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 10/07/2016			ETED		
	PROVIDER OR SUPPLIE	R VING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
Bldg. 01	State Licensure the Indiana State accordance with Survey Date: 10 Facility Number Provider Number AIM Number: At this Life Safe Altenheim Heal was found not in Requirements for Medicare/Medic 483.70(a), Life 2000 Edition of Protection Asso Safety Code (LS Health Care Occ 16.2. This facility, occ wings of the first building with a determined to be construction and The facility has smoke detection.	er: 000103 er: 155196 100290000 ety Code survey, th and Living Community in compliance with or Participation in eaid, 42 CFR Subpart Safety from Fire and the the National Fire ciation (NFPA) 101, Life SC), Chapter 19, Existing cupancies and 410 IAC cupying the A, B and C et floor of a three story	K 0	000	This plan of correction is to serve Altenheim Family First Senior Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Family First Senior Living or its management company that the allegations contained in the survey report are at true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Altenheim Family First Senior Living's Life Safety Code Survey.	n t s s	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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.

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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	<u>01</u>		
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, 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	
K 0046 SS=F Bldg. 01	corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The facility has a capacity of 87 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/13/16 - DA NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review, observation and interview; the facility failed to document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights for 1 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all	K 0046	K046 – Emergency Light Documentation 1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice? *The check off sheet has been modified to show that the functionatesting of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. 2. How will other residents having the potential to be affected by the	al	

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	OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/07/2016		
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, 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		
	residents, staff and visitors. Findings include:		same deficient practice by identified and what corrective action will be taken?			
	Based on review of "Direct Supply TELS: Emergency Power Generators Test Generator Under Load", "EPSS Weekly Test Log" and "Battery Backup Emergency Light Testing for 2016" documentation with the Director of Maintenance and the Regional Facilities Manager during record review from 8:45 a.m. to 11:50 a.m. on 10/07/16, documentation of monthly functional testing for not less than 30 seconds for three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated there are three battery operated emergency lights located at the emergency generator inside the facility and acknowledged documentation of monthly functional testing for not less than 30 seconds for the three battery powered emergency lights located at the emergency generator for September 2016 was not available for review. Based on observations with the Director of Maintenance and the Regional Facilities		*All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit and document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur? *Administrator/Designee will review documentation monthly to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. *Maintenance Director/Designee Director will be educated by Octobe 27 2016 by Administrator/Designee on ensuring that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly.	er		
	Manager during a tour of the facility from 12:40 p.m. to 3:05 p.m. on 10/07/16, each of the three battery powered		4. How will the corrective actions be monitored to ensure the deficient practice will not recur,			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDING B. WING	<u>01</u>	COMPL: 10/07/	ETED	
	ROVIDER OR SUPPLIER EIM HEALTH & LIVING COM	IMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BI REGULATORY OR LSC IDENTI	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	emergency lights at the er generator location inside t illuminated when its respe	the facility		and what quality assurance program.		
	button was pushed. 3.1-19(b)			*Emergency Lighting CQI will be completed weekly X 4, monthly x 2, the quarterly thereafter until compliance is 100% to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly by the Maintenance Director/Designee. *The results of these audits will be 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%.		
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STAN Fire drills include the transmalarm signal and simulation fire conditions. Fire drills are unexpected times under var at least quarterly on each shamiliar with procedures and drills are part of established Responsibility for planning a drills is assigned only to con who are qualified to exercise Where drills are conducted I PM and 6:00 AM a coded ar may be used instead of aud 18.7.1.2, 19.7.1.2 Based on record review as	nission of a fire of emergency e held at rying conditions, nift. The staff is d is aware that routine. and conducting mpetent persons e leadership. between 9:00 nnouncement lible alarms.	K 0050	1. What corrective Actions will be		10/27/2016
	the facility failed to docur	·	K 0030	accomplished for those residents found to have been affected by the		10/2//2010

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLE			ETED		
		155196	B. WING 10/07/2			2016		
				CTD DET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER							
A1 TENI II		INIC COMMUNITY		3525 E HANNA AVE INDIANAPOLIS, IN 46237				
ALTENHI	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 APPROPRIATION OF THE ACTION OF THE APPROPRIATION OF THE APPROPRIATION OF THE APPROPRIATION OF THE ACTION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	conducted on the	e first shift for 1 of 4			deficient practice?			
	quarters. This deficient practice could							
	affect all residen	ts, staff and visitors in			*Fire drills have been completed and			
	the facility.	,			documented for all 1st, 2nd, and 3rd			
	the facility.				quarters on each shift in 2016.			
	r: 1: : 1 1							
	Findings include				2. How will other residents having			
					the potential to be affected by the			
	Based on review	of "Direct Supply:			same deficient practice by identified and what corrective			
	TELS - Fire Drills" and "Fire Drill				action will be taken?			
	Report" documentation with the Director				action will be taken:			
	of Maintenance and the Regional				*All residents, staff, and visitors in			
		er during record review			the Rehabilitation Facility have the			
	from 8:45 a.m. to				potential to be affected by the			
					alleged deficient practice.			
		entation of a fire drill						
	conducted on the	e first shift in the fourth			*The Maintenance Director will			
	quarter (October	, November, December)			follow a schedule on a 12 month			
	2015 was not ava	ailable for review. Based			calendar to ensure fire drills are			
	on interview at the	he time of record review,			completed quarterly on all shifts.			
		eilities Manager stated						
	_	rill documentation not			3. What measures will be put into			
	was available for				place or what systematic changes			
					will be made to ensure that the			
	_	ocumentation of a fire			deficient practice does not occur?			
	drill conducted of	on the first shift in the						
	fourth quarter 20	115 was not available for			*The Maintenance Director will use			
	review.				a schedule on a 12 month calendar			
					to follow to ensure fire drills are			
	3.1-19(b)				completed quarterly on all shifts.			
	3.1-51(c)				*Maintenance Director/Designee			
	J.1-J1(6)				Director will be educated by Octobe	r		
					27, 2016 by Administrator/Designee			
					on ensuring fire drills are completed			
					quarterly on all shifts.			
					, ,			
					*Administrator/Designee will audit			
					fire drills monthly to ensure they are	9		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	<u>01</u>	COMPLETED 10/07/2016	
	ROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, 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	
				being conducted quarterly on all shifts.		
				4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.		
				*A Fire Drill CQI will be completed monthly x4, quarterly x2, and monthly thereafter until compliance reached 100% to ensure they are being conducted quarterly on all shifts by the Maintenance Director/Designee.	3	
				*The results of these audits will be reviewed quarterly by the Quality Assurance Committee until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance i below 100%.	is	
K 0062 SS=E Bldg. 01	continuously main condition and are	DE STANDARD ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13,				
	facility failed to automatic sprink in accordance wi	ation and interview, the ensure a complete ler system was installed th NFPA 13, 1999	K 0062	1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice?	10/27/2016	
		Installation of Sprinkler .7.1 states all automatic		*Data Cable has been removed from the support bracket near the ceiling		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED			ETED	
		155196	B. WING 10/07/2016			2016	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8					
AL TENILI		VINIC COMMANDINITY			HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		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	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sprinkler system	s shall be maintained in			in the Storage Room outside the		
	accordance with NFPA 13, Standard for				kitchen near the loading dock.		
	the Installation of Sprinkler Systems.						
		5 states sprinkler piping			2. How will other residents having		
					the potential to be affected by the		
	_	not be used to support			same deficient practice by		
	nonsystem components. This deficient				identified and what corrective		
	practice could affect 10 residents, staff and visitors in the vicinity of the Storage				action will be taken?		
	Room outside the kitchen near the				*All residents, staff, and visitors in		
	loading dock.				the vicinity of the Storage Room		
	rouding doon.				outside of the Kitchen have the		
				potential to be affected by the			
	Findings include); 			alleged deficient practice.		
					*Maintenance Director/Designee		
	Based on observ	ation with the Director of			has audited automatic sprinkler		
	Maintenance and	d the Regional Facilities			systems to ensure the sprinkler pipe		
	Manager during	a tour of the facility from			locations are not used to support	•	
		05 p.m. on 10/07/16, a			non system components.		
	_	f data cable was run			non system components.		
	_				3. What measures will be put into		
		port bracket for a four			place or what systematic changes		
	inch in diameter	horizontal sprinkler pipe			will be made to ensure that the		
	near the ceiling i	in the Storage Room			deficient practice does not occur?		
	outside the kitch	en near the loading dock.					
		ew at the time of			*The Maintenance		
		Director of Maintenance			Director/Designee will check		
	•	l Facilities Manager			sprinkler systems weekly to ensure		
	_	· ·			the sprinkler pipe locations are not		
	_	ne aforementioned			being used to support non system		
	sprinkler pipe lo	cation was being used to			components.		
	support nonsyste	em components.					
					*Maintenance Director/Designee		
	3.1-19(b)				Director will be educated by Octobe	er	
	(0)				27, 2016 by Administrator/Designee	·	
					on ensuring sprinkler pipe locations		
					are not used to support non system		
					components.		

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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	onstruction 01	(X3) DATE SURVEY COMPLETED 10/07/2016			
	PROVIDER 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.			
				*Sprinkler System CQI will be completed will be completed week x4, monthly x2, and quarterly thereafter until compliance reache 100% to ensure sprinkler pipe locations are not used to support non system components.			
				*The results of these audits will be reviewed quarterly by the Quality Assurance Committee until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance below 100%.			
K 0064 SS=D Bldg. 01	inspected, and ma occupancies in ac NFPA 10. 18.3.5.6, 19.3.5.6	guishers shall be installed, aintained in all health care cordance with 9.7.4.1,					
	facility failed to of 4 portable fire kitchen each mo for Portable Fire 4-3.4.2 requires inspections at least of inspection and	ation and interview, the document inspection of 1 extinguishers in the nth. NFPA 10, Standard Extinguishers, Section fire extinguisher ast monthly with the date of the initials of the ng being recorded. In	K 0064	1. What corrective actions will be accomplished for those resident found to have been affected by th deficient practice? *The portable ABC type fire extinguisher in the Therapy Room is the Rehabilitation Wing has had its monthly inspection for October.	in		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED
		155196	B. W	ING		10/07/2016
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, 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)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
	addition, NFPA 10, Section 4-2.1 defines				2. How will other residents having	
		quick check" to ensure			the potential to be affected by the same deficient practice will be	
	_	sher is available and will			identified and what corrective	
	operate. It is int	ended to give reasonable			action will be taken?	
	assurance the fir	e extinguisher is fully				
	charged and ope	rable, verifying that it is			*Residents, staff, and visitors in the	
	in its designated	place, it has not been			Therapy Room in the Rehabilitation	
	actuated or tamp	pered with and there is no			Wing have the potential to be	
	obvious or physical damage or condition				affected by the alleged deficient	
	to prevent its operation. This deficient				practice.	
	practice could affect 5 staff and visitors				*All ABC type fire extinguishers have	_
	in the kitchen.				been audited by Maintenance	
	in the kitchen.				Director/Designee to ensure they	
	Findings include	··			have had their monthly inspections	
	1 manigs merade				completed.	
		ration with the Director of			3. What measures will be put into	
		d the Regional Facilities			place or what systemic changes wil	I
	Manager during	a tour of the facility from			be made to ensure that the	
	12:40 p.m. to 3:0	05 p.m. on 10/07/16, the			deficient practice does not recur?	
	portable ABC ty	pe fire extinguisher near			*Maintenance Director/Designee	
	the east exit doo	r from the kitchen had an			will audit all ABC type fire	
	inspection tag af	fixed to the extinguisher			extinguishers to ensure they are	
	which indicated	an annual inspection was			inspected monthly.	
	conducted in Jar	nuary 2016. However, a				
	monthly inspect	ion was not documented			*Maintenance Director/Designee	
	1	and September 2016.			Director will be educated by Octobe	
	1	ew at the time of			27, 2016 by Administrator/Designed	2
		Director of Maintenance			on ensuring all ABC type fire extinguishers are inspected monthly	,
	•	nonthly fire extinguisher			evringaistiers are hispected illolithin	·
		nentation was available			4. How the corrective actions will	
					be monitored to ensure the	
		cknowledged a monthly			deficient practice will not recur,	
	_	e aforementioned			what quality assurance program	
	-	inguisher in the kitchen			will be put into place?	
	was not documented for July, August and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUIL		NSTRUCTION	(X3) DATE : COMPL				
AND PLAN	OF CORRECTION	155196	B. WINC		01	10/07/			
		133190				10/07/	2010		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
ALTENH	EIM HEALTH & LIV	ING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237						
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	September 2016.				*Fire Extinguisher CQI will be				
					completed monthly x 4, and				
3.1-19(b)				quarterly thereafter until compliance is at 100% by					
					Maintenance Director/Designee.				
					Wallterlance Directory Designee.				
				*The results of these audits will be					
				reviewed by the Quality Assurance					
					Committee monthly times 4, and				
					quarterly thereafter until				
					compliance is at 100%. Frequency				
					and duration of reviews will be				
					increased as needed, if compliance i below 100%.	S			
					Delow 100%.				
K 0143	NFPA 101								
SS=E	LIFE SAFETY CO								
Bldg. 01		uid oxygen from one er shall be accomplished							
		fically designated for the							
	transferring that is								
		any portion of a facility							
	•	in ad autorated by							
		•							
	fire-resistive const								
		mechanically ventilated,							
		as ceramic or concrete							
permitted in accordance with NFPA 99 and									
	Compressed Gas								
	8-6.2.5.2 (NFPA 9	9)							
	· ·		K 014	3	1. What corrective Actions will be		10/27/2016		
					accomplished for those residents				
	•	reas where transferring			found to have been affected by the				
	transferring that is (a) separated from wherein patients are housed, exami separation of a fire fire-resistive const (b) the area that is sprinklered, and he flooring; and (c) in an area that indicating that tran that smoking in the permitted in accord Compressed Gas. 8-6.2.5.2 (NFPA 9 Based on observations)	as follows: any portion of a facility ined, or treated by a barrier of 1-hour ruction; and mechanically ventilated, as ceramic or concrete is posted with signs seferring is occurring, and is immediate area is not dance with NFPA 99 and Association. 9) ation and interview, the ensure 1 of 2 liquid	K 014	13	accomplished for those residents		10/27/2016		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 01 COMPLI B. WING 10/07/2				
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, 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)	ΤE	(X5) COMPLETION DATE
	posted with sign of oxygen is occ practice could at and visitors in th				*A temporary sign has been placed on the oxygen storage room door located on the locked unit indicating that the transferring of oxygen occurs in the room. *A permanent sign has been ordered through assigned vendor.	g	
	Maintenance and Manager during 12:40 p.m. to 3:0 oxygen storage a the Memory Car liquid oxygen co room and the are signs indicating oxygen occurs in	ation with the Director of the Regional Facilities a tour of the facility from 05 p.m. on 10/07/16, the and transfilling room near the Dining Room had six ontainers stored in the ear was not posted with the transferring of the room. Based on time of observation, the oterance and the			2. How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken? *Residents, staff, and visitors on the locked unit have the potential to be affected by the alleged deficient practice.	e	
	Regional Facilities were unaware if oxygen transfillies acknowledged the with signs indicates oxygen occurs in exit interview at Administrator according of oxygen takes	tes Manager stated they the room was used as an ing room but the room was not posted atting the transferring of the the room. Based on 3:25 p.m., the eknowledged transferring place in each of the two age and transfilling			*Maintenance Director/Designee have audited 2 of 2 oxygen transfilling room doors to ensure signs are present indicating that the transferring of oxygen occurs in the room. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?		

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		IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	01	COMPLETED 10/07/2016			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE					
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-19(b)			*Maintenance Director/Designee will audit the oxygen transfilling room doors to ensure a sign is present indicating that the transferring of oxygen occurs in the room. *Maintenance Director/Designee Director will be educated by Octobe 27, 2016 by Administrator/Designee on ensuring that transfilling room doors have a sign present indicating that the transferring of oxygen occurs in the room. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program. *O2 Room CQI will be comple by Maintenance Director/Designee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100% *The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	er B			

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	OF CORRECTION OF CORRECTION 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/07/2016	
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE JAPOLIS, 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	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office	K 0147	1. What corrective Actions will be accomplished for those residents found to have been affected by the deficient practice? *The power wheelchair and oxyger concentrator are no longer plugged into a power strip in room 1086. 2. How will other residents having the potential to be affected by the same deficient practice by identified and what corrective action will be taken? *Residents, staff, and visitors within the vicinity of room 1086 have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit rooms in the facility to ensure power strips are not being used as a substitute in place of fixin wiring and power strips are not being used in patient care vicinity be October 27, 2016.	n n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		lì í		ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	<u>01</u>	COMPL	
		155196	B. W	ING		10/07/	2016
NAME OF D	DOWNER OF CLIDALIE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIEF	C		3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDERIC DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\1L	DATE
	appliances not co	ommonly equipped with			3. What measures will be put into		
	grounding condu	actors in their power			place or what systematic changes		
		ermitted provided they			will be made to ensure that the		
	•	vithin the patient care			deficient practice does not occur?		
		•					
	_	eficient practice could			*Caring Hearts Representatives wil		
		its, staff and visitors in			audit rooms weekly to ensure pow	er	
	the vicinity of R	oom 1086.			strips are not being used as a		
					substitute in place of fixing wiring		
	Findings include	2:			and power strips are not being used in patient care vicinity.	u	
					in patient care vicinity.		
	Based on observ	ration with the Director of					
	Maintenance and the Regional Facilities						
	Manager during a tour of the facility from				*Administrator/Designee will		
	12:40 p.m. to 3:05 p.m. on 10/07/16, a				educate Maintenance Director and		
	•	•			Maintenance Assistant by October		
		Ichair was plugged into a			27, 2016 on ensuring power strips		
		oom 1086. In addition,			are not being used as a substitute i	n	
		entrator was plugged into			place of fixing wiring and power		
	a power strip on	the floor one foot from			strips are not being used in patient		
	the resident bed	in Room 1086. Based on			care vicinity.		
	interview at the	time of the observations,					
	the Director of N	Maintenance and the					
	Regional Faciliti	ies Manager			*Maintenance Director will		
		ower strips were being			education staff, including, Caring		
		ute for fixed wiring in			Hearts Reps by October 27, 2016 o	n	
		•			ensuring power strips are not being		
		one of the power strips			used as a substitute in place of fixir	ng	
	_	sed in the patient care			wiring and power strips are not		
	vicinity in Room	n 1086.			being used in patient care vicinity.		
	3.1-19(b)						
					4. How will the corrective actions		
					be monitored to ensure the		
					deficient practice will not recur,		
ı					and what quality assurance		
					program.		
			ı		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155196	B. WI	NG		10/07/	2016
	ROVIDER OR SUPPLIER			3525 E	.DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDERIG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					*Maintenance Director/Designee will complete the Patient Room Electrical Wiring CQI weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100% *The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.		
K 0000							
Bldg. 02	42 CFR 483.70(a Survey Date: 10 Facility Number: Provider Number AIM Number: 1 At this Life Safe Altenheim Healt was found not in Requirements fo	e Indiana State fealth in accordance with a). 7/07/16 1: 000103 17: 155196 100290000 1ty Code Survey, h and Living Community compliance with	K 00	000	This plan of correction is to serve Altenheim Family First Senior Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Family First Senior Living or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to respectfully request paper compliance for Altenheim Family First Senior Living's Life Safety Code Survey.		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 10/07/2016
ALTENH	ROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, 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
	2000 Edition of a Protection Assoc Safety Code (LS	Safety from Fire and the the National Fire station (NFPA) 101, Life C), Chapter 18, New upancies and 410 IAC			
	of Type V (111) fully sprinklered Wing has a fire a detection in the copen to the corridetectors hard w system in resider facility has a cap	chabilitation Wing 014 was determined to be construction and was . The Rehabilitation construction with smoke corridors, in all areas dor and has smoke ired to the fire alarm and sleeping rooms. The facity of 87 and had a the time of this survey.			
	access were spring providing facility sprinklered. Quality Review	residents have customary nklered and all areas y services were completed on 10/13/16 -			
K 0038 SS=E Bldg. 02	readily accessible with 7.1. 18.2.1, 1	arranged that exits are at all times in accordance 9.2.1	K 0038	What corrective actions will be	10/27/2016
	facility failed to	ation and interview, the ensure the means of of 7 exits were readily	K 0036	accomplished for those resident found to have been affected by the deficient practice?	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 02	(X3) DATE SURVEY COMPLETED 10/07/2016		
	PROVIDER OR SUPPLIER		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	CROSS-REFERENCED TO THE APPROP	N (X5) BE COMPLETION DATE		
	diagnosis requiri measures. LSC within a required	sidents without a clinical ng specialized security 18.2.2.4 requires doors I means of egress shall		*The 4 digit exit code is now pos at the main entrance for the Rehabilitation Wing.			
	requires the use of egress side. Exc door-locking arradelayed egress sl	with a latch or lock that of a tool or key from the eption No. 1 states angements without nall be permitted in		How will other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	g the		
	health care occup clinical needs of specialized secur safety, provided	pancies, or portions of pancies, where the the patients require rity measures for their that staff can readily rs at all times. This		*Residents, staff, and visitors needing to exit the facility at the main entrance on the Rehabilita Wing have the potential to be affected by the alleged deficient practice.	tion		
	deficient practice residents, staff a	e could affect 20 nd visitors if needing to t the main entrance for		*Maintenance Director/Designed will audit all exit doors on units housing residents that are not or locked unit to ensure an exit code posted by October 27, 2016.	na		
	Findings include			What measures will be put into place or what systemic changes			
	Maintenance and	ation with the Director of I the Regional Facilities a tour of the facility from		be made to ensure that the deficient practice does not recu	r?		
	12:40 p.m. to 3:0 main entrance do Wing was marke	or for the Rehabilitation as a facility exit and ylocked and could be		*Maintenance Director will audir exit doors on units housing resid that are not on a locked unit to ensure an exit code is posted weekly.			
	code but the code time of the surve and residents, sta	by entering a four digit e was not posted. At the y, the door was unlocked off and visitors could exit but entering the four digit		*Administrator/Designee will educate Maintenance Director/Designee to ensure all of doors on units housing residents that are not on a locked units ha			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 10/07/2016
ALTENHI	ROVIDER OR SUPPLIER	ING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	interview at the t Director of Main Regional Faciliti	ne door. Based on time of observation, the stenance and the es Manager stated the por for the Rehabilitation		an exit code is posted by October 27, 2016. How the corrective actions will be monitored to ensure the deficient practice will not recur, what qualit	
	door is locked at diagnosis requiri	d during the day, the night, residents with a ng specialized security		assurance program will be put into place? *Maintenance Director/Designee	•
	portion of the fact the four digit coor aforementioned	in the Memory Care cility and acknowledged de was not posted at the entrance to enable nd visitors to exit the		will complete the Exit Door CQI weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be	
	facility from the main entrance sn event of an evac	Rehabilitation Wing noke compartment in the uation at night. A		increased as needed if compliance below 100%. *The results of these audits will be	is
	requiring special would have to as	the clinical diagnosis ized security measures k a staff member to let did not know the code.		reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews	
	3.1-19(b)			will be increased as needed, if compliance is below 100%.	
K 0046 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CO Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1.	g of at least 1 1/2 hour ed automatically in .9.			
	interview; the far monthly function lighting in accor-	review, observation and cility failed to document nal testing of emergency dance with LSC 7.9 for evered lights for 1 of 12	K 0046	K046 – Emergency Light Documentation 1. What corrective Actions will be accomplished for those residents found to have been affected by the	10/27/2016

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	ſ ′	JILDING	onstruction 02	(X3) DATE S COMPL 10/07/	ETED
	PROVIDER 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 APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	months. LSC 7.5	9.3 Periodic Testing of			deficient practice?		
	Emergency Light a functional test day intervals for Equipment shall the duration of the of visual inspective kept by the owner authority having deficient practices.	ting Equipment requires to be conducted at 30 not less than 30 seconds. be fully operational for the test. Written records it is and tests shall be the for inspection by the jurisdiction. This is could affect all			*The check off sheet has been modified to show that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. 2. How will other residents having the potential to be affected by the same deficient practice by	1	
	residents, staff and visitors.				identified and what corrective action will be taken?		
	TELS: Emergence Test Generator U Weekly Test Log Emergency Light documentation w Maintenance and Manager during a.m. to 11:50 a.m. documentation of testing for not less three battery powers.	of "Direct Supply by Power Generators Under Load", "EPSS g" and "Battery Backup to Testing for 2016" with the Director of I the Regional Facilities record review from 8:45 h. on 10/07/16, f monthly functional ses than 30 seconds for wered emergency lights			*All residents, staff, and visitors in the Rehabilitation Facility have the potential to be affected by the alleged deficient practice. *Maintenance Director/Designee will audit and document monthly functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?		
	September 2016 review. Based o record review, th Maintenance stat operated emerge emergency gener	was not available for interview at the time of the Director of the there are three battery included lights located at the rator inside the facility and documentation of			*Administrator/Designee will review documentation monthly to ensure that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conducted monthly. *Maintenance Director/Designee	N	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 10/07/2016		
	PROVIDER OR SUPPLIER		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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) SE COMPLETION DATE		
	than 30 seconds powered emerge emergency generations with Maintenance and Manager during 12:40 p.m. to 3:0 each of the three emergency lights generator locations.	I the Regional Facilities a tour of the facility from 5 p.m. on 10/07/16, battery powered at the emergency in inside the facility in its respective test		Director will be educated by Octo 27 2016 by Administrator/Design on ensuring that the functional testing of emergency lighting in accordance with LSC 7.9 for three battery powered lights is conduct monthly. 4. How will the corrective action be monitored to ensure the deficient practice will not recur, and what quality assurance program. *Emergency Lighting CQI will be completed weekly X 4, monthly x the quarterly thereafter until compliance is 100% to ensure that the functional testing of emerger lighting in accordance with LSC 7 for three battery powered lights conducted monthly by the Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee weekly until compliar is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	ee		
K 0050 SS=F Bldg. 02	alarm signal and s fire conditions. Fir unexpected times	he transmission of a fire imulation of emergency					

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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>02</u>		COMPL	ETED	
		155196	B. WI	NG		10/07/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDER OR SUPPLIER			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) edures and is aware that		TAG	DEFICIENCE!		DATE
	l '	stablished routine.					
	•	planning and conducting					
		only to competent persons					
	•	to exercise leadership.					
	Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2						
	· · · · · · · · · · · · · · · · · · ·	review and interview,	K 0	050	1. What corrective Actions will be		10/27/2016
	the facility failed	d to document fire drills			accomplished for those residents		
	conducted on the	e first shift for 1 of 4			found to have been affected by the	9	
	quarters. This d	eficient practice could			deficient practice?		
	_	its, staff and visitors in			*Fire drills have been completed an	ud	
	the facility.	,			documented for all 1st, 2nd, and 3rd		
					quarters on each shift in 2016.		
	Findings include	2:					
		•			2. How will other residents having		
	Based on review	of "Direct Supply:			the potential to be affected by the		
		lls" and "Fire Drill			same deficient practice by identified and what corrective		
		ntation with the Director			action will be taken?		
		and the Regional					
		ger during record review			*All residents, staff, and visitors in		
	from 8:45 a.m. to	, .			the Rehabilitation Facility have the		
		nentation of a fire drill			potential to be affected by the		
	1	e first shift in the fourth			alleged deficient practice.		
		, November, December)			*The Maintenance Director will		
		ailable for review. Based			follow a schedule on a 12 month		
					calendar to ensure fire drills are		
		he time of record review,			completed quarterly on all shifts.		
	_	cilities Manager stated					
		rill documentation not			3. What measures will be put into		
	was available for				place or what systematic changes will be made to ensure that the		
		ocumentation of a fire			deficient practice does not occur?		
		on the first shift in the			asimonic practice does not occur:		
	•	115 was not available for			*The Maintenance Director will use	!	
	review.				a schedule on a 12 month calendar		

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 10/07/2016
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	3525 E	ADDRESS, CITY, STATE, ZIP COD HANNA AVE NAPOLIS, IN 46237	E	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION DATE
IAU	3.1-19(b)	LSC IDENTIFTING INFORMATION)	IAG	to follow to ensure fire drills a completed quarterly on all shift *Maintenance Director/Design Director will be educated by O 27, 2016 by Administrator/Design on ensuring fire drills are completed quarterly on all shifts. *Administrator/Designee will a fire drills monthly to ensure the being conducted quarterly on shifts. 4. How will the corrective active active active deficient practice will not recurred and what quality assurance program. *A Fire Drill CQI will be complete monthly x4, quarterly x2, and monthly thereafter until complete reached 100% to ensure the seeing conducted quarterly on shifts by the Maintenance Director/Designee. *The results of these audits with reviewed quarterly by the Quarterl	re fts. nee ctober signee pleted audit ey are all ons Ir, eted liance are all Il be lity ncy
K 0064 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CO Portable fire exting	DE STANDARD guishers shall be installed,			

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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>02</u>		COMPLETED	
		155196	B. W	ING		10/07/	2016
NAME OF P	PROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN				HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY			INDIAN	NAPOLIS, IN 46237			
(X4) ID		TATEMENT OF DEFICIENCIES		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)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		aintained in all health care cordance with 9.7.4.1,					
	NFPA 10. 18.3.5.6						
	i	ation and interview, the	K 0	064	1. What corrective actions will be		10/27/2016
		document inspection of 1			accomplished for those resident		
	1 -	e extinguishers in the			found to have been affected by the		
	•	of the Rehabilitation			deficient practice?		
		h. NFPA 10, Standard			*The portable ADC ture fire		
	•	Extinguishers, Section			*The portable ABC type fire extinguisher in the Therapy Room in	,	
	4-3.4.2 requires	· ,			the Rehabilitation Wing has had its		
		•			monthly inspection for October.		
	inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines						
					2. How will other residents having		
					the potential to be affected by the		
	· ·				same deficient practice will be		
	-	quick check" to ensure			identified and what corrective action will be taken?		
		sher is available and will			action will be taken:		
	_	ended to give reasonable			*Residents, staff, and visitors in the		
		e extinguisher is fully			Therapy Room in the Rehabilitation		
		rable, verifying that it is			Wing have the potential to be		
	_	place, it has not been			affected by the alleged deficient		
	_	ered with and there is no			practice.		
		cal damage or condition			*All ABC type fire extinguishers have		
	* *	eration. This deficient			been audited by Maintenance	-	
	1 ^	fect 5 residents, staff and			Director/Designee to ensure they		
	visitors in the Th	nerapy Room of the			have had their monthly inspections		
	Rehabilitation W	ling.			completed.		
					3. What measures will be put into		
	Findings include	y:			place or what systemic changes wil		
					be made to ensure that the		
		ation with the Director of			deficient practice does not recur?		
	Maintenance and	d the Regional Facilities					
		a tour of the facility from			*Maintenance Director/Designee		
	12:40 p.m. to 3:0	05 p.m. on 10/07/16, the			will audit all ABC type fire		
	portable ABC ty	pe fire extinguisher in			extinguishers to ensure they are		
					inspected monthly.		

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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) TAG THO Therapy Room of the Rehabilitation Wing had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in January 2016. However, a monthly inspection was not documented for September 2016. Based on interview at the time of observation, the Director of Maintenance stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for September 2016. 3.1-19(b) SUMMARY STATEMENT OF DEFICIENCY INDIANAPOLIS, IN 46237 ID PREFIX TAG PREFIX TAG **Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring all ABC type fire extinguishers are inspected monthly. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be unto recur, what quality assurance program will be put into place? **Fire Extinguisher CQI will be completed monthly x 4, and quarterly thereafter until compliance is at 100% by Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee monthly times 4, and quarterly thereafter until compliance is at 100%. Frequency		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	` ′	UILDING 'ING	ONSTRUCTION 02	(X3) DATE COMPL 10/07	ETED	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (The Therapy Room of the Rehabilitation Wing had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in January 2016. However, a monthly inspection was not documented for September 2016. Based on interview at the time of observation, the Director of Maintenance stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented for September 2016. 3.1-19(b) PREFIX TAG *Maintenance Director/Designee Director will be educated by October 27, 2016 by Administrator/Designee on ensuring all ABC type fire extinguishers are inspected monthly. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? *Fire Extinguisher COI will be completed monthly x 4, and quarterly thereafter until compliance is at 100% by Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee monthly times 4, and quarterly thereafter until									
and duration of reviews will be increased as needed, if compliance is below 100%.	(X4) ID PREFIX	summary (EACH DEFICIE REGULATORY O the Therapy Ro Wing had an in extinguisher wh inspection was 2016. Howeve was not docume Based on interv observation, the stated no other inspection docu for review and inspection for ti portable fire ex documented for	statement of deficiencies NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) om of the Rehabilitation spection tag affixed to the nich indicated an annual conducted in January r, a monthly inspection ented for September 2016. riew at the time of e Director of Maintenance monthly fire extinguisher imentation was available acknowledged a monthly the aforementioned tinguisher was not		ID PREFIX	*Maintenance Director/Designee Director will be educated by Octobe 27, 2016 by Administrator/Designee on ensuring all ABC type fire extinguishers are inspected monthle 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? *Fire Extinguisher CQI will be completed monthly x 4, and quarterly thereafter until compliance is at 100% by Maintenance Director/Designee. *The results of these audits will be reviewed by the Quality Assurance Committee monthly times 4, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance	er e y.	COMPLETION	

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