PRINTED: 12/19/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING			ETED
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	<u> </u>	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0004	conducted by the Department of 1 42 CFR 483.73. Survey Date: 1 Facility Number Provider Number: At this Emerger Altenheim Heal was found not in Emergency Prefor Medicare and Providers and Stime of the survey Quality Review DA The requirement	Health in accordance with 1/20/17 r: 000103 er: 155196	E 00	000	Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its managem company that the allegation contained in the survey reports a true and accurate portration of the provision of nursing or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and Stat Law. The Plan of Correction submitted in order to respon to the allegation of noncompliance cited during the Annual Life Safety Cood Survey on November 20, 20 Please accept this plan of correction as Altenheim Hea & Living's credible allegatio of compliance by December 2017.	ent s ort yal care n s te n is nd	
SS=C Bldg	Based on record	I review and interview,	E 00	004	I. The corrective action	s	12/08/2017

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

TITLE

000103

(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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	l í	JILDING	ONSTRUCTION	(X3) DATE S COMPL 11/20/	ETED
	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 BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	an emergency pr reviewed and up	to develop and maintain eparedness plan that was dated at least annually in 42 CFR 483.73(a). This e could affect all			to be accomplished for Altenheim Health & Liv to be found in compliant is to:	ing	
	Based on review Preparedness Plathe Director of Marcord review from the p.m. on 11/20/17 complete emerge by the facility was twelve month perfor review. Based				Created Emergency Preparedness Binder addressing all E Tag requirements. Steps we made towards the completion of the Emergency Preparedne Binder, however was no able to complete prior to entrance of survey.	ss t	
	had its emergence reviewed by the recent twelve me the aforemention policies and proof facility and com- assessment and com-	ted the facility has not by preparedness program facility within the most onth period and agreed ted plan does not address redures based on a munity based risk communication plan azards approach to assist			III. The facility will put in place the following systematic changes to ensure that the deficient practice does not recurrent. Emergency preparedness	nt r.	
	the facility in add their patient pop- identifying the coperations and the collaborate with	dressing the needs of ulations, along with ontinuity of business he facility's ability to			plan will be reviewed an updated annually by Administrator and DON. IV The facility will		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196			A. BUILDING B. WING	INSTRUCTION	COMPLETED 11/20/2017		
	ROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUN	NITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DI (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	for review.			monitor the corrective action by implementing the following measures.			
				Review of Emergency Preparedness Binder on annual basis during safet meeting by Administrator DON or designee.	· I		
				V. Plan of Correction completion date.			
				Plan of Completion date i December 8, 2017	s		
E 0013 SS=C Bldg							
Ü	Based on record review and in the facility failed to develop a implement emergency prepare policies and procedures. The and procedures must be revieu pdated at least annually in activity with 42 CFR 483.73(b). This	edness policies wed and ccordance	E 0013	I. The corrective actions to be accomplished for Altenheim Health & Livin to be found in complian- is to:	ng		
	practice could affect all occup Findings include:	oants.		Created Emergency Preparedness Binder addressing all E Tag			

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	OF CORRECTION IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	COMPLETED 11/20/2017			
	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 PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE			
TAG	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. Step made towards the completion of the Emergency Prepar Binder, however wable to complete pentrance of survey III. The facility will place the followin systematic changensure that the depractice does not Emergency prepar plan will be review updated annually be Administrator and IV The facility will monitor the correspondence of the following means	edness as not rior to put into g es to eficient recur. edness ed and by DON. ill ctive enting sures.			
		Preparedness Bind annual basis during meeting by Admini	g safety			

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	OF CORRECTION OF CORRECTION 155196 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/20/2017		
	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		
E 0029 SS=C			V. Plan of Correction completion date. Plan of Completion date December 8, 2017	is		
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 & Livit to be found in compliant 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.	ng ce		

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	of Correction identification number: 155196	A. BUILDING B. WING	ONSTRUCTION	COMPLETED 11/20/2017
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	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		III. The facility will put in place the following systematic changes to ensure that the deficien practice does not recur	t
	contains how the facility coordinates patient care within the facility, across health care providers, and coordination with state and local public health departments.		Emergency preparednes 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 safe meeting by Administrator DON or designee.	·
			V. Plan of Correction completion date.	
			Plan of Completion date	is

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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 B. WING			COMPLETED 11/20/2017	
		155196	D. W	_		11/20/	2017
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
	EIM HEALTH & LIV		INDIANAPOLIS, IN 46237				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
1710	REGGE/TTORT OR	LEGE IDENTIFIER IN GRAZITORY		1710	December 8, 2017		DATE
					December 0, 2017		
E 0037 SS=C Bldg	Based on record	review and interview,	E 0	037	I. The corrective actions	s	12/08/2017
	1	d to ensure the emergency ining and testing			to be accomplished for Altenheim Health & Livi	na	
		s a training program. The			to be found in complian	_	
		st do all of the following:			is to:		
	(i) Initial training	g in emergency					
	preparedness po	licies and procedures to					
	all new and exist	ting staff, individuals			Created Emergency		
	ı ^	es under arrangement,			Preparedness Binder		
		consistent with their			addressing all E Tag		
	_	ii) Provide emergency			requirements. Steps were	e	
		ining at least annually;			made towards the	-	
	` ′	cumentation of the			completion of the		
	training; (iv) De				Emergency Preparednes	s	
	_	nergency procedures in			Binder, however was not		
		42 CFR 483.73(d)(1). ractice could affect all			able to complete prior to		
	occupants.	active could affect aff			entrance of survey.		
	occupants.						
	Findings include	: :					
					III. The facility will put in	ito	
	Based on review	of "Disaster			place the following		
	Preparedness Pla	an" documentation with			systematic changes to		
	the Director of N	Maintenance during			ensure that the deficient	-	
	record review from	om 8:45 a.m. to 12:00			practice does not recur.		
	p.m. on 11/20/17	7, documentation for a					
		ency preparedness					
	program reviewe	ed by the facility within			 Emergency preparedness	s	
	the most recent t	welve month period was			Emergency preparedness	ر	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE : COMPL		
		155196	B. WI			11/20/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		3525 E HANNA AVE				
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
		review. Based on			plan will be reviewed and		
	interview at the time of record review, the Director of Maintenance stated the				updated annually by Administrator and DON.		
					Auministrator and DON.		
	-	onducted 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						
					IV The facility will		
					monitor the corrective		
					action by implementing		
	recent twelve mo			the following measures.			
					Review of Emergency		
					Preparedness Binder on		
					annual basis during safet	у	
					meeting by Administrator	,	
					DON or designee.		
					V. Plan of Correction		
					completion date.		
					oompronon autor		
					Diamet C. I. II.	_	
					Plan of Completion date i	S	
					December 8, 2017		
E 0039							
SS=C Bldg							
ыug	Rased on record	review and interview,	E 00)39	I. The corrective actions	2	12/08/2017
		I to conduct exercises to			to be accomplished for	•	12/00/2017
	_	cy plan at least annually,			Altenheim Health & Livii	na	
	_	ounced staff drills using			to be found in complian	•	
	unuilli				oompilan		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	r í	JILDING	ONSTRUCTION	(X3) DATE S COMPLI 11/20/	ETED
	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	facility must do a participate in a fi community-base community-base accessible, an ind If the LTC facili natural or man-n requires activation the LTC facility in a community- facility-based full year following the event; (ii) condu- that may include				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.	ss	
	exercise that is c individual, facili exercise that incl led by a facilitate clinically-releval and a set of prob messages, or pre	ommunity-based or ty-based. (B) a tabletop ludes a group discussion or, using a narrated, nt emergency scenario, lem statements, directed pared questions designed emergency plan; (iii)			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.		
	analyze the LTC maintain docume tabletop exercise and revise the LT plan, as needed	facility's response to and entation of all drills, es, and emergency events, FC facility's emergency in accordance with 42			Emergency preparednes plan will be reviewed and updated annually by Administrator and DON.		
	practice could af Findings include	fect all occupants.			IV The facility will monitor the corrective action by implementing the following measures		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING		COMPLETED	
		155196	B. W	NG		11/20/2017	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	the Director of Norecord review from the p.m. on 11/20/17 complete emerge program reviewed the most recent to the most recent to the Director of Norecord facility has not complete the disaster draward disaster draward from the Director of Norecord facility has not comprehenced by the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director of Norecord facility has not comprehenced from the Director facility has not comprehenced from t	of "Disaster an" documentation with Maintenance during om 8:45 a.m. to 12:00 7, documentation for a ency preparedness ed by the facility within welve month period was review. Based on time of record review, Maintenance stated the onducted a community ill or had its emergency ogram reviewed by the e most recent twelve			Review of Emergency Preparedness Binder on annual basis during safet meeting by Administrator DON or designee. V. Plan of Correction completion date. Plan of Completion date is December 8, 2017	,	
K 0000							
Bldg. 01							
	State Licensure State Indiana State accordance with Survey Date: 11 Facility Number Provider Number AIM Number: 1 At this Life Safe	: 000103 r: 155196 00290000	K 0	000	Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its manageme company that the allegations contained in the survey repo is a true and accurate portray of the provision of nursing correction of the provision of nursing correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction	ent 6 rt yal are 1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 01 COMPLETED					
		155196	B. W	B. WING			11/20/2017	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
IAU	was found not in Requirements for Medicare/Medic	a 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 sisists of Building 01 and ailding 01 consists of the gs of the first floor of a ling with a basement and to be of Type II (222) I was fully sprinklered. a fire alarm system with on all levels in the all areas open to the acility has smoke wired to the building in the A, B and C lity has a capacity of 87 s of 82 at the time of this residents have customary inklered. All areas		IAU	submitted in order to respon to the allegation of noncompliance cited during the Annual Life Safety Coode Survey on November 20, 201 Please accept this plan of correction as Altenheim Hea & Living's credible allegation of compliance by December 2017.) 7 Ith	DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	01	COMPL	LETED
		155196	B. W	ING		11/20	/2017
		1		omp see	DDDEGG GWYL GDATT GW GOL		
NAME OF F	PROVIDER OR SUPPLIER	£			ADDRESS, CITY, STATE, ZIP CODE		
A1		WN 10 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			HANNA AVE		
ALTĒNH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0222	NFPA 101						
SS=D	Egress Doors						
Bldg. 01	Egress Doors						
J	Doors in a require	d means of egress shall					
		vith a latch or a lock that					
	I -	of a tool or key from the					
	egress side unless using one of the						
		ocking arrangements:					
		OR SECURITY THREAT					
	LOCKING	1.5					
	<u> </u>	king arrangements for the					
		eeds of the patient are cking device shall be					
		door and provisions shall					
	1 •	apid removal of occupants					
		l of locks; keying of all					
	1 -	ied by staff at all times; or					
	I	e 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					
	ARRANGEMENT	S					
		king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					
		at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
		d by a complete smoke (or is constantly monitored					
	1	ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.	god to dimeon the deere					
	18.2.2.2.5.2, 19.2.	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENTS						
	Approved, listed d	lelayed-egress locking					
	systems installed	in accordance with					
							İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED B. WING 11/20/2017				
		155196	B. W.	ING		11/20/	2017
NAME OF P	PROVIDER OR SUPPLIER	8	•	1	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, 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)	TE	COMPLETION
TAG	,			TAG	DEFICIENCE		DATE
	7.2.1.6.1 shall be assemblies servin contents in buildin by an approved, significant detection system as supervised autom 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detection auto	permitted on door g low and ordinary hazard gs protected throughout supervised automatic fire or an approved, atic sprinkler system2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies lance with 7.2.1.6.2 shall .2.4 BY EXIT ACCESS NGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an ised automatic sprinkler .2.4 ration and interview, the ensure 1 of over 50 rere provided with only chanism to release the LSC Section 19.2.2.2 uplying with 7.2.1 shall SC Section 7.2.1.5.10 other fastening device on	K 0	222	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The double lock located of) 10	12/08/2017
	releasing device method of opera	be provided with a that has an obvious tion and that is readily all lighting conditions.			egress door has been removed.	211	
	mechanism shall	l open the door leaf with ne releasing operation.			II. The facility will identify other residents		

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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. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		155196	B. W	ING		11/20/2	2017
e o e				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	ę.		3525 E	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)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· ·	\longrightarrow	DATE
	7.2.1.5.10.1 states the releasing mechanism for any latch shall be located				that may potentially be		
		·			affected by the deficient	[
		inches, and not more			practice.		
	•	above the finished floor.					
	_	ractice could affect all					
	over five staff an	nd visitors.			The Facility Maintenance	,	
					Staff were re-educated of		
	Findings include	2:					
	Based on observations with the Director of Maintenance during a tour of the				topics of ensuring that one		
					locking method is used for all doors. The Maintenan		
	facility from 1:00 p.m. to 4:00 p.m. on				Director and/or designee		
	11/20/17, the corridor door to the				will physically inspect all		
		m near the entrance to			doors to ensure proper		
		equipped with two			operation of door locks.		
	_	consisting of door					
	_	eypad lock and a separate					
		dbolt lock. Based on			III. The facility will put in	nto	
		time of the observations,		place the following			
		·			systematic changes to		
		Maintenance agreed the			ensure that the deficien		
		the Conference Room					
	was equipped w	•			practice does not recur.		
	mechanisms to r	release the door and open.					
					All doors will be audited		
					monthly during fire drills t	<u>.</u> 0	
					ensure the use of one loc		
					mechanism, per Life Safe		
					Code regulations.	, ty	
					Code regulations.		
					IV The facility will		
					monitor the corrective		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING O1			(X3) DATE SURVEY COMPLETED	
ANDILAN	OI CORRECTION	155196		A. BUILDING <u>01</u> COMPLETED B. WING 11/20/2017				
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	·		(X5)	
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
					action by implementing the following measures.			
					All monthly door lock and will be reviewed at the facility QAPI meeting whi is held monthly to ensure repairs have been checked by the Maintenance Director or Corporate Facilities. Results of this audit will be reviewed at a monthly Quality Assurance Committee meeting and frequency and duration or reviews will be adjusted a needed.	ch ed the ce		
					V. Plan of Correction completion date.			
					Plan of Completion date December 8, 2017	s		
K 0225 SS=E Bldg. 01	Stairways and Sn Stairways and Sn as exits are in acc	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED B. WING 11/20/2017				
		155196	D. W.	_		11/20/2	2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
AI TENILI	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE IAPOLIS, IN 46237		
					1AF OLIS, IN 40231		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	DATE
1110		ation and interview, the	K 0		I. The corrective actions		12/08/2017
		ensure items stored in 1	100		to be accomplished for	'	12/00/2017
	1	escape stairways would			those residents found to	,	
		h egress. LSC 7.2.2.5.3.1			have been affected by the		
	states open space				deficient practice.		
		not be used for any			denoient praeties.		
		the potential to interfere					
		s deficient practice could					
	_	•			All resident have the		
	affect over 15 residents, staff and visitors using the exit stairwell by the Laundry.				potential for being affecte	:d	
	Findings include:				by this deficient practice.		
					Housekeeping departmer	I	
					and maintenance staff ha	ve	
	Rased on observ	ations with the Director			been re-educated on		
		during a tour of the			leaving all stairwells exits		
		0 p.m. to 4:00 p.m. on			free from storage items.		
	_	it stairwell near the			Items were removed		
		ry was marked as a			immediately from area.		
	facility exit. A r						
		and additional cardboard					
		elving were stored in the			II. The facility will		
		tside the Laundry in the			identify other residents		
		d on interview at the time			that may potentially be		
		ons, the Director of			affected by the deficient		
		reed the aforementioned			practice.		
	_	assement was used for					
		ould interfere with egress.					
	storage willen ee	vara mitoriore with egress.					
	3.1-19(b)				All resident have the		
	3.1 17(0)				potential to be affected by	′ I	
					this deficient practice. The		
					facility Maintenance staff		
					were re-educated on		
					ensuring stairwell exits ar		
					free form storage, and oth	ner	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017		
	ROVIDER OR SUPPLIER	ING COMMUNITY	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)	DATE		
				debris in accordance with Life Safety Code standard			
				III. The facility will put in place the following systematic changes to ensure that the deficient practice does not recur.	t		
				The Maintenance Director and / or designee will physically inspect all stairwell exits ongoing ensuring stairwells are 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 stairwel and that each is free from debris. Results of this aud will be reviewed at the	ı		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED			
	ĺ	55196	B. WING		11/20/2017		
	PROVIDER OR SUPPLIER EIM HEALTH & LIVIN	G COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				monthly Quality Assuran Committee meeting.	ce		
				V. Plan of Correction completion date.			
				Plan of Completion date December 8, 2017.	is		
K 0353 SS=C Bldg. 01	Sprinkler System - M Automatic sprinkler a are inspected, tested accordance with NFI Inspection, Testing, Water-based Fire Pr Records of system of inspection and testing secure location and a) Date sprinkler sy b) Who provided sy c) Water system su	PA 25, Standard for the and Maintaining of otection Systems. esign, maintenance, g are maintained in a readily available. estem last checked stem test pply source S information on n-required or partial					
	automatic sprinkler s 9.7.5, 9.7.7, 9.7.8, a	nd NFPA 25					
		on and interview, the sure 1 of 1 operating ost Indicator Valve	K 0353	I. The corrective action to be accomplished for those residents found t			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ĺ	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			
		155196	B. W	ING		11/20/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
			3525 E HANNA AVE			
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIANAPOLIS, IN 46237		
(X4) ID	SUMMARY STATEMENT 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 APPROPR DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	` ′	red to prevent tampering.			have been affected by the	ie
		tes life safety features			deficient practice.	
	obvious to the pr					
		e maintained or removed.				
		s shall be maintained in			The Maintenance staff	
		NFPA 25, Standard for			placed a pad lock on the	
		esting, and Maintenance			operating wrench to secu	re
		Fire Protection Systems,			the PIV and prevent the	. •
	2011 Edition. NFPA 25, Section 13.3.2.2 states the control valve inspection shall				loss of wrench or addition	nal
					tampering, per Life Safety	
	verify the valves are in the following condition: (a) in the normal open or closed position (b) sealed, locked or				Code.	′
	supervised (c) A	ccessible (d) Provided				
	with appropriate	wenches (e) Free from				
	external leaks (f)	Provided with				
	appropriate iden	tification. This deficient			II. The facility will	
	practice could af	fect all residents, staff			identify other residents	
	and visitors.				that may potentially be	
					affected by the deficient	
	Findings include	:			practice.	
	Based on observ	ations with the Director				
	of Maintenance	during a tour of the			All residents have the potentia	l to
	facility from 1:0	0 p.m. to 4:00 p.m. on			be affected by this deficient	
	11/20/17, the op	erating wrench for the			practice. The Maintenance sta	
	PIV was not seco	ured to the PIV to			members were re-educated or the requirements for securing to	
	prevent the loss of the wrench or				PIV wrench.	uic
	-	ring. The PIV was				
	_	of the building near the				
		Based on interview at the			The Maintenay Discrete	
		vations, the Director of			The Maintenance Director and designee will physically inspec	· ·
		reed the operating wrench			wrench to ensure it remains	``
	_	not secured to prevent			secured, ongoing.	

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	OF CORRECTION OF CORRECTION 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017		
	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		
	the loss of the wrench or additional tampering.					
	3.1-19(b)		III. The facility will put in place the following systematic changes to ensure that the deficien practice does not recur	t		
			The wrench will be audit daily on going to maintain Life Safety Code standar	n		
			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 whis held monthly to ensure the wrench remains secured properly. Result of this audit will be reviewat the monthly Quality Assurance Committee meeting.	ich e		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/20/2017			ETED	
		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
				V. Plan of Correction completion date.		
				Plan of Completion date in December 8, 2017.	is	
Portable Fire Extinuistalled, inspector accordance with Portable Fire Extinuistalled Fire Extinuistalled Fire Extinuistalled or facility failed to fire extinguishe maintenance in 10. LSC 9.7.4.1 extinguishers shinspected and movith NFPA 10. Section 7.3.1.1. shall be subject intervals of not time of hydrostal specifically indicates each fire tag or label seculindicates the modern accordance with modern accordance in the seculindicates the modern accordance with portable provided in the seculindicates accordance with portable provided in the provided in the seculindicates accordance with portable provided in the prov	nguishers Iguishers are selected, ed, and maintained in NFPA 10, Standard for Inguishers.	K 0	355	to be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director have contacted the vended to complete the annual maintenance of the two firextinguishers per Life Safety Code. II. The facility will identify other residents	o he or or	12/11/2017
I	NFPA 101 Portable Fire Exti 18.3.5.12, 19.3.5. Based on observ facility failed to fire extinguisher maintenance in 10. LSC 9.7.4.1 extinguishers sh inspected and m with NFPA 10. Section 7.3.1.1. shall be subject intervals of not time of hydrosta specifically indi electronic notifi states each fire of tag or label secu indicates the mo	OF CORRECTION IDENTIFICATION NUMBER: 155196 PROVIDER OR SUPPLIER IEIM HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	NFPA 101 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	DEPROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 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	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFCEBNCES (RACH DEFCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 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. 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. Standard for 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 extinguishers shall have a tag or label securely attached that indicates the month and year the	PROVIDER OR SUPPLIER FROM HEALTH & LIVING COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 Portable Fire Extinguishers 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 had documented annual maintenance in accordance with NFPA 10. States portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be selected, inspected and maintained in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.3 states each fire extinguishers shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 11/20/2017			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE				
ALTENH	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		
	identifies the nar performing the v practice could af staff and visitors	vork. This deficient fect over 20 residents,		All residents have the potential be affected by this deficient			
	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		practice. The Maintenance Director and staff members w re-educated on the importance ensure all fire extinguishers h received the annual maintena serviced	e to ave			
			III. The facility will put in place the following systematic changes to ensure that the deficient practice does not recur	ıt .			
	maintenance tags did not indicate ainual maintenance was documented for the two portable fire extinguishers within the most recent twelve month period. 3-1.19(b)		Audits of all extinguishe will be performed by Maintenance Director or designee monthly	r			
				IV The facility will monitor the corrective action by implementing the following measures			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDING B. WING	01	COMPLETED 11/20/2017		
	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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE		
			Result of the monthly a will be reviewed at the facility QAPI meeting w is held monthly to ensure the wrench remains secured properly. Resured properly. Resured this audit will be reviewed the monthly Quality Assurance Committee meeting. V. Plan of Correction completion date. Plan of Completion date.	which are ults ewed		
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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155196		(X2) MUI A. BUI B. WIN	LDING	nstruction 01	(X3) DATE : COMPL 11/20/	ETED	
	PROVIDER OR SUPPLIER			3525 E	APOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) There is no impediment to the closing of the		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	doors. Clearance and floor covering Roller latches are regulations on cor containing flamma materials. Powere 7.2.1.9 are permist that release when pulled are permitted Dutch doors meet permitted. Door frames shall steel or other mate 8.3, unless the sm sprinklered. Fixed are allowed per 8. compartments the area or fire resista window assemblie 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observ facility failed to corridor doors w means suitable for closed, had no in latching and wor smoke. This defaffect over 20 re	between bottom of door is not exceeding 1 inch. prohibited by CMS ridor doors and rooms able or combustible d doors complying with sible. Hold open devices the door is pushed or ed. Nonrated protective height are permitted. Ing 19.3.6.3.6 are be labeled and made of erials in compliance with toke compartment is fire window assemblies 3. In sprinklered re are no restrictions in nace of glass or frames in its. Parts 403, 418, 460, 482, its details of doors such as angs, automatics closing atton and interview, the ensure 2 of over 50 ere provided with a parkeeping the door angediment to closing, alld resist the passage of ficient practice could sidents, staff and visitors.	K 03	63	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	o ne	12/08/2017

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017
	PROVIDER OR SUPPLIER	R YING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY 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 APPROPRIATION DEFICIENCY)	(X5) COMPLETION DATE
	11/20/17, the co Shop and the co Shop were each position with a v under the door. time of the obse Maintenance aga	0 p.m. to 4:00 p.m. on rridor door to the Beauty tridor door to the Gift propped in the fully open wedge placed on the floor Based on interview at the rvations, the Director of reed the aforementioned ad an impediment to ning.		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 hole open devices according to the standards and practice set forth by Life Safety Code The Maintenance Director and / or designee will physically inspect both rooms to ensure door closure working properly and that both doors are free from devices that could keep doors open.	e d o es
				III. The facility will put in place the following systematic changes to	to

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	OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUILDING B. WING	ONSTRUCTION 01	COMPLETED 11/20/2017
	ROVIDER OR SUPPLIE	R /ING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE JAPOLIS, 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 APPROPRI DEFICIENCY)	DATE
				ensure that the deficien practice does not recur	
				Beauty Shop and Gift Sh will be audited daily ongoing to ensure door closers are working prop and doors are free from device that could keep doors open, per Life Sai Code standards.	perly any
				IV The facility will monitor the corrective action by implementing the following measures	
				The Beauty Shop and G Shop audits will be reviewed at the facility QAPI meeting which is h monthly to ensure compliance, ongoing.	
				V. Plan of Correction completion date.	

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	OF CORRECTION OF CORRECTION 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017
	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
			Plan of Completion date December 8, 2017	is
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 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 action to be accomplished for those residents found to have been affected by the deficient practice.	0

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED
		155196	B. W	ING		11/20/2017
NAME OF F	DROVADED OD GUIDDI IEE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	C		3525 E	HANNA AVE	
	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, 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 LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
1710		f the findings made and	+	1110	Elevator was tested for	DATE
		nises as required by			recall on 12/01/2017, recall	all
		SA B44, Safety Code for			keys to be secured so	
		scalators. This deficient			Maintenance Director car	1
		ffect over five residents,			perform monthly test.	
	staff and visitors	·			,	
	Findings include	2.				
					II. The facility will	
	Based on record	review with the Director			identify other residents	
	of Maintenance	during record review		that may potentially be affected by the deficient		
	from 8:45 a.m. to	•				
		nentation of monthly			practice.	
	firefighter's serv	ice recall testing for the				
	most recent twel	ve month period was not				
	available for rev	iew. Based on interview			All resident could be	
	at the time of red	cord review, the Director			affected by the deficient	
		stated the facility does			practice. The Maintenance	e
		vator recall testing and			staff members were	
	stated document	ation of monthly			educated on the	
	_	ice recall testing for the			requirement for keeping	
		we month period was not			elevators inspected,	
	available for rev				according to the standard	
		th the Director of			and practices set forth by Life Safety Code	
		ring a tour of the facility			Life Salety Code	
		to 4:00 p.m. on 11/20/17,				
	_	uipped with firefighter's				
		ere noted in the facility.				
		"Hydraulic Elevator			III 71 C 114	
		sks and Records"			III. The facility will put in	το
		n the first floor elevator			place the following	
		ndicated firefighter's			systematic changes to	
		sting had been performed			ensure that the deficient	
	ioi one month of	f the most recent twelve			practice does not recur.	

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	OF CORRECTION OF CORRECTION 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017
	PROVIDER OR SUPPLIER	3525 E	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	month period during their annual elevator inspection on 03/14/17.			
	3.1-19(b)		Monthly audits to be completed by Maintenar Director or designee to ensure that all fire recal test have been complete for that required testing period, ongoing per Life Safety Code standards.	I ed
			IV The facility will monitor the corrective action by implementing the following measures	_
			Each monthly recall test be reviewed during QAF meeting which is held monthly to ensure compliance, ongoing.	
			V. Plan of Correction completion date.	
			Plan of Completion date	e is

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/20/2017
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
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		December 8, 2017	
	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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	l í	JILDING	onstruction 01	(X3) DATE : COMPL 11/20/	ETED
	PROVIDER 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)	TE.	(X5) COMPLETION DATE
	Based on record interview; the far of 3 emergency to backup lights was 110, Standard for Standby Power Standby Pow	review, observation and cility failed to ensure 3 ask generator battery s maintained. NFPA r Emergency and bystems, 2010 Edition, uires the Level 1 or ipment location(s) shall battery-powered ng. This requirement of units located outdoors at do not include walk-incition 7.9.3.1.1 (1) all testing shall be ally, with a minimum of 3 cimum of 5 weeks r not less than 30 ectional testing shall be	K 0	918	I. The corrective action to be accomplished for those residents found to have been affected by the deficient practice. Maintenance Director to conduct and maintain log for the monthly emergent testing of the battery backup lights according to Life-Safety standards. II. The facility will identify other residents	o he gs ccy	12/08/2017
	conducted annual 1/2 hours if the esystem is battery records of visual shall be kept by by the authority deficient practice residents, staff at Findings include Based on review Documentation" load testing with	lly for a minimum of 1 mergency lighting powered and (5) Written inspections and tests the owner for inspection having jurisdiction. This e could affect all and visitors in the facility.			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 emerger light testing according to standards and practices forth by Life Safety Code	t ce ncy the set	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/20/2017
	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
	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 in place the following systematic changes to ensure that the deficient practice does not recurred. Monthly audits to be completed by Maintenant Director or designee to ensure that all monthly emergency light testing have been completed for that required testing periongoing per Life Safety Code standards. Results audits will be reviewed during the monthly quality assurance meetings. TELLS task has been added to the preventative maintenance plate form.	t ce dd, of y
			monitor the corrective action by implementing the following measures	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPL	ETED	
		155196	B. Wl	B. WING		11/20/	2017
	ROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
					Monthly audits reflecting a completion of emergency light testing completed by Maintenance Director or designee. V. Plan of Correction completion date.	,	
K 0000					Plan of Completion date i December 8, 2017	s	ļ
Bldg. 02	42 CFR 483.90(a Survey Date: 11 Facility Number: Provider Number: AIM Number: 1 At this Life Safet Altenheim Healt	e Indiana State fealth in accordance with a). //20/17 = 000103 r: 155196 00290000	K 0	000	Submission of this plan of correction in no way constitutes an admission by Altenheim Health & Living Community or its manageme company that the allegations contained in the survey reports a true and accurate portray of the provision of nursing carrother 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 submitted in order to respond to the allegation of	rt yal are e is	

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	OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/20/2017		
	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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Medicare/Medic 483.90(a), Life S 2012 Edition of Protection Assoc Safety Code (LS	r Participation in aid, 42 CFR Subpart Safety from Fire and the the National Fire ciation (NFPA) 101, Life C), Chapter 19, Existing upancies and 410 IAC			noncompliance cited during the Annual Life Safety Coode Survey on November 20, 2017 Please accept this plan of correction as Altenheim Heal & Living's credible allegation of compliance by December 2017.	7 th	
	Building 02. Bu one story Rehabit constructed in 20 to be of Type V was fully sprinkl Wing has a fire a detection in the copen to the corridetectors hard w system in resider facility has a cap	sists of Building 01 and ilding 02 consists of the illitation Wing 014 and was determined (111) construction and lered. The Rehabilitation alarm system with smoke corridors, in all areas dor and has smoke ired to the fire alarm at sleeping rooms. The eacity of 87 and had a the time of this survey.					
	access were spring providing facility sprinklered.	residents have customary nklered and all areas y services were completed on 11/30/17 -					
K 0353 SS=C Bldg. 02	DA NFPA 101 Sprinkler System - Sprinkler System -	- Maintenance and Testing - Maintenance and Testing er and standpipe systems					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPL	ETED
		155196	B. WI	B. WING		11/20/	2017
ALTENH	PROVIDER OR SUPPLIER	ING COMMUNITY		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		(VE)
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
TAG	are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler. b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observed facility failed to wrenches for the (PIV) were secured. LSC 4.6.12.2 states obvious to the purequired, shall be Sprinkler system accordance with the Inspection, Tof Water-Based 2011 Edition. Notates the control verify the valves condition: (a) in closed position (supervised (c) A with appropriate external leaks (f)	ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a nd readily available. It system last checked System test Supply source RKS information on non-required or partial er system. It and NFPA 25 ation and interview, the ensure 1 of 1 operating er Post Indicator Valve ared to prevent tampering. It is life safety features ablic, even if not the maintained or removed. It is shall be maintained in NFPA 25, Standard for eresting, and Maintenance Fire Protection Systems, are Post Indicator Valve are in the following the normal open or b) sealed, locked or ccessible (d) Provided wenches (e) Free from	K 0		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 secuthe PIV and prevent the loss of wrench or addition tampering, per Life Safety Code. II. The facility will	ne re	12/08/2017

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/20/2017
	ROVIDER OR SUPPLIEF		3525 E	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN 46237	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE
	and visitors.	fect all residents, staff		identify other residents that may potentially be affected by the deficien	
	of Maintenance	ations with the Director during a tour of the		practice. All residents have the potenti	al to
	11/20/17, the op PIV was not second prevent the loss additional tampe located outside of	0 p.m. to 4:00 p.m. on erating wrench for the ured to the PIV to of the wrench or tring. The PIV was of the building near the Based on interview at the		be affected by this deficient practice. The Maintenance st members were re-educated of the requirements for securing PIV wrench.	aff on
	time of the obser Maintenance agr for the PIV was	rvations, the Director of reed the operating wrench not secured to prevent rench or additional		The Maintenance Director an designee will physically inspersive wrench to ensure it remains secured, ongoing.	
	3.1-19(b)			III. The facility will put i place the following systematic changes to ensure that the deficier practice does not recur	nt
				The wrench will be audi daily on going to maintai Life Safety Code standa	in
				IV The facility will	

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	of Correction identification number: 155196	A. BUILDING B. WING	02	COMPLETED 11/20/2017	
	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
			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 review at the monthly Quality Assurance Committee meeting.	S	
			V. Plan of Correction completion date.		
			Plan of Completion date is December 8, 2017.	s	
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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A BILLIPING Q2 COMPLITION 11/20/2017	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLER ALTENHEIM HEALTH & LIVING COMMUNITY SERVIX (AS ID SEMMANY STATEMENT OF DEPICIENCIES PREFIX TAG SEGULATORY OR SCIENTIFYING INFORMATION) 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 readity viable). EES electrical panels and circuits are marked and readity identifiable. EES electrical panels and circuits are marked and readity identifiable. EES electrical panels and circuits are marked and readity identifiable. EES of 3 amergency power source is a design consideration for new installations. 6.44, 6.54, 6.64, 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 ambly to mist located quintors.	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED			
ALTENHEIM HEALTH & LIVING COMMUNITY (V4) ID PREFIX TAG SIMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 completent 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 readity available. EES electrical panels and circuits are marked and readity identifiable. Hindrizing the possibility of damage of the emergency power source is a design consideration for new installations. 8.4.4, 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 annive to mist negative authors.	155196			B. WING 11/20/2017			
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shall not apply to units located outdoors for the monthly emergency	TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			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 log	s 12/08/2017 ne	
					for the monthly emergend		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	02	COMPLETED		
155196		B. W	B. WING		11/20/2017		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDED'S DI 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 APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	in enclosures tha	t do not include walk-in			backup lights according to	0	
	access. LSC Sec	etion 7.9.3.1.1 (1)			Life-Safety standards.		
	requires function	nal testing shall be					
	conducted month	nly, with a minimum of 3					
	weeks and a max	ximum of 5 weeks					
	between tests, fo	r not less than 30			II. The facility will		
	seconds, (3) Fun	ctional testing shall be			identify other residents		
	conducted annua	ally for a minimum of 1			that may potentially be		
	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				affected by the deficient		
					practice.		
					All resident could be		
	deficient practice				affected by the deficient		
residents, staff and visitors in the					practice. The Maintenance	e l	
	Findings include:				staff members were		
					educated on the		
					requirement for keeping		
	Rased on review	of "TFLS Lagbook			monthly logs for emerger	ıcv	
	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?"				light testing according to	· I	
					standards and practices		
					forth by Life Safety Code		
						,	
					III. The facility will put in	ito	
					place the following		
					systematic changes to		
					ensure that the deficient		
		rview at the time of			practice does not recur.		
	record review, th						
	Maintenance stated the facility has three						
battery backup lights located in the							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 02 COMPLETED B. WING 11/20/2017			ETED		
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY		<u> </u>	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)	TE	(X5) COMPLETION DATE
	agreed the afore documentation of duration of batter Based on observ of Maintenance facility from 1:0 11/20/17, three located in room and each l	lid not indicate the ery backup light testing. vations with the Director during a tour of the 10 p.m. to 4:00 p.m. on battery backup lights the basement generator lighting system in its respective test			Monthly audits to be completed by Maintenand 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 audits will be reviewed during the monthly quality assurance meetings. TELLS task has been added to the preventative maintenance plate form.	od, of	
					IV The facility will monitor the corrective action by implementing the following measures.		
					Monthly audits reflecting completion of emergency light testing completed by Maintenance Director or designee.	,	
					V. Plan of Correction completion date.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02	COMPLETED		
		155196	B. WING		11/20/2017		
	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	
				Plan of Completion date i December 8, 2017	is		

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