2	4/16 at 1:30 p.m.			Skilled Nursing Facility with a		
	Diagnoses inclu-	ded, but were not limited			catheterhave the potential to b	ne l	
	to, obstructive u	ropathy (condition when			affected by this alleged deficie		
	urine flow is blo	cked).			practice. Director of		
		,			Nursing/Designee will review		
	A recanitulated	physician's order for			residents with cathetersto ens		
		rith an original order date			their tubing is not touching the	;	
		eated Resident #38 had a			floor by September 16, 2016.  Director Nursing/Designee wil	.	
	· · · · · · · · · · · · · · · · · · ·				review all residents with cathe		
		eter (a tube which drains			toensure tubing is positioned	II	
	urine from the b	ladder).			allow free flow by September		
					2016. 3. What measures wil	llbe	
	A care plan date	d 9/28/15 and current			put into place or what		
	through Septemb	per, 2016, indicated a			systematic changes will be		
	problem of, "Re	sident has a suprapubic			made to ensure that		
	urinary catheter.	• •			thedeficient practice does no	ot	
	1	ot allow tubing or any			occur? Director of		
	· ·	age system to touch the			Nursing/Designee will review residents with catheters each	chift	
	floor."	age system to toden the			daily to ensure their tubing is	II	
	11001.				touching the floor Director		
	0.00046	7 11 1/00			Nursing/Designee will review	all	
		0:43 a.m., Resident #38			resident with catheters each s	hift	
		ting in a wheelchair in			daily to ensure tubing is		
	the hallway, with	h catheter tubing resting			positioned to allow free flow	by	
	on the floor.				Nursing staff will be educated the Director ofNursing/Design	-	
					by September 16, 2016 on		
	On 8/22/16 at 5:	13 p.m., Resident #38			ensuring tubing does not touc	h	
		ting in a wheelchair in			thefloor and that it is positione		
		with catheter tubing and			allow free flow.		
		ting on the floor.			4. How will thecorrective		
	uramage dag ies	mg on me noor.			actions be monitored to ens	ure	
	0.0/00/14 6 10	15 0 .: 6 1			the deficient practice will		
		15 p.m., Certified			notrecur, and what quality	_	
	_	nt (CNA) #8 was			assurance program. Cathete Tubing Audit will completed by		
	observed to help	Resident #38 transfer			Director of	<sup>y</sup>	
	from the wheelc	hair to bed. During the			NursingServices/Designee		

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2016
	PROVIDER OR SUPPLIER IEIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	transfer, CNA #8 placed the catheter bag on the floor and pulled it across the floor under the wheelchair and laid it on the floor, before hanging it on the side of the bed.  On 8/24/16 at 2:52 p.m., the Director of Nursing (DON), indicated catheter tubing and drainage bags should not touch the floor.  2. The clinical record review for Resident #155 was completed on 8/22/16 at 3:18 p.m. Diagnoses included, but were not limited to, pressure area of sacral region (area near bottom of spine and palliative care (care to improve quality of life).	IAG	weekly x 4, monthly x 2, and quarterly thereafter untilcompliance is at 100%. The results of these audits wireviewed by the QualityAssura Committee weekly x 4, month times 2, and quarterly thereaft untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is be 100%.	II be ance ly ter
	A recapitulated physician's order for August, 2016, with an original start date of 8/19/16, indicated Resident #155 had an indwelling urinary catheter.			
	On 8/22/16 at 10:35 a.m., Resident #155 was observed lying in bed with the catheter drainage tubing positioned in an upward looped position to prevent free flow of urine through the tube toward the drainage bag.			
	On 8/23/16 at 9:30 a.m., Resident #155 was observed lying on their right side, with the catheter drainage tube resting			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL	
		155196	B. W	ING		08/26/	/2016
	PROVIDER OR SUPPLIEF		<u> </u>	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237	<b>!</b>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  4155's right leg, leaving a		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	red indentation.	17 p.m., Resident #155					
	was observed ly with catheter tub upward looped p	ing on their right side, bing positioned in an position to prevent free ough the tube toward the					
	was observed ly with catheter tub upward looped p	34 a.m., Resident #155 ing on their right side, bing positioned in an position to prevent free ough the tube toward the					
	indicated cathete under Resident # should hang dow	52 p.m., the DON er tubing should not be 4155's leg, and the tubing on to the drainage bag a looped position.					
	provided a policy 2015, titled, "En Drainage Bag" a policy currently policy indicated, bag and tubing correvent contamination. The policy lacket	30 p.m., the DON y revised in September, nptying a Urinary nd indicated it was the used by the facility. The "Keep the drainage off the floor at all times to nation and damage" d information on image tubing to allow for					
<u> </u>	free flow of urin	e from the bladder to 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. BUILDING 00 COMPLETED 155196 B. WING 08/26/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ DATE drainage bag. 3.1-41(a)(2)F 0323 483.25(h) FREE OF ACCIDENT SS=D HAZARDS/SUPERVISION/DEVICES Bldg. 00 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. F 0323 1. What correctiveActions will be 09/16/2016 accomplished for those residents Based on observation, interview, and found to have been affected bythe record review, the facility failed to ensure deficient practice? hazardous chemicals were locked in The cabinet lock in the shower room patient areas as indicated by facility on A Hall has been replaced and policy for 15 of 22 residents in 1 of 1 islocked. shower rooms observed. 2. How will otherresidents having the potential to be affected by the Findings include: same deficient practice byidentified and what corrective action will be On 8/22/2016 at 10:30 a.m., During initial tour on Hall (A), observed an All residents residing inthe Skilled unlocked shower room with cabinet (with Nursing Facility have the potential to be affected. lock) on wall. The door on the cabinet was easily opened. The cabinet Administrator/Designee will educate contained a 1 gallon container of Turbo Maintenance Director Clean. The label on Turbo Clean andMaintenance Assistant on indicated, wear gloves, if ingested call ensuring the shower rooms are free MD (Medical Director), drink plenty of of accident hazards. water and induce vomiting if necessary, a Nursing Facility Staff will be 1/2 gallon container of CID-A-LII educated by the Director Disinfectant Cleaner with label that ofNursing/Designee by September

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155196	B. W	ING		08/26/	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			HANNA AVE		
ΔΙ ΤΕΝΙΗ	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	-	rsible eye damage and			16, 2016 on ensuring the cabinets in	n	
	skin burns, harm	iful if swallowed, and			the showerrooms are properly		
	one 7.5 ounce C	lean and Free Body			locked and that if the locks are not		
	Wash with a lab	el that indicated may			in tact to notify theMaintenance		
	cause eye damaş	•			Director/Designee.		
		<del>,</del>			3. What measures willbe put into place or what systematic changes		
	On 9/22/2015 at	10:45 a m. During			will be made to ensure that		
		10:45 a.m., During			thedeficient practice does not		
	interview with the				occur?		
	`	AA) indicated, the AA			Maintenance Director/Designee wil	,	
	indicated the cal	pinet should have been			audit cabinets in shower roomsdail		
	locked.				to ensure they are properly locked	<b>'</b>	
					and intact.		
	On 8/24/2016 at	9:55 a.m., The Director					
		rided the policy, Physical			Administrator/Designee will educat	е	
		2011, and indicated the			Maintenance Director		
	· ·				andMaintenance Assistant by		
	1 ~ -	ent. A review of the			September 16, 2016 on ensuring th	e	
	1 *	, "Basic Safety Rules:			shower rooms arefree of accident		
	_	asic safety rules and tips			hazards.		
	highlight many a	areas of safety practices.					
	Some of the rule	es may apply to your job			Nursing Facility Staff will be		
	duties and some	may not, but you need to			educated by the Director		
		at you can recognize an			ofNursing/Designee by September		
		and report it. These are			16, 2016 on cabinets in the shower	if	
		vill be followed up with			rooms areproperly locked and that the locks are not in tact to notify th		
		in this chapterNever			MaintenanceDirector/Designee.		
		-			4. How will thecorrective actions b	e	
	_	nical unattended or			monitored to ensure the deficient		
	unlocked in patie	ent areas."			practice will notrecur, and what		
					quality assurance program.		
	On 8/24/2016 at	11:15 a.m., Director Of			Locked Cabinet/Hazardous Chemica	al	
	Nursing provide	d Census Detail by Level			Audit will be completedby the		
	of Care dated 8/2	24/2016. The census			Maintenance Director/Designee		
		t of 22 residents, on Hall			weekly x 4, monthly x 2, and		
	(A) self ambulat	*			quarterlythereafter until complianc	e	
	(A) sen annoulat	C.			is at 100%		
					The results of these audits will be		

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	OF CORRECTION  IDENTIFICATION NUMBER:  155196	A. BUILDING B. WING	00	COMPLETED 08/26/2016
	PROVIDER OR SUPPLIER HEIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(1)		reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			
	In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			
	The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976			

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CTATEMENT OF DEFICIENCIES AND PROVIDED (SUBDILIED OF LA			_		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155196	B. WING		08/26/2016	
NAME OF F	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	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		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	when the facility u drug distribution s quantity stored is dose can be readi					
		ration, interview, and	F 0431	What correctiveactions will be	09/16/2016	
		ne facility failed to ensure		accomplished for those residents		
	a vial of tubercu	lin (a method used to		found to have been affected bythe		
	diagnose silent [	latent] tuberculosis [TB]		deficient practice? The undated open vialof Tuberculin		
	infection), was d	lated when opened as		was discarded.		
	indicated by faci	ility policy in 1 of 1		How will other residentshaving the		
	medication stora	ige areas observed.		potential to be affected by the		
	Findings Include			same deficient practice be identifiedand what corrective action will be taken?  All residents have the potential to b	e	
	On 8/24/16 at 9:	10 a.m., during		affected by thealleged deficient		
		age task, observed an		practice. Medications stored in		
	opened vial of tu			medication room refrigeratorswill b	e	
	^	ge unit refrigerator		audited to ensure multi dose vials		
		tment medication storage		were dated with date opened		
		currently being used for		bySeptember 16, 2016 by		
	· · · · · · · · · · · · · · · · · · ·	ot dated when opened.		DON/Designee		
		or action opened.		What measures will beput into place or what systemic changes wil		
	On 8/24/16 at 9:	20 a m During		be made to ensure that	'	
		Associate Director (AD),		thedeficient practice does not		
		` ''		recur?		
		(tuberculin vial) should		Licensed Nursing staff will be		
	nave been labele	ed with an opened date.		educated on dating multi dosevials		
	00/04/0016	0.42 Th. D'		upon opening by SDC/Designee by		
		9:43 a.m., The Director		September 16, 2016.		
	• •	ided a policy, Drug		The Multi Dose Medication Date		
		d), and indicated it was		Opened Audit will becompleted daily by the DON/Designee.		
		y being used by facility.		How the correctiveactions will be		
	"Drug Storage p	olicy indicated,7.		monitored to ensure the deficient		
	Insulin and PPD	(tuberculin) vaccine and		practice will not recur and		
	other multi-dose	vials requiring		whatquality assurance program wil	ı İ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/26/2016	
	PROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE JAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
	_	d to be dated when s should be discarded f the open date."		be put into place? The Multi Dose Medication Date Opened Audit will becompleted weekly x 4, monthly x 2, and quarterly thereafter until compliance is100%. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 0465 SS=E Bldg. 00	TABLE ENVIRON The facility must p sanitary, and com residents, staff an Based on observ facility failed to and comfortable residents, in that have live ants an environment.  Findings include  1. On 8/19/16 a a.m., in resident #37 requested th drawer of her nig drawer was open	fortable environment for d the public. ation and interview, the ensure a safe, sanitary, environment for the facility was found an unkept	F 0465	What correctiveactions will be accomplished for those resident found to have been affected bythe deficient practice? Resident #37room was deep cleaned. Resident #37'slight fixture was cleaned. Dining room on the Long Term Care Unit was deepcleaned, including windowsills. Room#1071's bathroom floor was repaired. Room#1088's bathroom floor was repaired. Room # 1092's ceiling was cleaned, lightfixture was cleaned, and floor was repaired. Eco Lab completed treatment	

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in, out, and around the things in the top

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196  B. WING  OO  OR/26/2016  STREET ADDRESS, CITY, STATE, ZIP CODE	
155196 B. WING 08/26/2016  STREET ADDRESS. CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
3525 E HANNA AVE	
ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING ACTION SHOULD BE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  DATE	JΝ
THE RESIDENT OF ESCHELLING THE ORIGINATION)	
drawer of the resident's nightstand.  Resident #37 indicated she had  forpests on the Long Term Care Unit, including resident rooms and dining	
Resident #37 indicated site had	
mentioned the ants to staff several times	
starting roughly four days prior, to the potential to be affected by the	
current observation.  same deficient practice will be	
identified and what corrective	
It was also observed that there were action will be taken.	
stains above the resident's bed.  All residents residing on theLong	
Something was splattered on the ceiling.  Term Care Unit have the potential to	
be affected by the same	
allegeddeficient practice. Resident	
There were also dead bugs in the light rooms onLong Term Care Unit were	
fixture cover located inside the resident's audited by	
room near the door to enter and exit the Maintenance/Housekeeping/Design	
room. ee for floorrepairs needed and	
cleanliness of room and light	
2. On 8/19/16 at approximately 11:00 fixtures.	
one the diameter access was absorbed as	
dinning room was also utilized as an wascleaned including window sills and Eco Lab completed treatment	
where or what systemic shapers will	
up for residents to assemble puzzles. The	
table had small black insects crawling on thedeficient practice does not	
it. The windows along the left side of the recur?	
room had soiled windowsills. The Education will be completed	
windowsills were covered with dirt, dust, withhousekeeping staff on proper	
debris, and dead insects.	
resident diningroom.	
3. On 8/24/16 at 11:00 a.m., during	
Staff will be educated difficultioning	
, and repairing nothing 27 depletions	
was observed. Resident's bathroom had  16, 2016.	
eight (8) small holes in the floor in front  Administrator/Designee will	
of toilet. Holes were approximate a half complete 10 random room auditsweekly on Long Term Care	
inch in diameter and were discolored and Unit for cleanliness of rooms, light	
black. They also appeared to be filled  fixtures, diningrooms, and repairs	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155196 B. WING 08/26/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3525 E HANNA AVE ALTENHEIM HEALTH & LIVING COMMUNITY INDIANAPOLIS, IN 46237 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ with an unknown black substance. How the correctiveactions will be monitored to ensure the deficient 4. On 8/24/16 at 11:00 a.m., during practice will not recur, what quality environmental tour, resident room #1088 assurance program will be put into was observed. The floor cove had about a four inch section missing from the outer The Environmental/Resident Room left side of the bathroom door. There was Audit will be completed byAdministrator/designee weekly x a noticeable discoloration where the 4, monthly x 2, and quarterly piece was missing. thereafter until 100% compliance is met 5. On 8/24/16 at 11:00 a.m., during The results of these audits will be environmental tour, resident room #1092 reviewed by the QualityAssurance was observed. There was a discolored Committee weekly x 4, monthly times 2, and quarterly thereafter splatter stain in the ceiling. There were untilcompliance is at 100%. dead insects in the light fixture cover Frequency and duration of reviews located inside the resident's room near the will be increased asneeded, if door to enter and exit the room. There compliance is below 100%. was also section of floor cove missing on the left side of the room. 3.1-19(f)F 0469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL SS=E **PROGRAM** Bldg. 00 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. F 0469 09/16/2016 What correctiveactions will be accomplished for those resident Based on observation and interview, the found to have been affected bythe facility failed to maintain an effective deficient practice? pest control program for 47 of 47 Resident #37'sroom was deep residents who resided on the A/B wing. cleaned. Dining room on theLong Term Care Unit was deep cleaned,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		155196	B. W	ING		08/26/	2016
		1	1	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			HANNA AVE		
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	, 	1	(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	Findings include		1	1110	including window sills.		Bille
	Tilldings illerade				Eco lab treated dining room on the		
	1 0 00/10/201	12			Long TermCare Unit and resident		
		16 at approximately			#37's previous room.		
	-	sident room #1092,			How other residentshaving the		
	Resident #37 rec	quested that the surveyor			potential to be affected by the		
	open the top dra	wer of her nightstand.			same deficient practice will be		
	When the top dra	awer was opened it was			identifiedand what corrective		
	•	was an abundance of ants			action will be taken. All residents		
		and around the things in			residing on theLong Term Care Unit		
	the top drawer o	•			have the potential to be affected by	′	
	-	dent #37 indicated that			the same allegeddeficient practice.		
	_				Resident rooms on theLong Term		
		ed it to staff several			Care Unit were audited by		
		ast time being roughly			Maintenance/Housekeeping/design	ie	
	four days prior to	o the current observation			e forpresence of pests.		
					What measures will beput into	ıı	
	On 8/19/16 at 9:	52 a.m., the Interim			place or what systemic changes will be made to ensure that	II.	
	Administrator in	dicated it was her belief			thedeficient practice does not		
	that part of the is	ssue was caused by the			recur?		
	-	had so much food in her			Education will be completed		
		indicated Resident #37			withhousekeeping staff on proper		
	•				cleaning of resident rooms and		
	_	plaint on July 11th, of			resident diningroom by		
		. Maintenance was called			Housekeeping Supervisor by		
		ime. She was unaware of			September 16, 2016.		
	any other compl	aints from the resident.			Administrator/Designee will		
	The administrate	or was unable to provide			complete 10 random room		
	documentation f	or follow up after the			auditsweekly on Long Term Care		
	July 7th complai	int.			Unit for cleanliness of rooms, light		
	*				fixtures, diningrooms and repairs		
	2 On 8/19/16 at	t approximately 11:00			needed		
		room was observed.			How the correctiveactions will be monitored to ensure the deficient		
	, ,				practice will not recur, whatquality	,	
	_	so utilized as an activity			assurance program will be put into		
		entrance into the dinning			place?		
		a card table set up for			The Environmental/Resident Room		
	residents to asse	mble puzzles. The table			Audit will be completed		

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
	155196	B. WING		08/26/2016
ALTENH (X4) ID	PROVIDER OR SUPPLIER  EIM HEALTH & LIVING COMMUNITY  SUMMARY STATEMENT OF DEFICIENCIES	3525 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237  PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	had small black insects crawling on it. The windows along the left side of the room had soiled windowsills. The windowsills were covered with dirt, dust, debris, and dead insects.  3. On 8/18/16 at 4:00 p.m., observed two small black ants crawling on the card table used by residents to put puzzle together. The table was located in the back, on the left side of the room, from entry door. There were 12 dead black ants along the windowsills, on the right side of room from entry door. This room was used for meal service and activities for residents.  On 8/24/16 at 4:30 p.m., the Interim Administrator provided EcoLab invoices dated 4/11/16, 5/11/16, 6/14/16, 7/28/16, 8/5/16, 8/18/16, all invoices indicated, "Target Pest: Ants."		byAdministrator/designee weekly x 4, monthly x 2, and quarterly thereafter until100% compliance is met.  The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%.  Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 9999				
Bldg. 00	3.1-14 PERSONNEL  (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel.  This training shall include, but not	F 9999	What correctiveactions will be accomplished for those resident found to have been affected bythe deficient practice?  No specificresident was affected by the alleged deficient practice.  Activity staff #1 completed required	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155196		155196	B. WING		08/26/2016		
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
A1 TEN111		VINIC COMMANDATIV			HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY				INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	limited to, the fo	ollowing:			ResidentRights, Alzheimer's and		
	(1) Residents' Ri				Dementia, and Abuse training.		
	` /	the required inservice			Cook #2 completed required		
					Alzheimer's and Dementiatraining.		
		ion (1), staff who have			How other residentshaving the		
		with residents shall have a			potential to be affected by the		
	minimum of six	(6) hours of			same deficient practice will be		
	dementia-specifi	ic training within six (6)			identifiedand what corrective		
	_	employment, or within			action will be taken.		
					All residents have the potentialto be	9	
	thirty (30) days for personnel assigned to the Alzheimer's and dementia special				affected by the same alleged		
		•			deficient practice.		
	care unit, and three (3) hours annually				Facility staff will be in-serviced on		
	thereafter to meet the needs or				completing therequired annual		
	preferences, or both, of cognitively				education by SDC/Designee by		
	impaired resider	nts and to gain			September 16, 2016		
	•	f the current standards of			House wideaudit will be completed		
	care for resident				by the SDC/Designee to verify staff		
	care for resident	s with defilentia.			completed ResidentRights,		
					Alzheimer's and dementia, and		
	This State rule is	s not met as evidenced			Abuse training have been complete	I .	
	by:				forthe year by September 16, 2016.		
					What measures will beput into		
	Based on record	review and interview,			place or what systemic changes wil	'	
		d to ensure facility staff			be made to ensure that		
	1				thedeficient practice does not		
	_	uired 3 hours of annual			recur?		
	1	entia, annual training for			Facility staff will be in-serviced on		
	resident rights, a	and annual training for			completing therequired annual		
	abuse for 2 of 5	employee files reviewed			education including, Resident Rights	5,	
	for annual inserv	vices. (Activity Staff #1			Alzheimer's and Dementia, and		
	and Cook #2)	, , , , , , , , , , , , , , , , , , ,			Abuse training.		
	III COOK    2)				The Education Audit will be		
	Tri., 41 1 1 1				completed by SDC/Designee		
	Findings include	· ·			weeklyto verify staff has completed		
					required annual education.		
	Employee Files	were reviewed on			How the corrective actions will be		
	8/19/16 at 10:15	a.m. with the following			monitored to ensure the deficient		
	findings:	S			practice will not recur, whatquality		
	illiuliigs.				assurance program will be put into		

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED	CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391
ALTENHEIM HEALTH & LIVING COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Activity Staff #1 was hired on 7/1/13.  a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016.  b. A Resident's Rights training was documented 4/7/15. No other Resident's Rights training was documented until 8/23/16 (4 days after employee records were reviewed).  c. An Abuse training was documented 4/7/15. No other	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Activity Staff #1 was hired on 7/1/13.  a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016.  b. A Resident's Rights training was documented 4/7/15. No other Resident's Rights training was documented until 8/23/16 (4 days after employee records were reviewed).  c. An Abuse training was documented 4/7/15. No other Abuse training was				3525 E	HANNA AVE	
1. Activity Staff #1 was hired on 7/1/13.  a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016.  b. A Resident's Rights training was documented 4/7/15. No other Resident's Rights training was documented until 8/23/16 (4 days after employee records were reviewed).  c. An Abuse training was documented 4/7/15. No other Abuse training was	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
employee records were reviewed).  2. Cook #2 was hired on 3/4/14.  a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016.  b. A Resident's Rights training was documented 3/4/14. No other Resident's Rights training was documented in the employee file.  c. An Abuse training was documented on		a. Three hours documented in 2 training was documented 4/7 Rights training 8/23/16 (4 days were reviewed).  c. An Abuse tra 4/7/15. No other documented untemployee record 2. Cook #2 was a. Three hours documented in 2 training was documented in 2 training was documented 3/4 Rights training employee file.	of dementia training was 2014. No dementia cumented in 2015 or  Rights training was 7/15. No other Resident's was documented until after employee records or along was til 8/23/16 (4 days after ds were reviewed).  Is hired on 3/4/14.  In dementia training was 2014. No dementia cumented in 2015 or Rights training was 4/14. No other Resident's was documented in the		The Education Audit will be completed by SDC/Designee weeklyx 4, monthly x 2, and quarterly thereafter until 100% compliance is met.  The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%.  Frequency and duration of reviews will be increased asneeded, if	

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8/12/15. No other Abuse training was documented in the employee file.

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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>00</u>		00	COMPLETED	
		155196 B. WING		08/26/2016			
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
R 0000	On 8/23/16 at 3:56 p.m., the Acting Administrator provided an undated policy titled, "Ongoing Training" and indicated it was the current policy used by the facility. The policy indicated, "All associates will be required to complete a minimum of two (2) courses each month in the CarDon University System. Courses will be assigned in the following subject matters throughout the year: Resident's Rights and Abuse PreventionAlzheimer's/Dementia (minimum three one-hour courses per year)"						
D. 1 . 00							
Bldg. 00	Table 1.14 C	and Charles Described (* 1	D 04	200	This also of some 1		
	This visit was for a State Residential Licensure Survey.  Residential Census: 46 Residential Sample: 7  These State findings are cited in accordance with 410 IAC 16.2-5.  Q.R. completed by 14466 on September 02, 2016.		R 00	000	This plan of correction is to serve Altenheim Family FirstSenior Living's credible allegation of compliance. Submission of this plan ofcorrection does not constitute an admission by Altenheim Family First SeniorLiving or its management company that the allegations contained in the surveyreport are a true and accurate portrayal of the provision of nursing care andother services in this facility. Nor does this submission constitute an agreementor admission of the survey allegations. We would like to respectfully requestpaper	·	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	G <u>00</u>	COM	COMPLETED	
		155196	B. WING		08/2	26/2016
	PROVIDER OR SUPPLIER		352	EET ADDRESS, CITY, STATE, 7 5 E HANNA AVE IANAPOLIS, IN 46237	ZIP CODE	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		ION SHOULD BE THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC	CY)	DATE
				compliance for Altenho First Senior Living's Re- andState Licensure Sur Residential Licensure S	certification rvey and	
R 0120	410 IAC 16.2-5-1.4	4(e)(1-3)				
	Personnel - Nonco	•				
Bldg. 00	(e) There shall be education and trai advance for all per at least annually. Is not limited to, re and control of infe safety, accident pr specialized popula administration, and appropriate, as fol (1) The frequency education and trai accordance with the facility person this shall include a inservice per caler hours of inservice nonnursing persor (2) In addition to the inservice hours, st	an organized inservice ning program planned in rsonnel in all departments Training shall include, but esidents' rights, prevention ction, fire prevention, revention, the needs of ations served, medication d nursing care, when lows: and content of inservice ning programs shall be in ne skills and knowledge of nel. For nursing personnel, at least eight (8) hours of ndar year and four (4) per calendar year for nnel.				
		-specific training within six				
	l ' '	ree (3) hours annually				
		the needs or preferences,				
		vely impaired residents				
	1	gain understanding of the of care for residents with				
	dementia.	C. Caro for regidents with				
		ds shall be maintained				
	and shall indicate					
	(A) The time, date					
	(B) The name of the					
	(C) The title of the					
	(D) The names of					
	(E) The program o	content of inservice.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/26/2016	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			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		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		acknowledge attendance					
	by written signatur	review and interview,	R 0	120	What correctiveactions will be		09/16/2016
		·	KU	120	accomplished for those residents		09/10/2010
	_	d to ensure nursing staff			found to have been affected bythe		
	_	uired 3 hours of annual			deficient practice?		
		entia, annual training for			No specificresident was affected by	/	
		nd annual training for			the alleged deficient practice.		
		employee files reviewed			Activity staff #1 completed required	ł	
	*	cal Nurse (LPN) #1,			ResidentRights, Alzheimer's and		
	Certified Nursin	g Assistant (CNA) #2,			Dementia, and Abuse training. Coo		
	and Registered N	Nurse (RN) #3)			#2 completed required Alzheimer's		
					and Dementiatraining.  How will other residentshaving the		
	Findings include	<b>:</b> :			potential to be affected by the	•	
					same deficient practice be		
	Employee files v	were reviewed on 8/19/16			identifiedand what corrective		
		th the following findings:			action will be taken?		
	<i>at</i> 10.15 <i>a</i> .111. W1	in the following intumgs.			All residents have the potentialto b	e	
	1 I DN #1 was 1	hired on 5/1/2010.			affected by the same alleged		
	1. Lin #i wasi	mred on 3/1/2010.			deficient practice. Facility staff will		
	a There have a	of dementia training was			be In-serviced by SDC/Designee by		
		•			September 16, 2016 oncompleting the required annual education.		
		014. No other dementia			House wide audit will be completed	ı	
	_	umented until 1 hour was			by SDC/Designee to verify	•	
	^	23/16 (4 days after			staffcompleted Resident Rights,		
	employee files w	vere reviewed).			Alzheimer's and Dementia, and		
					Abuse Training yearlyby September		
	b. A Resident's	Rights training was			16, 2016.		
	documented on 2	2/12/14. The next			What measures will beput into		
	Resident's Right	s training was			place or what systemic changes wi	II	
	documented on 8	8/22/16 (3 days after			be made to ensure that		
	employee record	ls were reviewed).			thedeficient practice does not		
		,			recur? Facility staff will be in-serviced		
	c. An Abuse tra	ining was documented on			oncompleting the required annual		
		er Abuse training was			education including, Resident Right	s,	
		il 8/22/16 (3 days after			required Alzheimer's and Dementia		
	documented until	11 0/22/10 (5 days after			and Abuse training by SDC/Designe	e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2016	
NAME OF P	ROVIDER OR SUPPLIER	<del>-</del>		ADDRESS, CITY, STATE, ZIP CODE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY		E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
	employee record	ls were reviewed).		by September 16, 2016.	
	2. CNA #2 was	hired on 7/1/15.		The Education Audit will be completed by SDC/Designee weeklyto verify staff has complet	ted
	a. A Resident's	Rights training was		required annual education.  How will the corrective actions be	pe
	documented on ?	7/2/15. No other		monitored to ensure the deficien	
	Resident's Right	s training documentation		practice will not recur, and	
	was found in CN	IA #2's employee file.		whatquality assurance program	will
				be put into place?  The Education Audit will be	
		ining was documented		completed by SDC/Designee wee	eklyx
		ther Abuse training was		4, monthly x 2, and quarterly	
		il 8/23/16 (4 days after		thereafter until 100% compliance	e is
	employee record	ls were reviewed).		met.	
	3. RN #3 was hi	ired on 12/20/11.		*The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly	re
		Rights training was 2/5/14. No other		times 2, and quarterly thereafter untilcompliance is at 100%.	
				Frequency and duration of review will be increased asneeded, if	NS
	Resident's Right			compliance is below 100%.	
	documented in R	RN #3's employee file.		p	
	On 8/23/16 at 3:	56 p.m., the Acting			
		ovided an undated policy			
	•	Training" and indicated			
		t policy used by the			
		licy indicated, "All			
	associates will b	e required to complete a			
	minimum of two	(2) courses each month			
	in the CarDon U	niversity System.			
	Courses will be	assigned in the following			
		hroughout the year:			
	Resident's Right				
	PreventionAlz	heimer's/Dementia			
	(minimum three	one-hour courses per			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPL	ETED
		155196	B. W	ING		08/26/2016	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		1	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	year)"						
R 0144	410 IAC 16.2-5-1.	5(2)					
11.0144		fety Standards - Deficiency					
Bldg. 00		all be clean, orderly, and in					
g. 00		pair, both inside and out,					
		reasonable comfort for all					
	residents.						
		ation and interview, the	R 0	144	What corrective actions will	be	09/16/2016
	facility failed to	provide housekeeping			accomplished for those	_	
	services necessa	ry to maintain a sanitary,			residents found to have been	1	
	orderly, and con	nfortable interior.			affected by the deficient practice? Room 3313 has be	aan	
	3,				deep cleaned by housekeepin		
	Findings include	••			including carpet and bathroom		
	1 mamgs merade	·•			Room 3315 has been deep		
	During anxiron	mental tour on 8/26/16 at			cleaned by housekeeping,		
	_				including carpet and bathroom	۱.	
	11:00 a.m. the fo	ollowing was observed:			Room 2113 has been deep		
					cleaned by housekeeping, including carpet and bathroom	1	
	_	partment #3313, the			How will other residents hav		
		es of paper and needed to			the potential to be affected b	_	
	*	athroom had a small			the same deficient practice b	-	
	plastic container	sitting on the floor			identified and what correctiv	е	
	between the sho	wer ad toilet over			action will be taken?		
	flowing with soi	led wash clothes. The			Housekeeping Supervisor has		
	_	of the sink and shower			audited all rooms in Residentia		
	had discolored f	ilm.			ensure the carpet is swept and free of stains, the bathrooms a		
		-			clean, and the rooms are free		
	During an interv	iew on 8/25/16 at 2:30			odor. All residents residing in		
	_	48 indicated he was			Residential have the potential		
					be affected by the same allege	ed	
	_	had been 2 weeks since			deficient practice. Facility		
	-	d been cleaned and			Housekeeping Supervisor has	;	
		changed on his bed.			been in-serviced by Housekeeping Supervisor on I	how	
	Resident #48 inc	licated they are suppose			to properly clean the Resident		
	to clean and cha	nge the sheets weekly.			Apartments. Facility		

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
155196		155196	B. WI	NG		08/26/2	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .		3525 E	HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY					APOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE ACTION.			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	2. In resident ap apartment carpet stains and was he scraps of paper, In the bathroom, a discolored film was brown subst places, there was approximately l'interior of toilet.  During an interva.m., Resident #4 sleep on soiled lithey had not clear Indicated she had could tell it was  3. In resident ap a foul odor exter carpet soiled with multiple clumps	partment #3315, the shad multiple color eavily soiled, contained and needed to be swept. The sink and shower had an, on the toilet seat there cance smeared in two is a worn discolored place. If (inch) by 3", and the was soiled.  We was soiled.  We was soiled.  We was soiled.  We was and the man for two weeks and the apartment. She in need of cleaning.  We was adding to the hallway, the his scraps of paper, and of black hair. The black in the air as you walked.		TAG	Housekeeping staff in-serviced Administrator on how to proper clean the Residential Apartme.  What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?  Administrator/Designee will complete 10 random room and weekly on the Residential Unit cleanliness of carpet, bathroor and toensure room is free of odor. Facility Housekeeping Supervisor will be in-serviced thousekeeping Supervisor on he to properly clean the Residential Apartments by September 16,2016. Facility Housekeepin staff will be in-serviced by Administrator on how to prope clean the Residential Apartme by September16, 2016.  How the corrective actions whe monitored to ensure the deficient practice will not recomplete 10 random for cleanliness of floor, bathroom, and to ensure the room is free odor. The results of these aud will be reviewed by the Quality Assurance Committee weekly 4, monthly times 2, and quartee thereafter until compliance is a 100%. Frequency and duration reviews will be increased as needed, if compliance is below 100%.	d by rly rly rly rls.  lits for n,  py now dal g rly nts  iill ur, e?  of lits x rly t n of	DATE

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