STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING -- B. WING	11/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/20/17 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Emergency Preparedness survey, Altenheim Health and Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 87 certified beds. At the time of the survey, the census was 82. Quality Review completed on 11/30/17 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Life Safety Coode Survey on November 20, 2017 Please accept this plan of correction as Altenheim Health & Living's credible allegation of compliance by December 8, 2017.**	
E 0004 SS=C Bldg. --	Based on record review and interview,	E 0004	**I. The corrective actions**	12/08/2017

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

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

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	the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and agreed the aforementioned plan does not address policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach to assist the facility in addressing the needs of their patient populations, along with identifying the continuity of business operations and the facility's ability to collaborate with local emergency preparedness officials was not available		**to be accomplished for Altenheim Health & Living to be found in compliance is to:** Created Emergency Preparedness Binder addressing all E Tag requirements. Steps were made towards the completion of the Emergency Preparedness Binder, however was not able to complete prior to entrance of survey. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Emergency preparedness plan will be reviewed and updated annually by Administrator and DON. **IV The facility will**	

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	155196	A. BUILDING -- B. WING	11/20/2017

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	for review.		**monitor the corrective action by implementing the following measures.** Review of Emergency Preparedness Binder on annual basis during safety meeting by Administrator, DON or designee. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
E 0013 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include:	E 0013	**I. The corrective actions to be accomplished for Altenheim Health & Living to be found in compliance is to:** Created Emergency Preparedness Binder addressing all E Tag	12/08/2017

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	155196	A. BUILDING -- B. WING	11/20/2017

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	Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. Policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and the aforementioned plan does not address policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach.		requirements. Steps were made towards the completion of the Emergency Preparedness Binder, however was not able to complete prior to entrance of survey. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Emergency preparedness plan will be reviewed and updated annually by Administrator and DON. **IV The facility will monitor the corrective action by implementing the following measures.** Review of Emergency Preparedness Binder on annual basis during safety meeting by Administrator,	

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	155196	A. BUILDING -- B. WING	11/20/2017

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			DON or designee. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
E 0029 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was	E 0029	**I. The corrective actions to be accomplished for Altenheim Health & Living to be found in compliance is to:** Created Emergency Preparedness Binder addressing all E Tag requirements. Steps were made towards the completion of the Emergency Preparedness Binder, however was not able to complete prior to entrance of survey.	12/08/2017

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	155196	A. BUILDING -- B. WING	11/20/2017

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	not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period and the plan does not include a communication plan that contains how the facility coordinates patient care within the facility, across health care providers, and coordination with state and local public health departments.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Emergency preparedness plan will be reviewed and updated annually by Administrator and DON. **IV The facility will monitor the corrective action by implementing the following measures.** Review of Emergency Preparedness Binder on annual basis during safety meeting by Administrator, DON or designee. **V. Plan of Correction completion date.** Plan of Completion date is	

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			December 8, 2017	
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was	E 0037	**I. The corrective actions to be accomplished for Altenheim Health & Living to be found in compliance is to:** Created Emergency Preparedness Binder addressing all E Tag requirements. Steps were made towards the completion of the Emergency Preparedness Binder, however was not able to complete prior to entrance of survey. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Emergency preparedness	12/08/2017

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	not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not conducted a community based disaster drill, conducted initial training in emergency preparedness policies and procedures or had its emergency preparedness program reviewed by the facility within the most recent twelve month period.		plan will be reviewed and updated annually by Administrator and DON. **IV The facility will monitor the corrective action by implementing the following measures.** Review of Emergency Preparedness Binder on annual basis during safety meeting by Administrator, DON or designee. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using	E 0039	**I. The corrective actions to be accomplished for Altenheim Health & Living to be found in compliance**	12/08/2017

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	the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include:		**is to:** Created Emergency Preparedness Binder addressing all E Tag requirements. Steps were made towards the completion of the Emergency Preparedness Binder, however was not able to complete prior to entrance of survey. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Emergency preparedness plan will be reviewed and updated annually by Administrator and DON. **IV The facility will monitor the corrective action by implementing the following measures.**	

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	Based on review of "Disaster Preparedness Plan" documentation with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not conducted a community based disaster drill or had its emergency preparedness program reviewed by the facility within the most recent twelve month period.		Review of Emergency Preparedness Binder on annual basis during safety meeting by Administrator, DON or designee. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/20/17 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code survey, Altenheim Health and Living Community	K 0000	**Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is**	

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	155196	A. BUILDING 01 B. WING	11/20/2017

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	was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 01 consists of the A, B and C wings of the first floor of a three story building with a basement and was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the A, B and C wings. The facility has a capacity of 87 and had a census of 82 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/30/17 - DA		**submitted in order to respond to the allegation of noncompliance cited during the Annual Life Safety Coode Survey on November 20, 2017 Please accept this plan of correction as Altenheim Health & Living's credible allegation of compliance by December 8, 2017.**	

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K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with			

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	7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors were provided with only one latching mechanism to release the door and open. LSC Section 19.2.2.2 states doors complying with 7.2.1 shall be permitted. LSC Section 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation.	K 0222	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The double lock located on egress door has been removed. **II. The facility will identify other residents**	12/08/2017

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	7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all over five staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, the corridor door to the Conference Room near the entrance to the B Wing was equipped with two latching devices consisting of door handle with a keypad lock and a separate thumb twist deadbolt lock. Based on interview at the time of the observations, The Director of Maintenance agreed the corridor door to the Conference Room was equipped with two latching mechanisms to release the door and open.		**that may potentially be affected by the deficient practice.** The Facility Maintenance Staff were re-educated on topics of ensuring that one locking method is used for all doors. The Maintenance Director and/or designee will physically inspect all doors to ensure proper operation of door locks. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All doors will be audited monthly during fire drills to ensure the use of one lock mechanism, per Life Safety Code regulations. **IV The facility will monitor the corrective**	

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			action by implementing the following measures. All monthly door lock audits will be reviewed at the facility QAPI meeting which is held monthly to ensure repairs have been checked by the Maintenance Director or Corporate Facilities. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2			

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	Based on observation and interview, the facility failed to ensure items stored in 1 of 4 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect over 15 residents, staff and visitors using the exit stairwell by the Laundry. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, the exit stairwell near the basement Laundry was marked as a facility exit. A metal shelf with cardboard boxes and additional cardboard boxes not on shelving were stored in the exit stairwell outside the Laundry in the basement. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned stairwell in the basement was used for storage which could interfere with egress. 3.1-19(b)	K 0225	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** All resident have the potential for being affected by this deficient practice. Housekeeping department and maintenance staff have been re-educated on leaving all stairwells exits free from storage items. Items were removed immediately from area. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident have the potential to be affected by this deficient practice. The facility Maintenance staff were re-educated on ensuring stairwell exits are free form storage, and other	12/08/2017

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			debris in accordance with Life Safety Code standards. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Director and / or designee will physically inspect all stairwell exits ongoing ensuring stairwells are free from clutter according to Life-Safety guidelines. **IV The facility will monitor the corrective action by implementing the following measures.** A daily check list will be provided to reflect the locations of each stairwell and that each is free from debris. Results of this audit will be reviewed at the	

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			monthly Quality Assurance Committee meeting. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 operating wrenches for the Post Indicator Valve	K 0353	**I. The corrective actions to be accomplished for those residents found to**	12/08/2017

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	(PIV) were secured to prevent tampering. LSC 4.6.12.2 states life safety features obvious to the public, even if not required, shall be maintained or removed. Sprinkler systems shall be maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 13.3.2.2 states the control valve inspection shall verify the valves are in the following condition: (a) in the normal open or closed position (b) sealed, locked or supervised (c) Accessible (d) Provided with appropriate wenches (e) Free from external leaks (f) Provided with appropriate identification. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, the operating wrench for the PIV was not secured to the PIV to prevent the loss of the wrench or additional tampering. The PIV was located outside of the building near the main entrance. Based on interview at the time of the observations, the Director of Maintenance agreed the operating wrench for the PIV was not secured to prevent		**have been affected by the deficient practice.** The Maintenance staff placed a pad lock on the operating wrench to secure the PIV and prevent the loss of wrench or additional tampering, per Life Safety Code. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected by this deficient practice. The Maintenance staff members were re-educated on the requirements for securing the PIV wrench. The Maintenance Director and / designee will physically inspect wrench to ensure it remains secured, ongoing.	

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	the loss of the wrench or additional tampering. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The wrench will be audited daily on going to maintain Life Safety Code standards. **IV The facility will monitor the corrective action by implementing the following measures.** Result of the daily audits will be reviewed at the facility QAPI meeting which is held monthly to ensure the wrench remains secured properly. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting.	

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			V. Plan of Correction completion date. Plan of Completion date is December 8, 2017.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 50 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies	K 0355	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Maintenance Director have contacted the vendor to complete the annual maintenance of the two fire extinguishers per Life Safety Code. **II. The facility will identify other residents that may potentially be**	12/11/2017

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	the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, Team 360 Services had affixed a maintenance tag to the portable fire extinguisher located in the corridor outside the Nursing Services Room in the northeast wing and to the portable fire extinguisher located in the corridor by the southeast stairwell but the tag did not indicate when the most recent annual maintenance was performed. Based on interview at the time of the observations, the Director of Maintenance agreed the maintenance tags did not indicate annual maintenance was documented for the two portable fire extinguishers within the most recent twelve month period. 3-1.19(b)		**affected by the deficient practice.** All residents have the potential to be affected by this deficient practice. The Maintenance Director and staff members were re-educated on the importance to ensure all fire extinguishers have received the annual maintenance serviced **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Audits of all extinguisher will be performed by Maintenance Director or designee monthly **IV The facility will monitor the corrective action by implementing the following measures.**	

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			Result of the monthly audits will be reviewed at the facility QAPI meeting which is held monthly to ensure the wrench remains secured properly. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed.			

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	There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the	K 0363	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Door closer have been added to beauty shop and Gift Shop doors	12/08/2017

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	facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, the corridor door to the Beauty Shop and the corridor door to the Gift Shop were each propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor doors had an impediment to closing and latching. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident could be affected by the deficient practice. The Maintenance staff members were educated on the requirement for keeping doors closed and free hold open devices according to the standards and practices set forth by Life Safety Code The Maintenance Director and / or designee will physically inspect both rooms to ensure door closer are working properly and that both doors are free from devices that could keep doors open. **III. The facility will put into place the following systematic changes to**	

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			ensure that the deficient practice does not recur. Beauty Shop and Gift Shop will be audited daily ongoing to ensure door closers are working properly and doors are free from any device that could keep doors open, per Life Safety Code standards. **IV The facility will monitor the corrective action by implementing the following measures.** The Beauty Shop and Gift Shop audits will be reviewed at the facility QAPI meeting which is held monthly to ensure compliance, ongoing. **V. Plan of Correction completion date.**	

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			Plan of Completion date is December 8, 2017	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation and interview; the facility failed to document testing of 2 of 2 elevator firefighter's service recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a	K 0531	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	12/08/2017

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	written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over five residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation of monthly firefighter's service recall testing for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility does not perform elevator recall testing and stated documentation of monthly firefighter's service recall testing for the most recent twelve month period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, two elevators equipped with firefighter's service recall were noted in the facility. Thyssen Krupp "Hydraulic Elevator Maintenance Tasks and Records" documentation in the first floor elevator machine room indicated firefighter's service recall testing had been performed for one month of the most recent twelve		Elevator was tested for recall on 12/01/2017, recall keys to be secured so Maintenance Director can perform monthly test. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident could be affected by the deficient practice. The Maintenance staff members were educated on the requirement for keeping elevators inspected, according to the standards and practices set forth by Life Safety Code **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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	month period during their annual elevator inspection on 03/14/17. 3.1-19(b)		Monthly audits to be completed by Maintenance Director or designee to ensure that all fire recall test have been completed for that required testing period, ongoing per Life Safety Code standards. **IV The facility will monitor the corrective action by implementing the following measures.** Each monthly recall test will be reviewed during QAPI meeting which is held monthly to ensure compliance, ongoing. **V. Plan of Correction completion date.** Plan of Completion date is	

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

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	NFPA 111, 700.10 (NFPA 70) Based on record review, observation and interview; the facility failed to ensure 3 of 3 emergency task generator battery backup lights was maintained. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. LSC Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) 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 residents, staff and visitors in the facility. Findings include: Based on review of "TELS Logbook Documentation" for emergency generator load testing within the most recent twelve month period with the Director of	K 0918	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Maintenance Director to conduct and maintain logs for the monthly emergency testing of the battery backup lights according to Life-Safety standards. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident could be affected by the deficient practice. The Maintenance staff members were educated on the requirement for keeping monthly logs for emergency light testing according to the standards and practices set forth by Life Safety Code	12/08/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 01 B. WING	11/20/2017

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	Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation of monthly battery light testing for thirty seconds was not available for review. The aforementioned documentation stated "yes" in three checkboxes in response to "Battery-Powered Lighting On-Site?" Based on an interview at the time of record review, the Director of Maintenance stated the facility has three battery backup lights located in the generator room in the basement and agreed the aforementioned documentation did not indicate the duration of battery backup light testing. Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, three battery backup lights were located in the basement generator room and each lighting system illuminated when its respective test button was pushed. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Monthly audits to be completed by Maintenance Director or designee to ensure that all monthly emergency light testing have been completed for that required testing period, ongoing per Life Safety Code standards. Results of audits will be reviewed during the monthly quality assurance meetings. TELLS task has been added to the preventative maintenance plate form. **IV The facility will monitor the corrective action by implementing the following measures.**	

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			Monthly audits reflecting the completion of emergency light testing completed by Maintenance Director or designee. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017	
K 0000 Bldg. 02	A Life Safety Code Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/20/17 Facility Number: 000103 Provider Number: 155196 AIM Number: 100290000 At this Life Safety Code Survey, Altenheim Health and Living Community was found not in compliance with	K 0000	**Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of**	

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of Building 01 and Building 02. Building 02 consists of the one story Rehabilitation Wing constructed in 2014 and was determined to be of Type V (111) construction and was fully sprinklered. The Rehabilitation Wing has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the fire alarm system in resident sleeping rooms. The facility has a capacity of 87 and had a census of 82 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/30/17 - DA		**noncompliance cited during the Annual Life Safety Coode Survey on November 20, 2017 Please accept this plan of correction as Altenheim Health & Living's credible allegation of compliance by December 8, 2017.**	
K 0353 SS=C Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure 1 of 1 operating wrenches for the Post Indicator Valve (PIV) were secured to prevent tampering. LSC 4.6.12.2 states life safety features obvious to the public, even if not required, shall be maintained or removed. Sprinkler systems shall be maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 13.3.2.2 states the control valve inspection shall verify the valves are in the following condition: (a) in the normal open or closed position (b) sealed, locked or supervised (c) Accessible (d) Provided with appropriate wenches (e) Free from external leaks (f) Provided with appropriate identification. This deficient	K 0353	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Maintenance staff placed a pad lock on the operating wrench to secure the PIV and prevent the loss of wrench or additional tampering, per Life Safety Code. **II. The facility will**	12/08/2017

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	practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, the operating wrench for the PIV was not secured to the PIV to prevent the loss of the wrench or additional tampering. The PIV was located outside of the building near the main entrance. Based on interview at the time of the observations, the Director of Maintenance agreed the operating wrench for the PIV was not secured to prevent the loss of the wrench or additional tampering. 3.1-19(b)		**identify other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected by this deficient practice. The Maintenance staff members were re-educated on the requirements for securing the PIV wrench. The Maintenance Director and / designee will physically inspect wrench to ensure it remains secured, ongoing. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The wrench will be audited daily on going to maintain Life Safety Code standards. **IV The facility will**	

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			monitor the corrective action by implementing the following measures. Result of the daily audits will be reviewed at the facility QAPI meeting which is held monthly to ensure the wrench remains secured properly. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting. **V. Plan of Correction completion date.** Plan of Completion date is December 8, 2017.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life			

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to ensure 3 of 3 emergency task generator battery backup lights was maintained. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors	K 0918	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Maintenance Director to conduct and maintain logs for the monthly emergency testing of the battery	12/08/2017

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	in enclosures that do not include walk-in access. LSC Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) 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 residents, staff and visitors in the facility. Findings include: Based on review of "TELS Logbook Documentation" for emergency generator load testing within the most recent twelve month period with the Director of Maintenance during record review from 8:45 a.m. to 12:00 p.m. on 11/20/17, documentation of monthly battery light testing for thirty seconds was not available for review. The aforementioned documentation stated "yes" in three checkboxes in response to "Battery-Powered Lighting On-Site?" Based on an interview at the time of record review, the Director of Maintenance stated the facility has three battery backup lights located in the		backup lights according to Life-Safety standards. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All resident could be affected by the deficient practice. The Maintenance staff members were educated on the requirement for keeping monthly logs for emergency light testing according to the standards and practices set forth by Life Safety Code **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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	generator room in the basement and agreed the aforementioned documentation did not indicate the duration of battery backup light testing. Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 4:00 p.m. on 11/20/17, three battery backup lights were located in the basement generator room and each lighting system illuminated when its respective test button was pushed. 3.1-19(b)		Monthly audits to be completed by Maintenance Director or designee to ensure that all monthly emergency light testing have been completed for that required testing period, ongoing per Life Safety Code standards. Results of audits will be reviewed during the monthly quality assurance meetings. TELLS task has been added to the preventative maintenance plate form. **IV The facility will monitor the corrective action by implementing the following measures.** Monthly audits reflecting the completion of emergency light testing completed by Maintenance Director or designee. **V. Plan of Correction completion date.**	

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			Plan of Completion date is December 8, 2017	