STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIES OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0031 SS=F	conducted by the In accordance with 42 Survey Date(s): 11. Facility Number: (Provider Number: AIM Number: 100) At this Emergency of Indianapolis was Emergency Prepare Medicare and Med and Suppliers, 42 (Control of The facility has 18-the survey, the central facility Review control of The requirement at MET as evidenced 403.748(c)(2), 41 403.748(c)(2), 41 441.184(c)(2), 48	2000032 155077 1273330 Preparedness survey, Envive of found not in compliance with extreme the extrements for iteration in the extreme for iteration in the extr	E 0000	PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the far alleged or conclusions set for on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitt to respond to the allegation of noncompliance cited during the Recertification and State Licensure completed on November 2, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 24, 2022. The provider respectfully requested desk review with paper compliance to be considered establishing that the provide in substantial compliance.	te cts orth ed of ss
Bldg	485.68(c)(2), 485	.102(c)(2), 485.625(c)(2), .727(c)(2), 485.920(c)(2), 1.12(c)(2), 494.62(c)(2)			
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE

KAVITA BERI HFA 11/22/2022

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION	(X3) DATE COMPL 11/02/	ETED	
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
IAU	Emergency Officia §403.748(c)(2), §4 §441.184(c)(2), §4 §483.73(c)(2), §4 §485.68(c)(2), §4 §485.920(c)(2). [(c) The [facility] in an emergency prepare plan that complies local laws and must least every 2 yes facilities]. The coninclude all of the form (i) Federal, State, emergency prepasion (ii) Other sources *[For LTC Facilities Contact information (i) Federal, State, emergency prepasion (ii) The State Lice Agency. (iii) The Office of to Ombudsman. (iv) Other sources *[For ICF/IIDs at § information for the (i) Federal, State, emergency prepasion (ii) Other sources (iii) The State Lice Agency.	als Contact Information 416.54(c)(2), §418.113(c)(2), 460.84(c)(2), §482.15(c)(2), 83.475(c)(2), §484.102(c)(2), 85.625(c)(2), §485.727(c)(2), 486.360(c)(2), §491.12(c)(2), 486.360(c)(2), §481.12(c)(2), 486.360(c)(2)		IAU			DATE	
	Agency.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			ETED	
		155077	B. WING 11/02/2022			2022	
				CTREET	ADDRESS OF A TE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
	OF INDIANIADOLIO				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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'	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Based on record rev	view and interview, the facility	E 00	031			11/24/2022
	failed to ensure the	emergency preparedness			POC- Life Safety		
		n included all applicable			ĺ		
	_	e. This deficient practice			Tag E0031		
	could affect all occi	-			SS-F		
					What corrective action(s) will	l	
	Findings include:				be accomplished for those	-	
	I mamga maraati				residents found to have beer	,	
	Based on review of	"Emergency Operations Plan"			affected by the deficient	•	
		d 09/28/22 with the Executive			practice?		
		or of Maintenance and the			practice:		
	· · · · · · · · · · · · · · · · · · ·	ance Director during record			No residents have been affect	od	
	_	m. to 1:45 p.m. on 11/01/22, the			by the deficient practice, but the		
		dness plan did not include			emergency preparedness plan		
		ana Department of Health				ı	
	_	ne at 317-460-7287 for			now includes contacting the		
		s that require a full or partial			Indiana Department of Health		
					(IDOH) by telephone at		
		nergency preparedness plan			317-460-7287 for emergency		
		the contact for IDOH using			incidents that require a full or		
	1	https://gateway.isdh.in.gov as			partial evacuation. The emerg	-	
		or by the secondary method			preparedness plan also includ		
		teway is nonoperational by			the contact for IDOH using the)	
		dent Reporting form and			Gateway link at		
		lents@isdh.in.gov. The			https://gateway.isdh.in.gov as	the	
		ets" section of the 09/28/22			primary method or by the		
	1 ~	ct the "Licensing Agency for			secondary method when the II	JOH	
		17/232-2960 which is the			Gateway is nonoperational by		
		interview at the time of record			completing the Incident Repor	ting	
		ve Director stated "IPLA" is			form and e-mailing it to		
	the Indiana Professi	ional Licensing Agency.			incidents@isdh.in.gov.		
	_	viewed with the Executive			How other residents having t		
		or of Maintenance and the			potential to be affected by th		
		ance Director during the exit			same deficient practice will b		
	conference.				identified and what corrective	е	
					action(s) will be taken.		
					No residents have been affect		
					by the deficient practice, but the		
					emergency preparedness plar	ı has	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/02/2022
	ROVIDER OR SUPPLIE		45 BE	ADDRESS, CITY, STATE, ZIP CO ACHWAY DR NAPOLIS, IN 46224	OD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION (X5) IOULD BE PPROPRIATE COMPLETION DATE
			now been updated in all binders located at seve locations in the building	eral different	
				What measures will be place and what system changes will be made ensure that the deficie practice does not recu	nic to ent
				The Emergency Prepart book will be Audited evonce a month by the M Director/designee. Maidirector /Designee will audit sheets back in the meeting next day to be The results of these aureviewed in Quality Assimeeting monthly for 6 runtil 100%complaince if for 3 consecutive month committee will identify a or patterns and make recommendations to replan of correction as incomposed in the second control of the second co	rery month aintenance intenance bring the e morning reviewed. dits will be surance months or is achieved hs. The QA any trends
				How the corrective act will be monitored to endeficient practice will recur, i.e., what quality assurance program with into place; and	nsure the not
				Maintenance Director/d will be Auditing the EPF month once a month. Maintenance director /I	P every

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD CHWAY DR		_
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this solid systems based on forth in paragraph §482.15(e)(1), §48 Emergency generations.	(e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.		TAG	will bring the audit sheets back the morning meeting next day be reviewed. The results of the audits will be reviewed in Quarance meeting monthly from this or until 100% complairs achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to rethe plan of correction as indicated. Date of compliance November 24th, 2022	y to nese ality or 6 nce vill s and vise	DATE
	the location requir	ements found in the Health					1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 2/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	Care Facilities Colliterim Amendments TIA 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or building 482.15(e)(2), §48. Emergency gener The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, Norde. 482.15(e)(3), §48. Emergency gener and LTC facilities source to power and LTC facilities source to power and LTC facilities source to power systems on the power systems on the standards incompared to the standards incomp	de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA nd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing ng is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must bergency power system g, and [maintenance] nd in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs of that maintain an onsite fuel benergency generators must have it will keep emergency perational during the sit evacuates. §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in peroved for incorporation by Director of the Office of the naccordance with 5 U.S.C. at part 51. You may obtain the sources listed below. In a copy at the CMS corporated by ore at the National ords Administration mation on the availability of						
	i inis material at NA	ARA, call 202-741-6030, or	1	1				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/02/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	of_federal_regular If any changes in a incorporated by redocument in the Fannounce the characteristic (1) National Fire FBatterymarch Parl Quincy, MA 02168 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issued (iii) Technical interination NFPA 99, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (vi) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Litedition, issued Auguin NFPA 101, Litedition, issued Auguin NFPA 101. (ix) TIA 12-1 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xii) NFPA 110, S Standby Power Syincluding TIAs to C2009. Based on record reversed.	rotection Association, 1 K, D, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	E 0041	POC- Life Safety	11/24/2022		
		ty failed to implement the ystem inspection, testing and		Tag E0041			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING		COMI	E SURVEY PLETED 2/2022			
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	maintenance required Care Facilities Code in accordance This deficient practice staff and visitors. a. Based on record in facility failed to ensign was performed for it generator. NFPA 99 2012 Edition, Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power Syst NFPA 110, Section shall be performed a approved by ASTM practice could affect visitors. Findings include: Based on record revisitors. Findings include: Based on record revisitors. Findings include:	ements found in the Health ence Director from 9:20 a.m. to 22, documentation of an annual the diesel fired emergency vailable for review, the prector ed the facility has one diesel		What corrective active accomplished for residents found to haffected by the deficient practice? No residents have been by the deficient practice? No residents have been by the deficient practice facility has performed quality test for the fact diesel-powered general desel-powered general desel-powered general desel-powered general desel-powered general desel-powered general desel-power described and what continued the deficient practice desel-power described and general facility's diesel-power described general desel-power deserved general de	on(s) will r those lave been cient een affected dice, but the diannual fuel cility's rator. s having the ted by the tice will be corrective en. een affected dice, but the dian audit on st for the red generator. ty test for the red generator be put into emic le to			
		. viewed with the Executive or of Maintenance and the		Annual fuel quality ted diesel-powered gener	st on the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/02/2022		
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
Corporate Mainter conference. b. Based on record interview; the facil period emergency emergency general 99 and NFPA 110. Code, 2012 Edition 1 and Type 2 esser sources (EPSS) she Class X, Level 1 g NFPA 110, the Sta Standby Powers Standby Powers States Level 1 once within every states Level 1 EPS	review, observation and ity failed to document 36 month generator testing for 1 of 1 ors in accordance with NFPA NFPA 99, Health Care Facilities and Section 6.4.1.1.6.1 states Type that electrical system power all be classified as Type 10, enerator sets per NFPA 110. Indard for Emergency and systems, 2010 Edition, Section EPSS shall be tested at least 36 months. Section 8.4.9.1	TAG	Audited every month once a month by the Maintenance Director/designee. Mainten director /Designee will bring audit sheets back in the mor meeting next day to be revie The results of these audits we reviewed in Quality Assurant meeting monthly for 6 month until 100%complaince is ach for 3 consecutive months. The committee will identify any troor patterns and make recommendations to revise the plan of correction as indicated.	ance the ning ewed. vill be ce ns or nieved ne QA ends		
4.2). Section 8.4.9 class is greater tha to terminate the test Section 8.4.9.5 statest shall be specif 8.4.9.5.3. Section EPS's, loading sha	its assigned class (See Section .2 states where the assigned in 4 hours, it shall be permitted at after 4 continuous hours. The sets the minimum load for this led in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3 states for spark-ignited all be the available EPSS load. Itice could affect all residents,		How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and Annual fuel quality test on the	put		
staff and visitors. Findings include:	,		diesel-powered generator wi Audited every month once a month by the Maintenance Director/designee. Mainten	ill be		
Director, the Director Corporate Mainter 1:45 p.m. on 11/01 emergency general four continuous he emergency general Based on interview the Director of Mainterview	view with the Executive tor of Maintenance and the ance Director from 9:20 a.m. to /22, thirty-six month period or testing documentation for urs for the diesel fired or was not available for review. v at the time of record review, intenance stated the facility has sergency generator and agreed		director /Designee will bring audit sheets back in the mor meeting next day to be reviee The results of these audits we reviewed in Quality Assurant meeting monthly for 6 month until 100% complaince is ach for 3 consecutive months. The committee will identify any troor patterns and make	the rning ewed. vill be ce ns or nieved ne QA		

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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 COMPLETED				
		155077	B. W	ING		11/02/2022	
	ROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR IAPOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	documentation of su	upplemental load testing for			recommendations to revise the	е	
	four hours within th	ne most recent three year			plan of correction as indicated		
	period was not avail	lable for review. Based on					
	observations with th	ne Executive Director, the					
	Director of Mainten	nance and the Corporate			Date of compliance		
		for during a tour of the facility			November 24th, 2022		
		1:50 a.m. on 11/02/22, the facility					
		emergency generator located					
	outside the building						
	_	Manufacturer's nameplate					
	rating for the generator stated it was rated at 600						
	kW.						
	TEL: C: 1:						
		viewed with the Executive					
		or of Maintenance and the					
	conference.	ance Director during the exit					
	conference.						
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	\mathbf{K}_{0}	000	PLAN OF CORRECTION FOR	₹	
	_	vas conducted by the Indiana	11 0	000	ENVIVE OF INDIANAPOLIS		
	-	th in accordance with 42 CFR			F000 INITIAL		
	483.90(a).				COMMENTS Preparation or		
					execution of this plan of		
	Survey Date(s): 11/	01/22 & 11/02/22			correction does not constitu	te	
					admission or agreement of		
	Facility Number: 0				provider of the truth of the fa	acts	
	Provider Number:				alleged or conclusions set fo	orth	
	AIM Number: 1002	273330			on the Statement of		
					Deficiencies. The Plan of		
	_	Code survey, Envive of			Correction is prepared and		
	-	und not in compliance with			executed solely because it is	•	
	Requirements for Pa	-			required by the position of		
		, 42 CFR Subpart 483.90(a),			Federal and State Law. The		
	-	re and the 2012 Edition of the			Plan of Correction is submitt		
		etion Association (NFPA) 101,			to respond to the allegation	Of	
		LSC), Chapter 19, Existing			noncompliance cited during		
	Health Care Occupa	ancies and 410 IAC 16.2			the Recertification and State		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155077	B. WING 11/02/2022			/2022	
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS	;		INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWDENG NAMES CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
					Licensure completed on		
	This one story facil	ity was determined to be of			November 2, 2022.Please		
		struction and was fully			accept this Plan of Correctio	n	
		icility has a fire alarm system			as the provider's credible	11	
	_	on in the corridors, in all areas			allegation of compliance as of	o.f	
		r and in rooms 11 through 19 in				Л	
	-	acility has battery operated			November 24, 2022. The	4-	
	_				provider respectfully request	S	
		all other resident sleeping			desk review with paper		
rooms. The facility has a capacity of 184 and had a census of 94 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached				compliance to be considered			
				establishing that the provide	r is		
				in substantial compliance.			
		g storage services and one					
		nousing an emergency					
	generator which we	ere each not sprinklered.					
	Quality Review cor	mpleted on 11/09/22					
		•					
K 0211	NFPA 101						
SS=E	Means of Egress						
Bldg. 01	Means of Egress						
		ays, corridors, exit					
	discharges, exit lo	ocations, and accesses are					
	in accordance wit	h Chapter 7, and the means					
	of egress is contir	nuously maintained free of					
	all obstructions to	full use in case of					
	emergency, unles	s modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1	1.10.1					
	Based on observation	on and interview, the facility	K 0	211	POC- Life Safety		11/24/2022
	failed to maintain th	he means of egress free from			_		
	obstructions in 1 of	8 means of egress. This			Tag K211		
	deficient practice co	ould affect 20 residents, staff			E Level		
	and visitors if need	ing to exit the facility by the					
		e main dining room.					
		-			What corrective action(s) wil	1	
	Findings include:				be accomplished for those		
	5				residents found to have beer	1	
	Based on observation	ons with the Executive			affected by the deficient	-	
					and delicion		

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Event ID:

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Facility ID: 000032

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 11/02/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Director, the Director Corporate Maintenanthe facility from 9:1 the exit door to the ceast side of the main facility exit with an keypad at the exit do but the code to releast posted at the exit do as a delayed egress delayed egress signathe time of the observation of the observ	or of Maintenance and the nee Director during a tour of 5 a.m. to 11:50 a.m. on 11/02/22, butside of the facility on the a dining room was marked as a exit sign. The door also had a port to release the door to open use the door to open was not or. The door was not marked door with the necessary age. Based on interview at revations, the Director of the keypad was not operable was on order. The Director of the door may be a delayed and the door was not posted delayed egress signage. Viewed with the Executive or of Maintenance and the nee Director during the exit		practice? No residents have been affect by the deficient practice, but the facility has no obstructions in means of egress now./p> How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken. No residents have been affect by the deficient practice, all the hallways are audited and diffet times to ensure that there is no obstructions in the means of egress./p> What measures will be put in place and what systemic	ted he the the be ve ted ie erent io			
				changes will be made to ensure that the deficient practice does not recur. Maintenance director /Design will complete random audits of Monday through Sunday four times a week on random shift including weekends for four weeks, then three times a we for two weeks, then two times week for the two weeks, once week for one weeks to ensure mean of egress are obstruction free. Maintenance director /Designee will review the aud with the IDT during morning	ek ea ea e that			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/02/2022	
	OVIDER OR SUPPLIE		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) meeting Monday through Frid The results of these audits wi reviewed in Quality Assurance meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any tre or patterns and make recommendations to revise th	DATE ay. Il be e s or eved e QA nds	
				How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place; and Maintenance director /Design will complete random audits of Monday through Sunday four times a week on random shift including weekends for four weeks, then three times a we for two weeks, then two times week for one weeks to ensure mean of egress are obstruction free. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief or 3 consecutive months. The committee will identify any tree or patterns and make	the out ee daily s ek a e that on ng ee eo or eeved ee QA

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Facility ID: 000032

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMEN	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIE		Ī	45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
nio	REGELITORY OF	CESC EDELYTH THYO ENGLISHMENT		me	recommendations to revise plan of correction as indicat Date of compliance November 24th , 2022		Bitts	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking ar CLINICAL NEEDS LOCKING Where special locking ar used, only one locking are used, only one locked, or keys carrother such reliables staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locked, are being met. In electrical locks the release upon loss building is protect.	cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ied by staff at all times; or e means available to the second of the seco						

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space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked

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DEPARTMENT OF HEALTH AND HUN	MAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES
am - men renim de presidentales	TIAL DE CAME ED (OTT

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPL	ETED
		155077	B. WI	B. WING 11/02			2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8	45 BEACHWAY DR				
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	space); and both t	the sprinkler and detection					
	_	iged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2						
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
	1 -	in accordance with					
	7.2.1.6.1 shall be						
		g 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-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.	10100 With 7.2.1.0.2 Shall					
	18.2.2.2.4, 19.2.2	2.4					
		BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
	approved, supervi	sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2]
		ation and interview, the facility	K 02	222	POC- Life Safety		11/24/2022
		means of egress through 2 of					
	-	accessible for residents			Tag K222		
		iagnosis requiring specialized			E Level	_	
		Doors within a required means			What corrective action(s) wi	II	
		be equipped with a latch or			be accomplished for those		
	^	ne use of a tool or key from the			residents found to have beer	1	
	_	therwise permitted by LSC			affected by the deficient		
	Section 19.2.2.2.4.	Door-locking arrangements	<u> </u>		practice?		

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CENTERS FOR MEDICARE & MEDICAID SERVICES		<u> </u>		OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155077	B. WING		11/02/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .		ACHWAY DR		
ENVIVE	OF INDIANAPOLIS			IAPOLIS, IN 46224		
	T			1	ı	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	n accordance with 19.2.2.2.5.2.				
		ice could affect over 40		No residents have been affect		
		visitors if needing to exit the		by the deficient practice, but the		
	facility.			facility doors have the code po		
				now at each exit door in all wi	_	
	Findings include:			Delayed egress signs are now	<i>'</i>	
				posted./p>		
		ons with the Executive				
	Director, the Director of Maintenance and the					
	_	ance Director during a tour of		How other residents having	the	
	the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22,			potential to be affected by th	e	
	the exit door to the	outside of the facility in the		same deficient practice will b	oe	
	vestibule for the A	Wing and in the vestibule for		identified and what correctiv	e	
	the B Wing were ea	ch marked as a facility exit with		action(s) will be taken.		
	an exit sign and cou	ald be opened by entering a				
	code into a keypad	at the door. However, the		No residents have been affect	ed	
	code was not posted	d at each exit door. Based on		by the deficient practice, all the	e	
	interview at the tim	e of the observations, the		hallway door and exits are aud		
	Executive Director	and the Director of		at different times to ensure that	at	
	Maintenance stated	residents who have a clinical		there is code posted at each e	exit	
	diagnosis to be in a	secure wing are in the C Wing		and delayed egress signs are	now	
	and D Wing, not all	residents in the A Wing and		posted./p>		
	B Wing have a clini	ical diagnosis to be in a secure				
	wing and agreed the	e keypad code to release the				
	exit door to open in	the vestibule for the A Wing		What measures will be put in	nto	
	and the B Wing was	s not posted at the keypad.		place and what systemic		
				changes will be made to		
	This finding was re	viewed with the Executive		ensure that the deficient		
	Director, the Direct	or of Maintenance and the		practice does not recur.		
	Corporate Maintena	ance Director during the exit		Maintenance director /Designe	ee	
	conference.			will complete random audits d	aily	
				Monday through Sunday four		
	3.1-19(b)			times a week on random shifts	s	
				including weekends for four		
	2. Based on observa	ation and interview, the facility		weeks, then three times a wee	ek	
	failed to ensure the	means of egress through 1 of		for two weeks, then two times	a	
	1 delayed egress lo	cks were readily accessible for		week for the two weeks, once		
		nd visitors. LSC 7.2.1.6.1,		week for one weeks to ensure		
	Delayed Egress Loc	cks allows approved, listed,		the facility doors have the cod	e	
	delayed egress lock	s shall be permitted to be		posted now at each exit door i		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE installed on doors serving low and ordinary wings. Maintenance director hazard contents in buildings protected /Designee will bring the audit throughout by an approved, supervised automatic sheets back in morning meeting fire detection system installed in accordance with every day to be reviewed. The Section 9.6, or an approved, supervised automatic results of these audits will be sprinkler system installed in accordance with reviewed in Quality Assurance Section 9.7, and where permitted in Chapters 12 meeting monthly for 6 months or through 42, provided: until 100% complaince is achieved (a) The doors unlock upon actuation of an for 3 consecutive months. The QA approved, supervised automatic sprinkler system committee will identify any trends installed in accordance with Section 9.7, or upon or patterns and make the actuation of any heat detector or not more recommendations to revise the than two smoke detectors of an approved, plan of correction as indicated./p> supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock How the corrective action(s) within 15 seconds upon application of a force to will be monitored to ensure the the release device required in 7.2.1.5.4 that shall deficient practice will not not be required to exceed 15 lbf nor required to be recur, i.e., what quality continuously applied for more than 3 seconds. assurance program will be put The initiation of the release process shall activate into place; and an audible signal in the vicinity of the door. Once Maintenance director /Designee the door lock has been released by the application will complete random audits daily of force to the releasing device, relocking shall be Monday through Sunday four by manual means only. times a week on random shifts Exception: Where approved by the authority including weekends for four having jurisdiction, a delay not exceeding 30 weeks, then three times a week seconds shall be permitted. for two weeks, then two times a (d) On the door adjacent to the release device, week for the two weeks, once a there shall be a readily visible, durable sign in week for one weeks to ensure that letters not less than 1 inch high and at least 1/8 the facility doors have the code inch in stroke width on a contrasting background posted now at each exit door in all that reads: wings. Maintenance director "PUSH UNTIL ALARM SOUNDS. /Designee will bring the audit DOOR CAN BE OPENED IN 15 SECONDS". sheets back in morning meeting This deficient practice could affect 20 residents, every day to be reviewed. The staff and visitors if needing to exit the facility by results of these audits will be the east exit door of the main dining room. reviewed in Quality Assurance

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ í	JILDING	onstruction 01	(X3) DATE COMPL 11/02/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	Based on observation Director, the Director Corporate Maintenance the facility from 9:1 the exit door to the east side of the main facility exit with an keypad at the exit do but the code to releast posted at the exit do as a delayed egress delayed egress signs the time of the obse Maintenance stated and a new keypad with the necessary of Corporate Maintenance to see if it was delay after pushing for less door did not go into delay was well less the door opened. This finding was re Director, the Director	ons with the Executive or of Maintenance and the ance Director during a tour of 1.5 a.m. to 11:50 a.m. on 11/02/22, outside of the facility on the in dining room was marked as a exit sign. The door also had a coor to release the door to open ase the door to open was not bor. The door was not marked door with the necessary age. Based on interview at ervations, the Director of the keypad was not operable was on order. The Director of the door may be a delayed ead the door was not posted delayed egress signage. The ance Director tested the door yed egress. The door did open as than five seconds but the order when pushed and the than fifteen seconds before			meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated. Date of compliance November 24th, 2022	or eved e QA nds	DATE
	3.1-19(b)						
K 0291 SS=F Bldg. 01							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/02/2022	
	ROVIDER OR SUPPLIER		STR 45 IND	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE AP	OULD BE COMPLETION
	interview; the facili and annual testing f	riew, observation and ty failed to document monthly for all battery backup lights in C 7.9. Section 7.9.3.1.1 states	K 0291	POC- Life Safety Tag K291 E Level	11/24/2022
	permitted to be cond (1) Functional testing with a minimum of weeks between tests seconds, except as of	y lighting systems shall be ducted as follows: ng shall be conducted monthly, 3 weeks and a maximum of 5 s, for not less than 30 otherwise permitted by		What corrective action be accomplished for the residents found to have affected by the deficients.	nose e been
	extended beyond 30 authority having jur (3) Functional testir for a minimum of 1 lighting system is be (4) The emergency	ng shall be conducted annually 1/2 hours if the emergency		practice? No residents have been by the deficient practice facility had now started document and check the Emergency operated lig the walk-in weatherproduction emergency generator lo	, but the to e test ht inside of shell for
	shall be kept by the authority having jur	of visual inspections and tests owner for inspection by the		How other residents had potential to be affected same deficient practice identified and what con action(s) will be taken.	I by the e will be rrective
	the Executive Direct Maintenance and th Director during reco 1:45 p.m. on 11/01/ operated light testin recent twelve month	Lights" documentation with		No residents have been by the deficient practice only one emergency open on the generator which checked and documented. What measures will be place and what system	, there is erated light is audited, ed. put into
		mergency generator location.		changes will be made t	

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	the Director of Mair tests exit signage lig annual functional tebattery operated light proof shell for the enfor the most recent the available for review the Executive Direct Maintenance and the Director during a toto 11:50 a.m. on 11/operated lighting syinside the walk-in with emergency geneits respective test but This finding was review Director, the Director	e Corporate Maintenance ur of the facility from 9:15 a.m. 02/22, only one battery stem was noted in the facility reather proof shell location for rator which functioned when		ensure that the deficient practice does not recur. Maintenance director /Designe will complete random audits of Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure emergency exit lights on the generator are checked and documented. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviee. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Maintenance director /Designe will complete random audits of Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times	aily sek a a a a that nee wed. I be e or eved e QA nds e the ut ee aily sek	

PRINTED: 11/30/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIER		-	STREET A 45 BEA INDIAN				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
					week for the two weeks, once week for one weeks to ensure emergency exit lights on the generator are checked and documented. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviee. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated Date of compliance.	e that me wed. Il be e or eved e QA nds		
K 0300 SS=F Bldg. 01	Section 18.3 and	RKS section any LSC						

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provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility

failed to replace battery operated smoke alarms installed in 47 of 63 resident sleeping rooms in

Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke

alarms shall be replaced when they fail to respond

to operability tests but shall not remain in service

accordance with NFPA 72. NFPA 72, 2010

Event ID:

0Z2N21

K 0300

Facility ID: 000032

POC-

SS-E

Tag K300

Life Safety

What corrective action(s) will

residents found to have been

be accomplished for those

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
		155077	B. W	ING		11/02/	/2022	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					ACHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
		s from the date of manufacture.			affected by the deficient			
		ice could affect all residents,			practice?			
	staff and visitors.	ice could affect all residents,			practice:			
	starr and visitors.				No residents have been affect	-od		
	Eindines in abida.					eu		
	Findings include:				by the deficient practice, but	_1		
	D 1 1 4	id d. E. V			resident room battery operate			
		ons with the Executive			smoke detectors documentation	on is		
	·	or of Maintenance and the			current at this time.			
		ance Director during a tour of						
		15 a.m. to 11:50 a.m. on 11/02/22,			How other residents having			
		umentation affixed to the Kidde			potential to be affected by th			
	Model i9010 battery operated smoke alarm				same deficient practice will be			
	installed on the ceil	ing in resident sleeping Room			identified and what correctiv	e		
	B11 and D4 stated t	the unit was manufactured			action(s) will be taken.			
	03/12/12 and to "rej	place the unit within 10 years						
	of installation date"	. The installation date was not			No residents have been affect	ted		
	recorded on either b	pattery operated smoke alarm.			by the deficient practice, build	ing		
	Based on interview	at the time of the			wide audit is completed to ens	sure		
	observations, the D	irector of Maintenance stated			battery operated smoke detec	tors		
	each resident sleepi	ng room which has a battery			preventive maintenance			
		rm has the same type of			documentation is current and			
		oke alarm installed in the room			documented.			
		sleeping room battery			What measures will be put			
		rms installed in the facility			into place and what systemic	C		
	were more than ten	•			changes will be made to			
					ensure that the deficient			
	This finding was re	viewed with the Executive			practice does not recur.			
	_	or of Maintenance and the			Maintenance director /Designe	20		
		ance Director during the exit			will complete random audits d			
	conference.	ince Breetor during the exit			Monday through Sunday four	any		
	conterence.				times a week on random shifts			
	3.1-19(b)					•		
	3.1-17(0)				including weekends for four	ale		
	2 Dagod on mass 1	raviary absorvation and			weeks, then three times a week			
		review, observation and			for two weeks, then two times			
	interview; the facili	-			week for the two weeks, once			
		the preventative maintenance			week for one weeks to ensure			
		ted smoke alarms in resident			battery operated smoke detec	tors		
		e. NFPA 101 in 4.6.12.3 states			documentation is current.			
	existing life safety f	features obvious to the public,			Maintenance director /Designe	ee		

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if not required by the Code, shall be maintained.

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will bring the audit sheets back in

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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 COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE NFPA 72, National Fire Alarm and Signaling Code, morning meeting every day to be 2010 Edition, 29.10 Maintenance and Tests states reviewed. The results of these fire-warning equipment shall be maintained and audits will be reviewed in Quality tested in accordance with the manufacturer's Assurance meeting monthly for 6 published instructions and per the requirements months or until 100%complaince of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, is achieved for 3 consecutive testing, and maintenance programs shall satisfy months. The QA committee will the requirements of this Code and conform to the identify any trends or patterns and equipment manufacturer's published instructions. make recommendations to revise This deficient practice could affect all residents, the plan of correction as indicated. staff, and visitors. Findings include: Based on record review with the Executive How the corrective action(s) Director, the Director of Maintenance and the will be monitored to ensure the Corporate Maintenance Director from 9:20 a.m. to deficient practice will not 1:45 p.m. on 11/01/22, resident room battery recur, i.e., what quality operated smoke detector preventive maintenance assurance program will be put documentation for the most recent twelve month into place; and period was not available for review. Based on Maintenance director /Designee interview at the time of record review, the Director will complete random audits daily of Maintenance stated he regularly tests battery Monday through Sunday four operated smoke detectors but does not document times a week on random shifts the testing and agreed resident room battery including weekends for four operated smoke detector testing and cleaning weeks, then three times a week documentation for the most recent twelve month for two weeks, then two times a period was not available for review. Based on week for the two weeks, once a observations with the Executive Director, the week for one weeks to ensure Director of Maintenance and the Corporate battery operated smoke detectors Maintenance Director during a tour of the facility documentation is current at all from 9:15 a.m. to 11:50 a.m. on 11/02/22, times. Maintenance director manufacturer's documentation affixed to the Kidde /Designee will bring the audit Model i9010 battery operated smoke alarm sheets back in morning meeting installed on the ceiling in resident sleeping Room every day to be reviewed. The B11 and D4 stated to test the unit weekly and to results of these audits will be clean the unit annually. Based on interview at the reviewed in Quality Assurance time of the observations, the Director of meeting monthly for 6 months or Maintenance stated each resident sleeping room until 100% complaince is achieved

which has a battery operated smoke alarm has the

for 3 consecutive months. The QA

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS				CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SIATE CONTENT	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION same type of battery operated smoke alarm			TAG	committee will identify any tre	nde.	DATE
	installed in the room. This finding was reviewed with the Executive Director, the Director of Maintenance and the Corporate Maintenance Director during the exit conference.				or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	е	
3.1-19(b)							
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automati option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated to by smoke resisting rs in accordance with 8.4.					
	a. Boiler and Fuel b. Laundries (large c. Repair, Mainter	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	(over 50 square feg. Laboratories (if Hazard - see K322 Based on observation failed to ensure 1 of as combustible storation in size were separated resistant partitions as closing or automatication 7.2.1.8. This deficities residents, staff and Central Supply room. Findings include: Based on observation Director, the Director Corporate Maintenathe facility from 9:1 the Central Supply combustible boxes agreater than 50 squadoor to the room was closing. Based on it observations, the Director door to area was not self closing. This finding was reported to the corridor door to the room to area was not self closing. This finding was reported to the process.	orage Rooms/Spaces set) classified as Severe 2) on and interview, the facility cover 13 hazardous areas such age rooms over 50 square feet ed from other spaces by smoke and doors. Doors shall be self ac closing in accordance with ent practice could affect over 10 visitors in the vicinity of the	K 0321		POC- Life Safety Tag K321 SS-E What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affect by the deficient practice, but Corridor door to the room now self-enclosure. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No residents have been affect by the deficient practice, build wide audit is completed to ensuall the rooms have self-enclose where needed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance director /Designer will complete random audits of Monday through Sunday four	n ted has the ne pe ted ing sure sure	11/24/2022

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/02/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
ENVIVE (OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				times a week on random shift	S	
				including weekends for four weeks, then three times a we	ok	
				for two weeks, then two times		
				week for the two weeks, once		
				week for one weeks to ensure		
				self-enclosures are present o		
				the needed doors. Maintenan		
				director /Designee will bring t		
				audit sheets back in morning		
				meeting every day to be revie		
				The results of these audits wi		
				reviewed in Quality Assuranc		
				meeting monthly for 6 months		
				until 100%complaince is achi		
				for 3 consecutive months. The		
				committee will identify any tre	nds	
				or patterns and make	_	
				recommendations to revise the		
				plan of correction as indicated	1.	
				How the corrective action(s)		
				will be monitored to ensure	the	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will be p	out	
				into place; and		
				Maintenance director /Design		
				will complete random audits of Monday through Sunday four	-	
				times a week on random shift		
				including weekends for four	-	
				weeks, then three times a we	ek	
				for two weeks, then two times		
				week for the two weeks, once		
				week for one weeks to ensure		
				self-enclosures are present o	n all	
				the needed doors. Maintenan	ce	
				director /Designee will bring t	ne	
				audit sheets back in morning		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMP!	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, Z ACHWAY DR	IP COD	
ENVIVE (OF INDIANAPOLIS			IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	CORRECTION ON SHOULD BE THE APPROPRIATE Y)	(X5) COMPLETION DATE
				meeting every day to The results of these reviewed in Quality meeting monthly for until 100%complain for 3 consecutive mommittee will ident or patterns and make recommendations to plan of correction as Date of compliance November 24th, 20	e audits will be Assurance r 6 months or ice is achieved ronths. The QA tify any trends ice o revise the is indicated	
K 0324 SS=D Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordance 19.3.2.5.2 * cooking facilities smoke compartments comply who 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer proposed as hazar be open to the cordinal through 19.3.2.5.5. Based on record revenue.	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 8.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not rridor.	K 0324	POC- Life Safety	y	11/24/2022

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/02/2022		
NAME OF P	PROVIDER OR SUPPLIER			ACHWAY DR	•	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		to ensure 1 of 1 kitchen range		Tag K324		
	I	ns was maintained in proper		SS-E		
	1	PA 96, Standard for Ventilation		What corrective action(s)		
		otection of Commercial s, 2011 Edition, Section 4.1.3		be accomplished for those		
		equipment shall be kept in		residents found to have be	en	
	working condition:	equipment shan be kept in		affected by the deficient practice?		
	(1) Cooking equipn	nent		practice:		
	(2) Hoods	icit		No residents have been affe	cted	
	(3) Ducts (if applied	able)		by the deficient practice, but		
	(4) Fans			kitchen range hood exhaust		
	(5) Fire-extinguishi	ng equipment		systems repair documents a		
		or energy control equipment		maintained in proper working		
		es maintenance and repairs		order.		
	shall be performed	on all components at intervals				
	necessary to mainta	in good working condition.		How other residents having	g the	
	This deficient pract	ice could affect over two		potential to be affected by	the	
	kitchen staff.			same deficient practice wil	l be	
				identified and what correct	ive	
	Findings include:			action(s) will be taken.		
		the kitchen range hood fire		No residents have been affe		
		inspection contractor's "Fire		by the deficient practice, Au		
		ocumentation dated 07/18/22		kitchen hood exhaust syster	n had	
		Director, the Director of		been completed./p>		
		e Corporate Maintenance		What many was will be wet	into	
	_	ord review from 9:20 a.m. to		What measures will be put	into	
	_	22, the kitchen range hood fire has deficiencies as a result of		place and what systemic changes will be made to		
		omments, Discrepancies of		ensure that the deficient		
	_	on of the 07/18/22 inspection		practice does not recur.		
		ro-switch at A* control box		Maintenance director /Desig	nee	
		vire connection to allow elec		will complete random audits		
		ivation". Based on interview		Monday through Sunday on	- I	
		d review, the Director of		times a week on random shi		
		he was not aware if any		including weekends for four		
		nde on or after 07/18/22 and		weeks, then one times a we	ek for	
		on of any corrections		two weeks, then one times a		
	~	er 07/18/22 was not available		for the one week to ensure b		
	for review at the tin			kitchen range hood exhaust		

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	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	01	COMPLETED 11/02/2022
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Director, the Director	viewed with the Executive or of Maintenance and the nee Director during the exit		systems repair documents are maintained in proper working order. Maintenance director /Designee will bring the audit sheets back in morning meeti every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achie for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place; and Maintenance director /Design will complete random audits of Monday through Sunday one times a week on random shift including weekends for four weeks, then one times a week to ensure kit range hood exhaust systems repair documents are maintai in proper working order. Maintenance director /Design will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly for months or until 100% complaints or until 100% complaints.	e e s or eved e QA nds e e d./p> the dially s k for week tchen e e k in b be e e ality or 6

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			NC	(X3) DATE SURVEY COMPLETED	
		155077	B. WII	NG			11/02/	/2022
	PROVIDER OR SUPPLIEI		•	45 BEA	CHWAY	CITY, STATE, ZIP COD DR IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH C	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					months. identify make re the plan Date of	ved for 3 consecutive. The QA committee wany trends or patterns commendations to read of correction as indicated compliance ber 24th, 2022	and vise	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with I Inspection, Testin Water-based Fire Records of syster inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMA	supply source RKS information on						
	automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record interview; the facili- hydrostatic flush for piping systems whit testing. NFPA 25, Testing and Mainter	•	K 03	353	POC- Tag K35 SS-F	Life Safety 53 prrective action(s) wil	II	11/24/2022

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states an obstruction investigation shall be

conducted for system piping whenever foreign

materials are in dry pipe valves or in check valves.

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be accomplished for those

affected by the deficient

residents found to have been

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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	JILDING	01	COMPLETED	
155077		B. W	B. WING 11/02/2022			2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			CHWAY DR		
FN\/I\/F	OF INDIANAPOLIS				IAPOLIS, IN 46224		
	01 11401/114/11 0210	,		II V DI/ (I V	7.4 0210, 114 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Section 14.3.3, stat				practice?		
	_	ates the presence of sufficient					
		pipe or sprinklers, a complete			No residents have been affect		
		hall be conducted by qualified			by the deficient practice, but r	epair	
	_	ficient practice could affect all			for hydrostatic flush for 2 of 2		
	residents, staff and	visitors.			automatic sprinkler piping sys		
					is in process which failed flow		
	Findings include:				testing and trip testing.	ļ	
	Based on review of	the sprinkler system			How other residents having	the	
	inspection contract	or's "Sprinkler Inspection			potential to be affected by th	10	
	Certificate" docum	entation dated 07/11/22 with			same deficient practice will	be	
	the Executive Direc	ctor, the Director of			identified and what corrective	re	
	Maintenance and th	ne Corporate Maintenance			action(s) will be taken.		
	Director during rec	ord review from 9:20 a.m. to					
	1:45 p.m. on 11/01	/22, the facility's two dry			No residents have been affec	ted	
	sprinkler systems f	ailed flow testing and trip		by the deficient practice, Audit for			
	_	the sprinkler system inspection			the facility wide hydrostatic flu	ısh	
		ce Proposal" documentation			had been completed and repa	air for	
		icated a quote to "remove and			hydrostatic flush for 2 of 2		
	flush each inspecto	r's test until clean water is			automatic sprinkler piping sys	tem	
		on interview at the time of		is in process which failed flow			
	· ·	Director of Maintenance and		testing and trip testing.			
		ntenance Director stated the			What measures will be put in	nto	
		roved and the sprinkler			place and what systemic		
	1 *	vas actively prepping the			changes will be made to		
	1 *	at the time of the survey but			ensure that the deficient		
		or completed the flush of the			practice does not recur.		
		ms. Based on observations			Maintenance director /Design		
		Director, the Director of			will complete random audits d	aily	
		ne Corporate Maintenance			Monday through Sunday one		
	_	our of the facility from 9:15 a.m.			times a week on random shift	s	
		/02/22, the sprinkler system			including weekends for four		
		vely prepping the system for			weeks, then one times a weel		
		ng additional sprinkler low			two weeks, then one times a	week	
		ance of flushing the two dry			for the one week to ensure		
	sprinkler systems for	or the facility.			hydrostatic flush for automatic	;	
					sprinkler piping system is in		
		eviewed with the Executive			process which failed flow testi	ng	
	Director, the Director of Maintenance and the				and trip testing. Maintenance	ļ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Corporate Maintenance Director during the exit director /Designee will bring the conference. audit sheets back in morning meeting every day to be reviewed. 3.1-19(b) The results of these audits will be reviewed in Quality Assurance 2. Based on record review and interview, the meeting monthly for 6 months or facility failed to maintain automatic sprinkler until 100% complaince is achieved systems in accordance with NFPA 25. LSC 9.7.5 for 3 consecutive months. The QA requires all sprinkler systems shall be inspected, committee will identify any trends tested, and maintained in accordance with NFPA or patterns and make 25, Standard for the Inspection, Testing, and recommendations to revise the Maintenance of Water-Based Fire Protection plan of correction as indicated. Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated How the corrective action(s) representative shall correct or repair deficiencies will be monitored to ensure the or impairments that are found during the deficient practice will not inspection, test and maintenance required by this recur, i.e., what quality standard. Corrections and repairs shall be assurance program will be put performed by qualified maintenance personnel or into place; and a qualified contractor. NFPA 25, 4.3.1 requires Maintenance director / Designee records shall be made for all inspections, tests, will complete random audits daily and maintenance of the system components and Monday through Sunday one shall be made available to the authority having times a week on random shifts jurisdiction upon request. This deficient practice including weekends for four could affect all residents, staff, and visitors in the weeks, then one times a week for facility. two weeks, then one times a week for the one week to ensure Findings include: hydrostatic flush for automatic sprinkler piping system is in Based on review of the sprinkler system process which failed flow testing inspection contractor's "Sprinkler Inspection and trip testing. Maintenance Certificate" documentation dated 07/11/22 with director /Designee will bring the the Executive Director, the Director of audit sheets back in morning Maintenance and the Corporate Maintenance meeting every day to be reviewed. Director during record review from 9:20 a.m. to The results of these audits will be 1:45 p.m. on 11/01/22, deficiencies were noted for reviewed in Quality Assurance the facility's sprinkler system during the meeting monthly for 6 months or inspection for the facility. The "Notes and until 100%complaince is achieved Recommendations" section of the 07/11/22 for 3 consecutive months. The QA sprinkler system inspection report stated committee will identify any trends

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
	OF PROVIDER OR SUPPLIED VE OF INDIANAPOLIS			45 BEAG	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION
TAG	"Accelerator failed A & B Wings" spri was out of service of C & D Wings". Be following statement waterflow switch for must have a waterflow system must have a System has excessifing interview at the time of Maintenance and Director provided a documentation date system inspection of each system on or a been performed bettrying to perform sport of the provided and the performed bettrying to perform sport of the provided and the performed bettrying to perform sport of the provided and fire department inspections NFPA 25, Standard and Maintenance of Systems, 2011 Edit and fire department inspected, tested, and with Chapter 13. Standard and maintenance of valutim. Section 4.3.1 all inspections, test	to activate" for the "west side inkler system and "Accelerator upon arrival" for the "east side of sprinkler systems had the its "systems have 1 PS10 for 2 dry systems. Each system show switch. Systems have 1 air is for 2 dry systems, each dry in air maintenance device. We air pressure". Based on the of record review, the Director of the Corporate Maintenance of the Corporate Maintenance of mapproved "Service Proposal" and 08/11/22 from the sprinkler contractor but stated repairs to offer 08/11/22 have not yet cause the facility was actively prinkler flushing first. I viewed with the Executive for of Maintenance and the sance Director during the exit of the Inspection, Testing, if Water-Based Fire Protection ion, Section 5.1.2 states valves a connections shall be and maintained in accordance ection 13.1.1.2 states Table illized for inspection, testing and wes, valve components and states records shall be made for so, and maintenance of the ponents and shall be made		TAG	or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	e	DATE

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Event ID:

0Z2N21

Facility ID: 000032

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIEF		4	5 BEAC	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224				
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX 'AG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE		
ind	available to the authorequest. This defice	nority having jurisdiction upon ient practice could affect all visitors in the facility.		710			DATE		
	Findings include:								
	Director, the Direct Corporate Maintena review from 9:20 a. monthly sprinkler s documentation for a October 2022 was n on interview at the Director of Mainter sprinkler system ga monthly sprinkler s documentation for a October 2022 was n on observations wit Director of Mainter Maintenance Direct	or of Maintenance and the ance Director during record m. to 1:45 p.m. on 11/01/22, ystem valve inspection August, September and not available for review. Based time of record review, the nance said he documents uge inspections but agreed ystem valve inspection August, September and not available for review. Based the time of record review, the nance said he documents uge inspections but agreed ystem valve inspection August, September and not available for review. Based he the Executive Director, the nance and the Corporate for during a tour of the facility 1:50 a.m. on 11/02/22, the facility sprinkler systems.							
	Director, the Direct	viewed with the Executive or of Maintenance and the ance Director during the exit							
	3.1-19(b)								
K 0355 SS=F Bldg. 01	installed, inspecte	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers.							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTI		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION ID:		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
155077		B. W	B. WING 11/02/2022			022	
				CTREET	ADDRESS SITU STATE ZID SOD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
	OE INDIANADOLIO				ACHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1. Based on observa	ation and interview, the facility	K 0	355	POC- Life Safety		11/24/2022
	failed to ensure 3 or	f 18 portable fire extinguishers			_		
	had documented an	nual maintenance in			Tag K355		
	accordance with NI	FPA 10. LSC 9.7.4.1 states			SS-F		
	portable fire exting	uishers shall be selected,					
	installed, inspected	and maintained in accordance			What corrective action(s) wil	il	
	with NFPA 10. NF	PA 10, Standard for Portable			be accomplished for those		
	Fire Extinguishers,	2010 Edition, Section 7.3.1.1.1			residents found to have been	n	
	states fire extinguis	hers shall be subject to			affected by the deficient		
	maintenance at inte	rvals of not more than one			practice?		
	year, at the time of	hydrostatic test, or when					
	specifically indicate	ed by an inspection or			No residents have been affect	ted	
	electronic notificati	on. Section 7.3.3 states each			by the deficient practice, porta	able	
	fire extinguisher sh	all have a tag or label securely			fire extinguisher monthly		
	attached that indica	tes the month and year the		inspection documentations hav		ıve	
	maintenance was po	erformed, identifies the person		been completed for medical record		ecord	
	performing the wor	k, and identifies the name of			room, central supply room, be	auty	
	the agency perform	ing the work. This deficient		shop and main shut off electrical			
	practice could affect	t all residents, staff and		and water room.			
	visitors.						
					How other residents having	the	
	Findings include:				potential to be affected by the	ie	
					same deficient practice will l	be	
		ons with the Executive			identified and what correctiv	re	
		or of Maintenance and the			action(s) will be taken.		
	_	ance Director during a tour of					
		15 a.m. to 11:50 a.m. on 11/02/22,			No residents have been affect		
		ble fire extinguishers located			by the deficient practice, Audi	t for	
		ords office in the A Wing short			the all the potable fire		
		pply room and the Beauty			extinguishers had been comp	leted	
	_	ffixed maintenance tag by an			and all monthly inspection		
	_	or indicating the date the most			documentations have been		
		tenance was performed was			completed for medical record		
	· ·	ed on interview at the time of			room, central supply room, be		
		e Director of Maintenance			shop and main shut off electric	cal	
		greater than twelve months			and water room.		
		nt annual maintenance was					
		aforementioned three portable					
	fire extinguishers.						
					What measures will be put ir	nto	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE This finding was reviewed with the Executive place and what systemic Director, the Director of Maintenance and the changes will be made to Corporate Maintenance Director during the exit ensure that the deficient conference. practice does not recur. Maintenance director /Designee 3.1-19(b) will complete random audits daily Monday through Sunday one 2. Based on observation and interview, the facility times a week on random shifts failed to ensure 4 of 18 portable fire extinguishers including weekends for four were inspected at least monthly and the weeks, then one times a week for inspections were documented including the date two weeks, then one times a week and initials of the person performing the for the one week to ensure inspection in accordance with NFPA 10. LSC portable fire extinguisher monthly 9.7.4.1 states portable fire extinguishers shall be inspection and documentation are selected, installed, inspected and maintained in complete. Maintenance director accordance with NFPA 10. NFPA 10, the /Designee will bring the audit Standard for Portable Fire Extinguishers, 2010 sheets back in morning meeting every day to be reviewed. The Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of results of these audits will be an electronic monitoring device/system at a reviewed in Quality Assurance minimum of 30-day intervals. Where monthly meeting monthly for 6 months or manual inspections are conducted, the date the until 100%complaince is achieved manual inspection was performed and the initials for 3 consecutive months. The QA of the person performing the inspection shall be committee will identify any trends recorded. Where manual inspections are or patterns and make conducted, records for manual inspections shall recommendations to revise the be kept on a tag or label attached to the fire plan of correction as indicate extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least How the corrective action(s) the last 12 monthly inspections have been will be monitored to ensure the performed. This deficient practice could affect all deficient practice will not residents, staff and visitors. recur, i.e., what quality assurance program will be put Findings include: into place; and Maintenance director /Designee Based on observations with the Executive will complete random audits daily

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Director, the Director of Maintenance and the

Corporate Maintenance Director during a tour of

the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22,

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Monday through Sunday one

including weekends for four

times a week on random shifts

If continuation sheet

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ELITERS I O	WIEDICHNE & MEDIC	- DERVICES			OldB it	3.0500 005	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155077	B. WING		11/02/20	22	
		100077	<i>B.</i> WING		11/02/202		
NAME OF	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ACHWAY DR			
ENVIVE	OF INDIANAPOLIS		INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	the affixed mainten	ance tags for the following		weeks, then one times a week	(for		
	ABC type portable	fire extinguisher locations had		two weeks, then one times a v			
		spection documentation:		for the one week to ensure			
		ecords office in the A Wing		portable fire extinguisher mon	thly		
		st, September and October		inspection and documentation	-		
	2022.			complete. Maintenance direct			
		pply room for August,		/Designee will bring the audit			
	September and Octo			sheets back in morning meeting	na		
	_	op for August, September and		every day to be reviewed. The	-		
	October 2022.	op for Hagasi, Septemoer and		results of these audits will be	·		
	d. in the Main Shut Off Electrical & Water for September and October 2022. Based on interview at the time of the			reviewed in Quality Assurance	_		
				meeting monthly for 6 months			
				until 100%complaince is achie			
	observations, the Director of Maintenance agreed			for 3 consecutive months. The			
		portable fire extinguisher		committee will identify any tre			
		missing monthly inspection			ius		
	documentation.	missing monumy inspection		or patterns and make recommendations to revise the			
	documentation.						
	This finding was ro	viewed with the Executive		plan of correction as indicated	1		
	_	or of Maintenance and the		Data of compliance			
	· ·	ance Director during the exit		Date of compliance			
	conference.	ince Director during the exit		November 24th , 2022			
	conference.						
	3.1-19(b)						
K 0362	NFPA 101						
SS=E	Corridors - Constr	ruction of Walls					
Bldg. 01	Corridors - Constr						
5	2012 EXISTING						
		arated from use areas by					
	-	with at least 1/2-hour fire					
		In fully sprinklered smoke					
	_	rtitions are only required to					
	resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the						
		ralls may terminate at the					
	1 -	igs where specifically					
	permitted by Code	-					
	I berningen by Cone	·.	ı	Ī	ı		

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Fixed fire window assemblies in corridor walls

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEM	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155077	B. WING		11/02/2022	
ENVIVE	F PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	sprinklered comparestrictions in area or frames. If the walls have at the rating		K 0362	POC- Life Safety Tag K362 SS-E What corrective action(s) with be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the deficient practice, but it rolling fire door for the kitcher the west wall of main dining ris now on track within the rolling opening to resist the transfer smoke now. How other residents having potential to be affected by the same deficient practice will identified and what correcting action(s) will be taken. No residents have been affected by the deficient practice, Aud the all the fire-resistant doors	en cted the n is in coom ing g door the he be ve	

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The rolling fire door for the kitchen is in the west

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the facility had been made. No

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
EINVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION sing room. The rolling fire door	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) other doors have the same	ATE	(X5) COMPLETION DATE
	was off track and w for the rolling door opening to not resis Director of Mainten door back on track	as not within the door frame which caused the rolling door t the transfer of smoke. The nance tried to put the rolling within the rolling fire door			deficient practice. What measures will be put in place and what systemic	nto	
	interview at the time Director of Mainten	the observations. Based on e of the observations, the sance agreed the rolling door nd would not resist the			changes will be made to ensure that the deficient practice does not recur. Maintenance director /Design will complete random audits of Monday through Sunday one		
		viewed with the Administrator Maintenance during the exit			times a week on random shift including weekends for four weeks, then one times a weel two weeks, then one times a for the one week to ensure fin	<for week</for 	
					resistant doors resist the trans of the smoke. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be revie The results of these audits will reviewed in Quality Assurance	ne wed. Il be	
					meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	or eved e QA nds	
					How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and	the	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVI COMPLETED 11/02/2022	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO ACHWAY DR	DD	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPROPRIATE	(X5) IPLETION DATE
				will complete random and Monday through Sundatimes a week on randor including weekends for weeks, then one times at two weeks, then one times are resistant doors resist the of the smoke. Maintenation director /Designee will be audit sheets back in more meeting every day to be a the results of these audit reviewed in Quality Assimeeting monthly for 6 muntil 100% complaince is for 3 consecutive month committee will identify a or patterns and make recommendations to replan of correction as incompate of compliance November 24th, 2022	y one n shifts four a week for nes a week ure fire e transfer nce oring the rning e reviewed. dits will be urance nonths or a sachieved as. The QA any trends	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke is only required to resist the experimental corridor doors and doors in its flammable or its flamma				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING <u>01</u>				COMPL	(3) DATE SURVEY COMPLETED 11/02/2022	
	OVIDER OR SUPPLIER F INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			TE	(X5) COMPLETION DATE
	apply to auxiliary standard apply to auxiliary standard auxiliary stan	n bottom of door and floor beeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ad protective plates of the permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments of or frames in window. Parts 403, 418, 460, 482, and S details of doors such as angs, automatics closing on and interview, the facility of over 75 corridor doors had no ang and latching into the door sist the passage of smoke, face could affect over 40	K 03	363		orrective action(s) wil		11/24/2022
	Findings include: Based on observation	ons with the Executive			residen	emplished for those ts found to have beer I by the deficient e?	1	
	Director, the Direct	or of Maintenance and the nce Director during a tour of			•	dents have been affect	ed	

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Event ID:

0Z2N21

Facility ID: 000032

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155077	B. W	ING		11/02/	/2022
				_			
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
				45 BEACHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		15 a.m. to 11:50 a.m. on 11/02/22,			by the deficient practice, but re	nom	
	the following was n				no A18, B23,C10 and the entr		
	a. the corridor door to Room A18 didn't latch into			door to the kitchen are all th		у	
					doors are now fixed and can la	atob	
	the door frame when tested to close multiple times because a hasp was affixed to the door and the					alcii	
					properly now.		
		lidn't allow the latching					
	mechanism on the door to protrude into the				How other residents having t		
		e door frame. The Director of			potential to be affected by th		
		ved the hasp which then			same deficient practice will be		
		latch into the door frame.			identified and what correctiv	е	
		d out of the face of the			action(s) will be taken.		
	corridor door to Room B23 by the door handle						
	which exposed the latching mechanism on the				No residents have been affect		
		sure the door was 1 3/4 inch			by the deficient practice, Audit		
		vood or other material capable			the all the doors in the facility	had	
	of resisting fire for	at least 20 minutes. Room B23			been made. No other doors ha		
	had been converted	to a conference room.			the same deficient practice.		
	c. the corridor door	to Room C10 was propped in					
		ion with a waste basket placed					
	on the floor up agai	nst the door.					
	d. two screws were	missing on the metal plate			What measures will be put in	ito	
	holding the latching	g mechanism in place on the			place and what systemic		
		tchen from the Main Dining			changes will be made to		
	Room by the kitche	n rolling fire door which			ensure that the deficient		
	caused the entry do	or to the kitchen to not latch			practice does not recur.		
		each time the door was tested			Maintenance director /Designe	ee	
	to close multiple tir	nes. The Main Dining Room			will complete random audits da		
	was open to the cor				Monday through Sunday one	,	
	Based on interview				times a week on random shifts	3	
		irector of Maintenance and			including weekends for four		
	· ·	tenance Director agreed the			weeks, then one times a week	for	
	_	ridor doors had an impediment			two weeks, then one times a v		
		ing into the door frame or			for the one week to ensure do		
		passage of smoke or were not			latch properly. Maintenance	0.0	
		nded core wood or other					
		resisting fire for at least 20			director /Designee will bring the	 	
	minutes.	resisting the for at least 20			audit sheets back in morning	uad	
	minutes.			meeting every day to be revi			
	TE1 : (" 1"	1 14 4 B			The results of these audits will		
	I his finding was re	viewed with the Executive			reviewed in Quality Assurance	•	

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Director, the Director of Maintenance and the

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meeting monthly for 6 months or

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/02/2022
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	Corporate Maintena conference. 3.1-19(b)	nce Director during the exit		until 100%complaince is achie for 3 consecutive months. The committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated.	e QA nds e
				How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Maintenance director /Design will complete random audits of Monday through Sunday one times a week on random shift including weekends for four weeks, then one times a week two weeks, then one times a week two weeks, then one times a for the one week to ensure do latch properly. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviee. The results of these audits wireviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief or 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	the out eee laily s k for week cors ne wed. Il be ee cor eved ee QA nds nds ee
				November 24th, 2022	

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· ′		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0712 SS=F Bldg. 01	alarm signal and seconditions. Fire driver and unexpected ticonditions, at least The staff is familia aware that drills a routine. Where driver 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1. Based on recordifacility failed to do staff training documprocedures on the staff training include: Based on review of documentation, "En In" documentation with Director of Mainter Maintenance Direct 9:20 a.m. to 1:45 p. of a second shift fir documentation on fourth quarter (Octo 2021 and in the sec 2022 was not available.)	ay be used instead of	K 0712	POC- Life Safety Tag K712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affected by the deficient practice, but fid drills have been completed or second shift. How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action(s) will be taken. No residents have been affected.	n ted ire n the ne be		

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of Maintenance stated the facility operates two

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by the deficient practice.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the What measures will be put into second shift in the aforementioned calendar place and what systemic quarters was not available for review. changes will be made to ensure that the deficient This finding was reviewed with the Executive practice does not recur. Director, the Director of Maintenance and the Maintenance director /Designee Corporate Maintenance Director during the exit will complete random audits daily conference. Monday through Sunday one times a week on random shifts 3.1-19(b) including weekends for four weeks, then one times a week for 2. Based on record review and interview, the two weeks, then one times a week facility failed to document the staff who for the one week to ensure fire participated in quarterly fire drills or staff training drills are completed on every shift documentation on fire drill procedures on the per regulations. Maintenance second shift for 2 of 4 quarters. LSC Section director /Designee will bring the 19.7.1.6 requires drills to be conducted quarterly audit sheets back in morning on each shift under varied conditions. LSC meeting every day to be reviewed. Section 19.7.1.8 states employees of health care The results of these audits will be occupancies shall be instructed in life safety reviewed in Quality Assurance procedures and devices. This deficient practice meeting monthly for 6 months or affects all residents, staff and visitors. until 100%complaince is achieved for 3 consecutive months. The QA Findings include: committee will identify any trends or patterns and make Based on review of "Fire/Disaster Drill" recommendations to revise the documentation, "Envive Healthcare Inservice Sign plan of correction as indicated. In" documentation and "2022 Fire Drill Schedule" documentation with the Executive Director, the Director of Maintenance and the Corporate How the corrective action(s) Maintenance Director during record review from will be monitored to ensure the 9:20 a.m. to 1:45 p.m. on 11/01/22, documentation deficient practice will not of the staff who participated in the second shift recur, i.e., what quality fire drills conducted on 03/31/22 at 6:00 p.m. and assurance program will be put on 06/21/22 at 2:00 p.m. was not available for into place; and

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review. Based on interview at the time of record

documentation of the staff who participated in the

review, the Director of Maintenance stated the

facility operates two shifts per day and agreed

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Maintenance director /Designee

will complete random audits daily

Monday through Sunday one

times a week on random shifts

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS	-	45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	review. This finding was review Director, the Director Corporate Maintena conference. 3.1-19(b) 3. Based on record facility failed to doc fire drills were cond within the most record deficient practice affection to the process of the deficient practice affection of the documentation, "En In" documentation with Director of Mainten Maintenance Direct 9:20 a.m. to 1:45 p.1 documentation for the conducted at "3:00" record the day the difference of Maintenance stat shifts per day and assecond shift fire drill record the date the conductor, the Director, the Director.	reviewed with the Executive or of Maintenance and the ance Director during the exit review and interview, the cument the date second shift ducted for one of four quarters and twelve month period. This fects all residents, staff and "Fire/Disaster Drill" vive Healthcare Inservice Sign and "2022 Fire Drill Schedule" the Executive Director, the ance and the Corporate or during record review from m. on 11/01/22, fire drill for "Jan-Dec" 2022 did not rill was conducted. Based on e of record review, the Director ed the facility operates two greed the aforementioned ll documentation did not drill was conducted. viewed with the Executive or of Maintenance and the ince Director during the exit		including weekends for four weeks, then one times a week two weeks, then one times a week two weeks, then one times a week for the one week to ensure fire drills are completed on every per regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviee. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance November 24th, 2022	week e shift ne wed. I be e or eved e QA nds

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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 COMPLETED 01 155077 B. WING 11/02/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS. IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3.1-19(b) K 0761 SS=F Bldg. 01 11/24/2022 Based on record review, observation and K 0761 POC-Life Safety interview; the facility failed to ensure annual inspection and testing of all fire door assemblies Tag K761 were completed in accordance of LSC 19.1.1.4.1.1. F Level Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved What corrective action(s) will self-closing fire door assemblies. (See also Section be accomplished for those 8.3.) LSC 8.3.3.1 Openings required to have a fire residents found to have been affected by the deficient protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door practice? assemblies and fire window assemblies and their accompanying hardware, including all frames, No residents have been affected closing devices, anchorage, and sills in by the deficient practice, but the accordance with the requirements of NFPA 80, facility annual inspection Standard for Fire Doors and Other Opening documentation of fire door Protectives, except as otherwise specified in this assembly in the facility now Code. NFPA 80 5.2.1 states fire door assemblies includes all the doors in the facility shall be inspected and tested not less than which were missed in the report. annually, and a written record of the inspection Like kitchen rolling fire door, shall be signed and kept for inspection by the oxygen containing room AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be How other residents having the performed by individuals with knowledge and potential to be affected by the understanding of the operating components of same deficient practice will be the type of door being subject to testing. NFPA identified and what corrective 80, 5.2.4.1 states fire door assemblies shall be action(s) will be taken. visually inspected from both sides to assess the overall condition of door assembly. No residents have been affected by the deficient practice, but audit NFPA 80, Section 5.2.4.2 states as a minimum, the of the document is made to following items shall be verified: ensure that all the required facility (1) No open holes or breaks exist in surfaces of doors are inspected and either the door or frame. documented.

(2) Glazing, vision light frames, and glazing beads

CTATEMENT OF DEPLOYENCIES VIA DROWNER (CLIRIC LED OF LA						J	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155077	B. W	ING		11/02/	2022
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	R			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	i	INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	are intact and secur	ely fastened in place, if so					
	equipped.				What measures will be put in	nto	
	(3) The door, frame, hinges, hardware, and				place and what systemic		
	noncombustible threshold are secured, aligned,				changes will be made to		
	and in working order with no visible signs of				ensure that the deficient		
	damage.				practice does not recur.		
	(4) No parts are missing or broken.				Maintenance director /Design	ee	
	(5) Door clearances do not exceed clearances				will complete random audits d		
	listed in 4.8.4 and 6.3.1.7.				Monday through Sunday four	•	
	(6) The self-closing device is operational; that is,				times a week on random shift		
	the active door completely closes when operated				including weekends for four		
	from the full open position.				weeks, then three times a we	ek	
	(7) If a coordinator is installed, the inactive leaf				for two weeks, then two times		
	closes before the ac				week for the two weeks, once		
		are operates and secures the					
	door when it is in th			week for one weeks to ensure that the facility annual inspection			
		vare items that interfere or			documentation of fire door		
		are not installed on the door or		assembly in the facility now			
	frame.	ne not instance on the door of			includes all the door.		
		ications to the door assembly			Maintenance director /Design	00	
		ed that void the label.			will bring the audit sheets bac		
	_	edge seals, where required, are			morning meeting every day to		
		their presence and integrity.			reviewed. The results of these		
	-	ice could affect all residents,					
	staff and visitors.	ice could affect all festdents,			audits will be reviewed in Qua	-	
	starr and visitors.				Assurance meeting monthly for months or until 100%complain		
	Findings include:					IC C	
	i manigs include:				is achieved for 3 consecutive	rill	
	Rosed on warrious of	"Maintananga Rindon Fina			months. The QA committee w		
		"Maintenance Binder, Fire			identify any trends or patterns		
	_	and Instructions" and "Fire" the Executive Director, the			make recommendations to re-		
					the plan of correction as indic	aled	
		nance and the Corporate					
		tor during record review from			How the corrective action(s)		
	9:20 a.m. to 1:45 p.m. on 11/01/22, annual				will be monitored to ensure	tne	
	-	ntation of fire door assemblies			deficient practice will not		
	in the facility within the most recent twelve month				recur, i.e., what quality		
	period did not include all fire doors in the facility.			assurance program will b			
	Doors to oxygen storage rooms were not included		into place; and				
	_	re Door Location" in "Fire"			Maintenance director /Design		
	documentation. In addition, the fire door				will complete random audits d	laily	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 11/02/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE (OF INDIANAPOLIS			NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR explanation and institems in NFPA 80, S inspection documented fire door was also noted on interview at the text of the doors in the facility items stated in the endocumentation. Base Executive Director, and the Corporate M tour of the facility from the facili	it could not be ensured all not be facility were included in			ee k in be elity or 6 nce ill and vise
	the inspection docur	mentation and the inspection aded all items in NFPA 80.			
	Director, the Directo	viewed with the Executive or of Maintenance and the nce Director during the exit			
K 0918 SS=F	NFPA 101	- Essential Electric Syste			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155077	A. BUII B. WIN		01	UN	COMPL 11/02/	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, C	CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS					IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PR	OVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
Bldg. 01	-	s - Essential Electric						
	System Maintenar	· ·						
	-	other alternate power						
		ated equipment is capable se within 10 seconds. If the						
		n 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							
	•	nths for 4 continuous hours.						
		der load conditions include						
	a complete simula							
		ual transfer of all EES						
		nducted by competent						
	·	nance and testing of stored rces (Type 3 EES) are in						
		IFPA 111. Main and feeder						
		e inspected annually, and a						
		lically exercising the						
		ablished according to						
	manufacturer requ	irements. Written records						
	of maintenance ar	nd testing are maintained						
	_	ole. EES electrical panels						
		arked, readily identifiable,						
	•	normal power circuits.						
		ssibility of damage of the						
		source is a design						
	consideration for r							
	NFPA 111, 700.10	(NFPA 99), NFPA 110,						
	· ·	review and interview, the	K 09	18	POC-	Life Safety		11/24/2022
		ure an annual fuel quality test	18 09		. 00-	2.10 Galoty		11/27/2022
	•	he facility's diesel-powered			Tag K9	18		
	_	9, Health Care Facilities Code,			F Level			
			1	l				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155077	B. WING		11/02/2022		
			STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R		ACHWAY DR			
ENVIVE	OF INDIANAPOLIS	3		NAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	E	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	2012 Edition, Secti	on 6.5.4.1.1.2 states Type 2 EES					
	(Essential Electrica	l System) generator sets shall					
	be inspected and te	sted in accordance with		What corrective action(s) will			
	Section 6.4.4.1.1.3.	Section 6.4.4.1.1.3 states		be accomplished for those			
	maintenance shall b	pe performed in accordance		residents found to have been			
	with NFPA 110, St	andard for Emergency and		affected by the deficient			
	Standby Power Sys	stems, 2010 Edition, Chapter 8.		practice?			
	NFPA 110, Section	8.3.8 states a fuel quality test					
	shall be performed	at least annually using tests		No residents have been affected	ed		
	approved by ASTM	I standards. This deficient		by the deficient practice, but the	е		
	practice could affect	et all residents, staff and		facility has started annual fuel			
	visitors.			quality test for diesel fired			
				emergency generator and four			
	Findings include:			continuous hour supplemental			
				load testing has been started.			
	Based on record rev	view with the Executive		How other residents having the	ne		
	Director, the Direct	tor of Maintenance and the		potential to be affected by the			
	Corporate Maintena	ance Director from 9:20 a.m. to		same deficient practice will be			
	_	/22, documentation of an annual		identified and what corrective			
	_	the diesel fired emergency		action(s) will be taken.			
		vailable for review. Based on					
	_	e of record review, the Director		No residents have been affecte	ed		
		ted the facility has one diesel		by the deficient practice, but			
	fired emergency ge	-		facility had inspected the			
	documentation of a	n annual fuel quality test for		generator and started the work	ing		
	the diesel fired eme	ergency generator was not		on missing documentation.	Ū		
	available for review						
				What measures will be put int	o		
	This finding was re	viewed with the Executive		place and what systemic			
		tor of Maintenance and the		changes will be made to			
	· ·	ance Director during the exit		ensure that the deficient			
	conference.	-		practice does not recur.			
				Maintenance director /Designe	е		
	3.1-19(b)			will complete random audits da			
				Monday through Sunday four	•		
	2. Based on record	review, observation and		times a week on random shifts			
		ity failed to document 36 month		including weekends for four			
	*	generator testing for 1 of 1		weeks, then three times a weel	k		

emergency generators in accordance with NFPA

99 and NFPA 110. NFPA 99, Health Care Facilities

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for two weeks, then two times a

week for the two weeks, once a

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WI	NG		11/02/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .	45 BEACHWAY DR				
ENVIVE	OF INDIANAPOLIS		INDIANAPOLIS, IN 46224				
			1	L		1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG		41	DATE
		, Section 6.4.1.1.6.1 states Type ial electrical system power			week for one weeks to ensure		
	• •	ll be classified as Type 10,			diesel fired emergency genera		
		nerator sets per NFPA 110.			documents are maintained per regulation. Maintenance direct		
	_	ndard for Emergency and			/Designee will bring the audit	ioi	
		stems, 2010 Edition, Section			sheets back in morning meetir	na	
		EPSS shall be tested at least			every day to be reviewed. The	-	
		6 months. Section 8.4.9.1			results of these audits will be		
	-	shall be tested continuously			reviewed in Quality Assurance	1	
		ts assigned class (See Section			meeting monthly for 6 months		
		2 states where the assigned			until 100%complaince is achie		
	class is greater than	4 hours, it shall be permitted			for 3 consecutive months. The		
	to terminate the test after 4 continuous hours.				committee will identify any trer	nds	
	Section 8.4.9.5 state	es the minimum load for this			or patterns and make		
	test shall be specifie	ed in 8.4.9.5.1, 8.4.9.5.2, or			recommendations to revise the	Э	
	8.4.9.5.3. Section 8	3.4.9.5.3 states for spark-ignited			plan of correction as indicated		
	EPS's, loading shall	be the available EPSS load.					
	-	ice could affect all residents,			How the corrective action(s)		
	staff and visitors.				will be monitored to ensure t	he	
					deficient practice will not		
	Findings include:				recur, i.e., what quality		
	D 1	· variation of			assurance program will be p	ut	
		view with the Executive			into place; and		
	•	or of Maintenance and the			Maintenance director /Designe		
	_	ance Director from 9:20 a.m. to 22, thirty-six month period			will complete random audits da	ally	
	_	or testing documentation for			Monday through Sunday four times a week on random shifts		
		or testing documentation for arrangements for the diesel fired				•	
		or was not available for review.			including weekends for four weeks, then three times a wee	ak	
		at the time of record review,			for two weeks, then two times		
		ntenance stated the facility has			week for the two weeks, once		
		ergency generator and agreed			week for one weeks to ensure		
		applemental load testing for			the diesel fired emergency		
		ne most recent three year			generator documents are		
		lable for review. Based on			maintained per		
	_	ne Executive Director, the			regulation.Maintenance directo	or	
		nance and the Corporate			/Designee will bring the audit		
		or during a tour of the facility			sheets back in morning meetir	ng	
		1:50 a.m. on 11/02/22, the facility			every day to be reviewed. The	-	
	has one diesel fired	emergency generator located			results of these audits will be		
			l				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	outside the building weatherproof shell. rating for the general kW. This finding was re Director, the Direct				reviewed in Quality Assurance meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	or eved e QA nds		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not used wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 98)	ent - Power Cords and ent - Power Cords and catient care vicinity are only ents of movable ed electrical equipment les that have been elified personnel and meet electronical equipment les that have been elified personnel and meet electronics, may not be used for e						

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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 COMPLETED 01 B. WING 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0920 POC-Life Safety 11/24/2022 failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring. LSC 19.5.1 Tag K920 requires utilities to comply with Section 9.1. LSC E Level 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, What corrective action(s) will unless specifically permitted, flexible cords and be accomplished for those cables shall not be used as a substitute for fixed residents found to have been wiring of a structure. LSC Section 4.5.7 states any affected by the deficient building service equipment or safeguard provided practice? for life safety shall be designed, installed and approved in accordance with all applicable NFPA No residents have been affected standards. This deficient practice could affect by the deficient practice, but the over 10 residents, staff and visitors in the vicinity facility has removed the extension of the B Wing nurse's station pantry. cord in the pantry in B wing and replaced it with fix wiring. Findings include: Based on observations with the Executive How other residents having the Director, the Director of Maintenance and the potential to be affected by the Corporate Maintenance Director during a tour of same deficient practice will be the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, identified and what corrective a refrigerator was plugged into an extension cord action(s) will be taken. in the pantry at the B Wing nurse's station. Based on interview at the time of the observations, the No residents have been affected Director of Maintenance agreed an extension cord by the deficient practice, but was being used as a substitute for fixed wiring at facility had audited all the areas to the aforementioned location. ensure there is no extension cords in any other areas of the facility. This finding was reviewed with the Executive Director, the Director of Maintenance and the What measures will be put into Corporate Maintenance Director during the exit place and what systemic conference. changes will be made to ensure that the deficient 3.1-19(b) practice does not recur. Maintenance director /Designee will complete random audits daily Monday through Sunday four

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times a week on random shifts

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	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	01	COMPLETED 11/02/2022		
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				including weekends for four weeks, then three times a week for two weeks, then two times week for the two weeks, once week for one weeks to ensure there is no extension cords in building per regulations. Maintenance director /Designe will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly for months or until 100% complain is achieved for 3 consecutive months. The QA committee wildentify any trends or patterns make recommendations to revithe plan of correction as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; and Maintenance director /Designe will complete random audits do Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure that there are no extension con in the building per regulations. Maintenance director /Designe will bring the audit sheets back morning meeting every day to	a a that the ee a in be lity or 6 ce ll and lise lated		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/02/2022		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS				CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					reviewed. The results of these audits will be reviewed in Qua Assurance meeting monthly for months or until 100% complain is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated Date of compliance November 24th, 2022	lity or 6 ce ill and vise	
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or eo Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withir space of non- or li construction, with that can be secure stored with flamms from combustibles sprinklered) or enc noncombustible cominimum 1/2 hr. fi Less than or equa In a single smoke cylinders available patient care areas of less than or equ required to be store	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.					

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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> COMPLI			ETED	
155077		155077	B. W	ING		11/02/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	on each door or groom, where the sa minimum "CAUTSTORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with intethreshold pressure established. Empavoid confusion. Care protected from 11.3.1, 11.3.2, 11.99) Based on observation failed to ensure 1 of gases such as oxygen falling in 1 of 2 oxystealth Care Faciliti 11.3.1 states storage equal to or greater the cubic feet) shall connected, with racks secure all cylinders connected, unconnected, unconn	ign readable from 5 feet is ate of a cylinder storage sign includes the wording as FION: OXIDIZING GAS(ES) NO SMOKING." If you can be seed in a cylinders are used in a cylinders are segregated. When facility employs gral pressure gauge, a cylinders are marked to cylinders stored in the open	K 0	923	POC- Life Safety Tag K923 E Level What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents have been affect by the deficient practice, but the facility has secured one of the nonflammable gases oxygen storage cylinders properly How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	ted ne t	11/24/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	onstruction <u>0</u> 1	X3) DATE SURVEY COMPLETED	
		155077	B. WING		11/02/2022
	PROVIDER OR SUPPLIE		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	freestanding on the the oxygen storage main dining room	rpe oxygen cylinders were floor near the corridor door to and transfilling room near the and was not properly secured		No residents have been affect by the deficient practice, but the facility had audited all the are	he as to
	fifteen 'E' type oxy room. Based on in	liquid oxygen containers and gen cylinders were stored in the terview at the time of the Corporate Maintenance Director		ensure there is no loose oxyg storage cylinders unsecured i building.	
	a cylinder stand or in the oxygen stora	cylinder was not supported in otherwise secured from falling ge and transfilling room and der storage rack in the room.		What measures will be put in place and what systemic changes will be made to	nto
	This finding was re	eviewed with the Executive		ensure that the deficient practice does not recur. Maintenance director /Design	
	· ·	tor of Maintenance and the ance Director during the exit		will complete random audits of Monday through Sunday four times a week on random shift including week onder for four	
	3.1-19(b)			including weekends for four weeks, then three times a we for two weeks, then two times week for the two weeks, once week for one weeks to ensure there is no unsecured oxygen	a a e that
				cylinders in the building. Maintenance director /Design will bring the audit sheets bac morning meeting every day to	ee k in
				reviewed. The results of these audits will be reviewed in Qua Assurance meeting monthly f months or until 100%complain	e ality or 6
				is achieved for 3 consecutive months. The QA committee w identify any trends or patterns	vill s and
				make recommendations to re the plan of correction as indic How the corrective action(s) will be monitored to ensure	ated
				deficient practice will not	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					assurance program will be p into place; and Maintenance director /Designe will complete random audits d Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure that there are no unsecured oxygen cylinders in the buildin Maintenance director /Designe will bring the audit sheets backmorning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly formonths or until 100% complair is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to revithe plan of correction as indicational patterns of the plan of correction as indicating the plan of correction as indica	ee ailly sek a a a that ee k in be e lity or 6 nce ill and	

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