STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 11/01/22 & 11/02/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/15/22 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At PSR survey to the Emergency Preparedness survey, Envive of Indianapolis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 96. Quality Review completed on 12/19/22	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/01/22 & 11/02/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/15/22 Facility Number: 000032 Provider Number: 155077	K 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 facts alleged or conclusions set forth on the Statement of**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
KAVITA BERI	HFA	12/28/2022

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AIM Number: 100273330 At this PSR survey, Envive of Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Wing. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 12/19/22		**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 submitted 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 June 1st 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to complete a full hydrostatic flush for 2 of 2 automatic sprinkler piping systems which failed flow testing and trip testing. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.3.1(3) states an obstruction investigation shall be conducted for system piping whenever foreign materials are in dry pipe valves or in check valves. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Certificate" documentation dated 07/11/22 with the Executive Director, the Director of Maintenance, and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, the facility's two dry sprinkler systems failed flow testing and trip testing. Review of the sprinkler system inspection contractor's "Service Proposal" documentation dated 08/11/22 indicated a quote to "remove and	K 0353	**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 repair for hydrostatic flush for 2 of 2 automatic sprinkler piping system is in process and a life safety code temporary waiver has been submitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for the facility wide hydrostatic flush had been completed and repair for hydrostatic flush for 2 of 2 automatic sprinkler piping system is in process which failed flow testing and trip testing. **What measures will be put into**	06/01/2023

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	flush each inspector's test until clean water is observed". Based on interview at the time of record review, the Director of Maintenance and the Corporate Maintenance Director stated the quote had been approved and the sprinkler system contractor was actively prepping the system for the flush at the time of the survey but had not yet started or completed the flush of the two sprinkler systems. Based on observations with the Executive 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, the sprinkler system contractor was actively prepping the system for the flush by installing additional sprinkler low point drains in advance of flushing the two dry sprinkler systems for the facility. Based on interview at the time of record review from 9:05 a.m. to 9:30 a.m. on 12/15/22, the Director of Maintenance stated the sprinkler system inspection contractor is still actively prepping the system for the flush at the time of this revisit. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. This deficiency was cited on 11/02/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and		**place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits after the sprinkler system is fixed. Daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure hydrostatic flush for automatic sprinkler piping system is in process which failed flow testing and trip testing. 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 or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends 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 put into place; and** Maintenance director /Designee will complete random audits after the sprinkler system is fixed. Daily Monday through Sunday one	

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	Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Certificate" documentation dated 07/11/22 with the Executive Director, the Director of Maintenance, and the Corporate Maintenance Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, deficiencies were noted for the facility's sprinkler system during the inspection for the facility. The "Notes and Recommendations" section of the 07/11/22 sprinkler system inspection report stated, "Accelerator failed to activate" for the "west side A & B Wings" sprinkler system and "Accelerator was out of service upon arrival" for the "east side C & D Wings". Both sprinkler systems had the following statements "systems have 1 PS10 waterflow switch for 2 dry systems. Each system must have a waterflow switch. Systems have 1 air maintenance device for 2 dry systems, each dry system must have an air maintenance device. System has excessive air pressure". Based on interview at the time of record review, the Director		times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure hydrostatic flush for automatic sprinkler piping system is in process which failed flow testing and trip testing. 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 or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance JUNE 1ST 2023	

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	of Maintenance and the Corporate Maintenance Director provided an approved "Service Proposal" documentation dated 08/11/22 from the sprinkler system inspection contractor but stated repairs to each system on or after 08/11/22 have not yet been performed because the facility was actively trying to perform sprinkler flushing first. Based on interview at the time of record review from 9:05 a.m. to 9:30 a.m. on 12/15/22, the Director of Maintenance stated parts are on order to correct sprinkler system deficiencies noted for the facility's sprinkler systems, but no timetable has been established to complete system repairs or replacement at the time of this revisit. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. This deficiency was cited on 11/02/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions 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 ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.			

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	Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls in 1 of 9 smoke compartments were constructed to resist the transfer of smoke. LSC 8.3.3.1 states fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage and sills shall be in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Openings Protectives. NFPA 80, 2010 Edition, Section 4.8.2.11 states for service counter fire doors, sills shall be provided as part of the fire door assembly. Section 4.8.2.2 states sills shall be constructed of noncombustible materials. Section 4.8.2.5 states for special purpose horizontally sliding accordion or folding doors with frames having a jamb depth of 4 inches or less, the sill width shall be equal to the jamb depth. Section 5.2.5.2 states no open holes or breaks shall exist in surfaces of either the door or frame. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the main dining room. Findings include: Based on observations with the Administrator and the Director of Maintenance during a tour of the facility from 9:30 a.m. to 10:10 a.m. on 12/15/22, the main dining room was open to the corridor. The rolling fire door for the kitchen is in the west	K 0362	Tag K362 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 affected by the deficient practice, but the rolling fire door for the kitchen is in the west wall of main dining room is now on track within the rolling door which caused the rolling door opening to resist the transfer smoke now. To fix the door permanently a life safety code temporary waiver has been submitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents have been affected by the deficient practice, Audit for	06/01/2023

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	wall of the main dining room. The rolling fire door was off track and was not within the door frame for the rolling door which caused the rolling door opening to not resist the transfer of smoke. Based on interview at the time of the observations, the Director of Maintenance agreed the rolling door is off track and would not resist the passage of smoke. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. This deficiency was cited on 11/02/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		the all the fire-resistant doors in the facility had been made. No other doors have the same deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Maintenance director /Designee will complete random audits after the door is permanently fixed. Daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire resistant doors resist the transfer of the smoke. 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 or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends 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**	

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			assurance program will be put into place; and Maintenance director /Designee will complete random audits after the door is permanently fixed. Daily Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week for two weeks, then one times a week for the one week to ensure fire resistant doors resist the transfer of the smoke. 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 or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance JUNE 1ST 2023	