PRINTED: 02/21/2024

	T OF HEALTH AND HU					FORM APPROVED	
STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	XID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u></u>	(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIED		45 E	EET ADDRESS, CITY, STATE, ZIP CO BEACHWAY DR DIANAPOLIS, IN 46224	D		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE API	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
Bldg	conducted by the Ir accordance with 42 Survey Date: 01/30 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency of Indianapolis was Emergency Prepare Medicare and Medand Suppliers, 42 C The facility has 184 the survey, the censury of Iron Iron Iron Iron Iron Iron Iron Iron	2000032 155077 2273330 Preparedness survey, Envive is found not in compliance with edness Requirements for icaid Participating Providers 2FR 483.73. 4 certified beds. At the time of issus was 96. Impleted on 02/05/24 42 CFR Subpart 483.73 is NOT by:	E 0000	Preparation or execution plan of correction does in constitute admission or a of provider of the truth of alleged or conclusions is the Statement of Deficier Plan of Correction is presexecuted solely because required by the position and State Law. The Plan Correction is submitted to the allegation of nonce cited during the Annual stated during	agreement of the facts et forth on encies. The epared and e it is of Federal of to respond ompliance Survey 2024. of er's mpliance . The uests desk liance to shing that		
E 0041 SS=F Bldg	•	8(e), 485.625(e) I LTC Emergency Power tion for Participation:					

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

(e) Emergency and standby power systems.

procedures plan set forth in paragraphs (b)(1)

§482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of

this section and in the policies and

(i) and (ii) of this section.

§483.73(e), §485.625(e)

TITLE (X6) DATE

Gregory Otter Executive Director 02/17/2024

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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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ	JILDING	NSTRUCTION	(X3) DATE COMPI 01/30	LETED		
	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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)) BE	(X5) COMPLETION DATE		
TAG	REGULATORY OF The [LTC facility a implement emergy systems based or forth in paragraph §482.15(e)(1), §4 Emergency gener generator must be the location required Care Facilities Counterim Amendment 12-4, TIA 12-5, ard Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or buildin 482.15(e)(2), §48 Emergency generation, testing requirements four Facilities Code, National Code. 482.15(e)(3), §48 Emergency generation and LTC facilities source to power end to the properties of the plan for her systems and the plan for her systems are sufficient to the properties of the plan for her systems and the plan for her systems and the plan for her systems and the plan for her systems are systems.	and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) eater location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA end TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new er when an existing eng is renovated. 3.73(e)(2), §485.625(e)(2) eater inspection and testing. H and LTC facility] must ergency power system end, and [maintenance] end in the Health Care EPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) eater fuel. [Hospitals, CAHs et that maintain an onsite fuel emergency generators must end wit will keep emergency		TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE		
	*[For hospitals at §483.73(g), and C The standards inc	serational during the s it evacuates. §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the							

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Event ID:

4CYK21

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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 01/30/2024	
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		•	45 BEAC	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Federal Register i	in accordance with 5 U.S.C.					
		R part 51. You may obtain					
	the material from the sources listed below.						
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	, ,	mation on the availability of ARA, call 202-741-6030, or					
	go to:	AIVA, Call 202-741-0030, Ol					
		es.gov/federal register/code					
	· ·	ations/ibr locations.html.					
		this edition of the Code are					
	, ,	eference, CMS will publish a					
	document in the F	ederal Register to					
	announce the cha	anges.					
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
	` '	th Care Facilities Code,					
		ed August 11, 2011. rim amendment (TIA) 12-2 to					
	NFPA 99, issued	, ,					
		FPA 99, issued August 9,					
	2012.	55, 155454 / tagaot 6,					
	(iv) TIA 12-4 to NI	FPA 99, issued March 7,					
	2013.						
	(v) TIA 12-5 to NF	FPA 99, issued August 1,					
	2013.						
	` '	FPA 99, issued March 3,					
	2014.						
	. ,	fe Safety Code, 2012					
	edition, issued Au	•					
	(VIII) TIA 12-1 to N 11, 2011.	IFPA 101, issued August					
		FPA 101, issued October					
	30, 2012.	TA 101, ISSUEU OCIODEI					
		FPA 101, issued October					
	22, 2013.						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155077	B. W	ING		01/30/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	;			IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	FPA 101, issued October					
	22, 2013.						
		standard for Emergency and					
		ystems, 2010 edition,					
	including HAs to a 2009	chapter 7, issued August 6,					
		view, observation and	E 0	041	1: What corrective action(s)	will	02/29/2024
	interview; the facili	ty failed to implement the			be accomplished for those		
	emergency power s	ystem inspection, testing and			residents found to have bee	n	
	maintenance requir	ements found in the Health			affected by the deficient		
	Care Facilities Cod	e, NFPA 110, and Life Safety			practice?		
	Code in accordance	e with 42 CFR 483.73(e)(2).			a. Weekly and monthly genera	ator	
	This deficient pract	ice could affect all residents,			inspections have been added	to	
	staff and visitors.				the Tels workorder system for	ron	
					time reminders and document	tation	
	Findings include:				requirements		
					b. The Director of Maintenance	e	
		of "Emergency Generator			called Evapar and had them		
		documentation with the			preform the Load bank.		
		the Maintenance Director and			c. Evapar has preformed a fu	el	
	_	tenance Director during record			sample.		
		.m. to 12:45 p.m. on 01/30/24,			d. Evapar has changed the		
		generator inspection			batteries.		
		January, February and March			2: How other residents havi	-	
		able for review. Based on			the potential to be affected by	-	
		e of record review, the			the same deficient practice	will	
	-	ance Director stated the facility			be identified and what		
		emergency generator and			corrective action will be take		
	1 -	rgency generator inspection			This deficient practice could a		
		January, February and March			all residents, staff, and visitors		
	2023 was not availa	ible for review.			3: What measures will be pu	τ	
	h hagad an marri	of "Emorganov Computer			into place or what systemic		
		of "Emergency Generator documentation with the			changes will be made to		
		the Maintenance Director and			ensure that the deficient		
		tenance Director during record			practice does not recur? The Director of Maintenance	hac	
	_						
		.m. to 12:45 p.m. on 01/30/24, entation for January, February			been educated by the Execut		
		as not available for review. In			Director on E 041 The General		
					is required to be inspected we	-	
	addition, load testin	ng documentation for load	I		and documented, Monthly loa	ıu	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI 01/30	LETED
NAME OF I	PROVIDER OR SUPPLIEF	2		T ADDRESS, CITY, STATE, ZIP CO EACHWAY DR)D	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF tests conducted wee	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION Ekly for the period of 04/05/23 id not indicate the actual load	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY) test documented, along sampling yearly to ensu	OULD BE PROPRIATE with fuel	(X5) COMPLETION DATE
	generator during the the time of record r Maintenance Direct	d for the diesel powered e test. Based on interview at eview, the Corporate for stated the facility has one may generator, load testing is		work in an emergency. 4: How the corrective a will be monitored to endeficient practice will in a what quality expense.	nsure the not recur	
	documented on a w oversized, and the f testing cannot achie	eekly basis, the generator is acility acknowledges load eve at least 30 % of the name do not record the load		i.e., what quality assur program will be put into The Director of Mainter perform monthly X6. The be placed into the Tels	to place? nance will nis audit will	
	Maintenance Direct test is performed bu bank testing docum	load test. The Corporate for stated an annual load bank at agreed supplemental load entation for the most recent d was not available for review.		scheduled reminders and documentation. Results of these review presented by the Executive Director to the QAPI co	s will be utive	
	documentation date Director, the Maint Corporate Maintena review from 9:10 a documentation of a the facility's diesel within the most rec- not available for rev	of "Fuel Analysis Report" d 12/19/22 with the Executive enance Director and the ance Director during record m. to 12:45 p.m. on 01/30/24, n annual fuel quality test for fuel fired emergency generator ent twelve month period was view. Based on interview at the		further recommendation	ns.	
	Director stated the emergency generate of an annual fuel que diesel fuel fired em most recent twelve	w, the Corporate Maintenance facility has one diesel fired or and agreed documentation hality test for the facility's ergency generator within the month period was not at the time of the survey.				
	inspection contractor Report" documenta Executive Director, the Corporate Main	of the emergency generator or's "Generator Maintenance tion dated 11/21/23 with the the Maintenance Director and tenance Director during record m. to 12:45 p.m. on 01/30/24, the				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/30/2024			
	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	replaced. The "Cor the 11/21/23 report test and need replace interview at time of Maintenance Direct Maintenance Direct Maintenance Direct Generator is tested to batteries are scheduled but agreed emergent replacement docum was not available for Based on observation Director and the Conduring a tour of the p.m. on 01/30/24, the emergency generate on the northeast side manufacturer's namindicated it was rate affixed to each of the indicated they were 2018. These findings were Director, the Maintenance Director, the Maintenance Director interviews at the second statement of the p.m. of th	or batteries need to be mments/Remarks" section of stated, "batteries failed load red (dated 2018)". Based on a the observations, the tor and the Corporate for stated the emergency weekly and will operate, the field to be replaced on 02/05/23 for generator battery frentation on or after 11/21/23 for review. The maintenance of the facility from 1:10 p.m. to 3:50 for facility from 1:10 p.m. to 3:50 for facility has one diesel fired for located outside the building for the property. The fire plate affixed to the generator red at 600 kW. Documentation for two starting batteries from manufactured in October The reviewed with the Executive for the property of the property of the property of the property of the generator red at 600 kW. Documentation for two starting batteries from mufactured in October The reviewed with the Executive for the property of						
K 0000								
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepare	ement facts rth on s. The			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155077	B. W	ING		01/30/	/2024
		l .		CTREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
	OF INDIANAPOLIS				APOLIS, IN 46224		
CINVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 40224		
(X4) ID	SUMMARY	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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Facility Number: 0	000032			executed solely because it is		
	Provider Number:	155077			required by the position of Fed	deral	
	AIM Number: 100	273330			and State Law. The Plan of		
					Correction is submitted to resp	ond	
	At this Life Safety Code survey, Envive of				to the allegation of noncomplia	ance	
	Indianapolis was fo	und not in compliance with			cited during the Annual Surve	y	
	Requirements for P	articipation in			conducted January 30, 2024.		
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			Please accept this Plan of		
	Life Safety from Fi	re and the 2012 Edition of the			Correction as the provider's		
	National Fire Prote	ction Association (NFPA) 101,			credible allegation of compliar	ıce	
	Life Safety Code (I	LSC), Chapter 19, Existing			as of February 29, 2024. The		
	Health Care Occupa	ancies and 410 IAC 16.2.			provider respectfully requests	desk	
					review with paper compliance	to	
	This one story facil	ity was determined to be of			be considered in establishing	that	
	Type III (211) cons	truction and was fully			the provider is in substantial		
	_	cility has a fire alarm system			compliance.		
		on in the corridors, in all areas					
	_	and in rooms 11 through 19 in					
	_	ncility has battery operated					
		all other resident sleeping					
	· ·	has a capacity of 184 and had					
	a census of 96 at the	e time of this survey.					
		idents have customary access					
	_	The facility has four detached					
		storage services and one					
	I -	lousing an emergency					
	generator which we	ere each not sprinklered.					
	Quality Review cor	mpleted on 02/05/24					
K 0100	NFPA 101						
SS=E	General Requiren						
Bldg. 01	General Requiren						
		RKS section any LSC					
		19.1 General Requirements					
		ssed by the provided					
	_	ficient. This information,					
		olicable Life Safety Code or					
	NFPA standard ci	tation, should be included					

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 01/30/2024 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 on Form CMS-2567. Based on observation and interview, the facility K 0100 1: What corrective action(s) will 02/29/2024 failed to ensure fire resistance rating labels on 1 of be accomplished for those 12 cross corridor door sets were not painted. In residents found to have been addition, the facility failed to ensure 2 of 12 cross affected by the deficient corridor door sets would self close and latch into practice? the door frame per 4.6.12.3. LSC 4.6.12.3 requires The Director of Maintenance existing life safety features obvious to the public repaired has repaired the doors to if not required by the Code, shall be either latch when closed. maintained or removed. This deficient practice 2: How other residents having could affect over 20 residents, staff and visitors. the potential to be affected by the same deficient practice will Findings include: be identified and what corrective action will be taken. Based on observations with the Maintenance This deficient practice could affect Director and the Corporate Maintenance Director over 20 residents, staff, and during a tour of the facility from 1:10 p.m. to 3:50 visitors. p.m. on 01/30/24, the south door in the cross 3: What measures will be put corridor door set in the A Wing by Room 10 was into place or what systemic not equipped with a fire resistance rating label. changes will be made to The north door in the cross corridor door set was ensure that the deficient equipped with a 3-hour fire resistance rating label. practice does not recur? Each door in the cross corridor door set in the B The Director of Maintenance has Wing was equipped with a 3-hour fire resistance been educated by the Executive rating label and latching hardware to latch each Director on K100. All smoke and door into the door frame but the door set failed to fire doors shall shut and latch on latch into the door frame when tested to close their own power to prevent smoke multiple times. In addition, the north door in the and fire from spreading. cross corridor door set in the D Wing by Room D8 4: How the corrective action was equipped with a 3-hour fire resistance rating will be monitored to ensure the label and latching hardware to latch the door into deficient practice will not recur the door frame but the door failed to latch into the i.e., what quality assurance door frame when tested to close multiple times. program will be put into place? Based on interview at the time of the The Director of Maintenance will observations, the Maintenance Director and the perform monthly review X6. This Corporate Maintenance Director agreed the doors audit will be placed into the Tels in the aforementioned cross corridor door sets system for scheduled reminders would not fully self close and latch into the door and documentation. frame when tested to close or were not equipped Results of these reviews will be with a fire resistance rating label. presented by the Executive

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BU B. W		01	COMPL 01/30/	
		155077	D. W.	_		01/30/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS			45 BEACHWAY DR INDIANAPOLIS, 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
	Director, the Mainte	e reviewed with the Executive enance Director and the ence Director during the exit			Director to the QAPI committe further recommendations.	e for	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 1. Based on observation or impediments to fire or other emerge could affect over 40 needing to exit the fire the facility from 8:50 a. wheeled wheelchair A Wing corridor ne projected four feet in corridor. Based on Maintenance Direct Maintenance Direct from 1:10 p.m. to 3.	Ays, corridors, exit cations, and accesses are in Chapter 7, and the means accessly maintained free of full use in case of its modified by 18/19.2.2 1	K 0	211	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? 1. The Director of Maintenanch has removed all furniture/obstructions to allow egress 2. All key knobs were removed from resident rooms 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be taked. This deficient practice could an over 40 residents, staff and visitors. 3: What measures will be put into place or what systemic changes will be made to	e d ng y vill en.	02/29/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155077	B. WIN	NG		01/30/	2024
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	the A Wing corrido	r near Room A1. In addition,			ensure that the deficient		
	furniture was stored	l in the east exit vestibule of			practice does not recur?		
	the C Wing which interfered with exit access.				The Director of Maintenance h	nas	
	Based on interview at the time of the				been educated by the Executi	ve	
		laintenance Director agreed			Director on K211 maintaining	а	
		means of egress were not			clear path of egress for emerg	ency	
		ned free of all obstructions or			evacuation purposes.		
	_	instant use in the case of fire			4: How the corrective action		
	or other emergency	•			will be monitored to ensure t		
					deficient practice will not red	ur	
	_	e reviewed with the Executive			i.e., what quality assurance	_	
		enance Director and the			program will be put into place		
		ance Director during the exit			The Director of Maintenance v	vill	
	conference.				perform monthly review X6.		
	2.1.10(1.)				Results of these reviews will b	е	
	3.1-19(b)				presented by the Executive	. .	
	2 D11	4:			Director to the QAPI committee	e for	
		ation and interview, the facility ridor doors to 2 of over 60			further recommendations.		
		oms were not provided with a					
		nich required a key to unlock					
		This deficient practice could					
	affect four residents	-					
	affect four residents	s and starr.					
	Findings include:						
	Based on observation	ons with the Maintenance					
		orporate Maintenance Director					
		facility from 1:10 p.m. to 3:50					
	_	he corridor door to resident					
	-	and D15 was equipped with a					
		ndle which required a key to					
		ridor side of the door. The					
		st mechanism to unlock the					
		de of the door. The exit from					
		be through a shared restroom					
		resident sleeping room. Based					
		time of the observations, the					
		ance Director stated the rooms					
	_	vated, the rooms were probably					

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 01/30/2024	
	ROVIDER OR SUPPLIER		4	5 BEAC	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	probably has the ker contractor forgot to agreed the aforement not continually main or impediments to f	supplies and the contractor y to unlock the door, the change out the lock and ntioned means of egress were ntained free of all obstructions full instant use in the case of					
	_	e reviewed with the Executive enance Director and the					
		nce Director during the exit					
	3.1-19(b)						
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special locking arr clinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carriful other such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special locking arresponding to the special locking to the special locking arresponding to the special locking arresponding to the special locking t	king arrangements for the seds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1,					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		 JILDING	01	COMPL 01/30	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS			APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		curity Locking requirements	TAG			DATE
		addition, the locks must be				
		at fail safely so as to				
		of power to the device; the				
	· ·	ed by a supervised				
	automatic sprinkle	er system and the locked				
	space is protected	l by a complete smoke				
	detection system	(or is constantly monitored				
	at an attended loc	ation within the locked				
		the sprinkler and detection				
	_ ·	ged to unlock the doors				
	upon activation.					
	18.2.2.2.5.2, 19.2					
	DELAYED-EGRE					
	ARRANGEMENT					
		lelayed-egress locking in accordance with				
	7.2.1.6.1 shall be					
		g low and ordinary hazard				
		gs protected throughout by				
		ervised automatic fire				
		or an approved, supervised				
	automatic sprinkle					
	18.2.2.2.4, 19.2.2	.2.4				
	ACCESS-CONTR	OLLED EGRESS				
	LOCKING ARRAN					
	Access-Controlled	l Egress Door assemblies				
		lance with 7.2.1.6.2 shall				
	be permitted.					
	18.2.2.2.4, 19.2.2					
	ELEVATOR LOBE					
	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				
		sed automatic sprinkler				
	system.					
	18.2.2.2.4, 19.2.2	2.4				
	1			1		•

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155077	B. W	NG		01/30/	2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	S.			ACHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS				IAPOLIS, IN 46224		
LINVIVE	OI HADIWIAL OFIO			וואוטואוו	7 11 OLIO, IIV 40224		
(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		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		on and interview, the facility	K 0	222	1: What corrective action(s)	will	02/29/2024
		means of egress through 2 of			be accomplished for those		
		y accessible for residents			residents found to have been	า	
		agnosis requiring specialized			affected by the deficient		
		Doors within a required means			practice?		
	_	be equipped with a latch or			The Maintenance Director has	3	
	_	the use of a tool or key from the			placed the code next to each		
	1 -	therwise permitted by LSC			keypad		
		ction 7.2.1.5.3 states locks, if			2: How other residents having	_	
	1 ~	require the use of a key, a tool,			the potential to be affected b	-	
		ge or effort for operation from			the same deficient practice v	vill	
	_	or-locking arrangements shall			be identified and what		
	_	ordance with 19.2.2.2.5.2. This			corrective action will be take		
		ould affect over 20 residents,		This deficient practice			
	staff and visitors.				over 20 resident, staff and visi		
					3: What measures will be put	t	
	Findings include:				into place or what systemic		
					changes will be made to		
		ons with the Maintenance			ensure that the deficient		
		rporate Maintenance Director			practice does not recur?		
	_	facility from 1:10 p.m. to 3:50			The Director of Maintenance h		
	1 ~	ne corridor door set in the C			been educated by the Executi		
		was equipped with magnetic			Director on K222 maintaining	the	
	_	teep the doors closed when			posting of the code at each		
		the fully closed position. The			keypad required to allow egre	ss in	
		leased to open by entering a			the event of an emergency		
	1	by Room C2 but the code was			4: How the corrective action		
		ypad. The corridor door set at			will be monitored to ensure t		
		O Wing from the center lobby			deficient practice will not rec	ur	
		with magnetic locking devices			i.e., what quality assurance	_	
		vas in the fully closed position.			program will be put into place		
		be released to open by			The Director of Maintenance v	vill	
		ne keypad but the code was			perform monthly review X6.		
	_	on interview at the time of the			Results of these reviews will b	е	
		orporate Maintenance Director			presented by the Executive		
	_	nouses residents with the			Director to the QAPI committe	e for	
	_	be in a secure but agreed the			further recommendations.		
		door set to open by the					
		ring and at the C Wing exit by					
	Room C2.		1		1		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ì í	LDING	onstruction 01	(X3) DATE : COMPL 01/30/	ETED
	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	These findings were Director, the Mainten Corporate Maintena conference. 3.1-19(b) NFPA 101 Exit Signage Exit Signage Exit Signage Exit Signage Exit and directiona accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6.1. Based on observatialed to install exit facility in accordance 7.10.1.2.1 states exit doors that obviously as exits, shall be mais readily visible from LSC 7.10.1.2.2 state egress path within a marked by approved where the continuat obvious. This defici	e reviewed with the Executive enance Director and the ince Director during the exit. al signs are displayed in 1.0 with continuous erved by the emergency ne-story existing less than 30 occupants exit travel is obvious.) exit travel is obvious.) etion and interview; the facility signage in 1 of 5 wings in the ce with LSC 7.10. LSC ts, other than main exterior exit of an another than any direction of exit access. Es horizontal components of the en exit enclosure shall be diexit or directional exit signs ion of the egress path is not ient practice could affect over	K 02	TAG	1: What corrective action(s) to be accomplished for those residents found to have beer affected by the deficient practice? 1. The Director of Maintenance replaced the missing exit signs 2. Not an exit signage placed proper door. 2: How other residents having the potential to be affected by the same deficient practice with the same deficient practice with the same deficient practice with the potential to be affected by the same deficient practice with the potential to the same deficient practice with the same deficient practice with the same deficient practice with the same deficient prac	will e age. on	
	20 residents, staff at Findings include:				be identified and what corrective action will be take This deficient practice could at over 20 residents, staff, and		
	Director and the Co during a tour of the	ons with the Maintenance rporate Maintenance Director facility from 1:10 p.m. to 3:50 the entrance to the D Wing at			visitors. 3: What measures will be put into place or what systemic changes will be made to	:	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155077	B. W	ING		01/30/	2024
				CTDEET A	DDDFGG CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
	OF INDIANADOLIO				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the corridor door se	t by Room D3 was not marked			ensure that the deficient		
	as a facility exit wit	th an exit sign. Based on			practice does not recur?		
	-	e of the observations, the			The Director of Maintenance h	as	
		ance Director stated the D			been educated by the Executiv		
	Wing had recently been renovated, the exit sign				Director on K293. The requirm		
	may not have been put back in place after the				of exit signage along with the		
	renovation and agreed the path of egress was not				importance of marking No exit		
		orridor door set closed.			doors.		
					4: How the corrective action		
	These findings were	e reviewed with the Executive			will be monitored to ensure t	he	
	_	enance Director and the			deficient practice will not rec		
	Corporate Maintenance Director during the exit				i.e., what quality assurance	· ui	
	conference.				program will be put into place	۵2	
	conference.				The Director of Maintenance w		
	3.1-19(b)				perform monthly review X6. Th		
	3.1 17(0)				audit will be placed into the Tels		
	2 Based on observa	ation and interview, the facility			system for scheduled reminde		
		f 1 doors to the outside of the			and documentation.	13	
		ng Activities Room was not			Results of these reviews will b	0	
	_	ty exit. LSC 7.10.8.3.1 states			presented by the Executive	C	
		or stairway that is neither an			Director to the QAPI committee	o for	
		kit access and that is located or			further recommendations.	E 101	
		s likely to be mistaken for an			luttilet recommendations.		
	_	ied by a sign that reads as					
		The NO EXIT sign shall have					
		-					
		ers 2 inches high, with a stroke					
		h, and the word EXIT below					
	· ·	s such sign is an approved					
		deficient practice could affect					
	5 residents, staff and	d Visitors.					
	E' 1' ' 1 1						
	Findings include:						
	Deceded 1	- u - sociale ale - Marina					
		ons with the Maintenance					
		orporate Maintenance Director					
	_	facility from 1:10 p.m. to 3:50					
	_	he exit door to the courtyard in					
		ies Room was not posted with					
		NO EXIT sign. Based on					
	interview at the tim	e of the observations, the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			JILDING	01	COMPL 01/30/	ETED		
	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)	TE	(X5) COMPLETION DATE	
K 0321	Maintenance Direct courtyard is not an e agreed the aforemen did not have a NO E These findings were Director, the Mainte	or and the Corporate or stated the door to the exit to the public way and ationed door to the courtyard EXIT sign posted. The reviewed with the Executive enance Director and the ance Director during the exit						
SS=E Bldg. 01	Hazardous Areas Hazardous Areas Hazardous Areas Hazardous areas a barrier having 1-ho (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door.	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have pplied protective plates that inches from the bottom of and zone locations of hat are deficient in						
	b. Laundries (large	Automatic Sprinkler N/A Fired Heater Rooms er than 100 square feet) ance, and Paint Shops						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155077	B. W	ING		01/30/2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					CHWAY 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection	n Rooms					
	(exceeding 64 gallons)						
	f. Combustible Sto	orage Rooms/Spaces					
	(over 50 square fe	eet)					
	g. Laboratories (if	classified as Severe					
	Hazard - see K322)						
		on and interview, the facility	K 0	321	1: What corrective action(s)	will	02/29/2024
	failed to ensure 4 of over 15 hazardous areas such as combustible storage rooms/spaces (over 50				be accomplished for those		
					residents found to have been	n	
	square feet) were separated from other spaces by				affected by the deficient		
	smoke resistant partitions and doors. Doors shall				practice?		
	be self closing or automatic closing in accordance				The Director of Maintenance I	nas	
		leficient practice could affect			had the dining room emptied	of all	
	over 20 residents, st	taff and visitors.			construction/combustible		
					materials.		
	Findings include:				2: How other residents havi	_	
					the potential to be affected b	-	
		ons with the Maintenance			the same deficient practice v	vill	
		orporate Maintenance Director			be identified and what		
		facility from 1:10 p.m. to 3:50			corrective action will be take		
	-	ne main dining room was being			This deficient practice could a	ffect	
	_	of combustible materials and			over 20 residents, staff, and		
	_	ridor. Combustible supplies			visitors.		
		10 wooden pallets in the room			3: What measures will be pu	t	
		e and supplies stockpiled from			into place or what systemic		
		ed in the facility. In addition,			changes will be made to		
	-	the ceiling of the B Wing			ensure that the deficient		
		storage room for a water leak			practice does not recur?		
		partially detached which			The Director of Maintenance h		
	_	ove. Resident sleeping rooms			been educated by the Executi		
		en converted to combustible			Director on K321. Hazardous		
		ns as part of the facility rridor door to each of the two			areas such as combustible	.0	
					storage rooms/spaces (over 5		
	rooms was not equipped with a self closing or				square feet) must be separate	eu	
		evice. Based on interview at			from other spaces by smoke		
		rvations, the Maintenance			resistant partitions and doors.		
		rporate Maintenance Director			Doors shall be self-closing or		
	agreed the aforemen	ntioned hazardous areas were			automatic closing.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077 A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	.ΤΕ	(X5) COMPLETION DATE
	resistant partitions a These findings were Director, the Mainte	other spaces with smoke and doors. e reviewed with the Executive enance Director and the ance Director during the exit		4: How the corrective action will be monitored to ensure to deficient practice will not redice., what quality assurance program will be put into place. The Director of Maintenance of perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	the cur ee? will	
K 0324 SS=D Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer particular facilities with 30 or fewer particular facilities NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on record rev	nt is protected in NFPA 96, Standard for oll and Fire Protection of ing Operations, unless: ng equipment (i.e., small is microwaves, hot plates, if for food warming or limited ance with 18.3.2.5.2, is open to the corridor in ents with 30 or fewer with the conditions under 15.3, or 15 in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not pridor.	K 0324	1: What corrective action(s) be accomplished for those	will	02/29/2024
		f 1 kitchen fire suppression ted semiannually. NFPA 96,		be accomplished for those residents found to have been	n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 01/30/2024		
	PROVIDER OR SUPPLIEI		45 BE	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
	SUMMARY (EACH DEFICIENT REGULATORY OF INDIANAPOLIS) 2011 Edition, Stand Fire Protection of COperations, Section the fire-extinguishing hoods containing a water system that is the grease removal plenums, and the exproperly trained, quacceptable to the aulease every six more could affect over two kitchen. Findings include: Based on review of suppression system "Kitchen Fire Suppression system" Kitchen Fire Suppression determined the Executive Direction of the suppression determined the suppression det	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION lard for Ventilation Control and Commercial Cooking 11.2.1 states maintenance of ing systems and listed exhaust constant or fire-activated is listed to extinguish a fire in devices, hood exhaust chaust ducts shall be made by italified, and certified person(s) ithority having jurisdiction at iths. This deficient practice ivo staff and visitors in the	45 BE	ACHWAY DR	DE PRIATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE	
	record review from 01/30/24, it was grebetween semiannual inspections conduct twelve month period time of record reviewand the Corporate May greater than se semiannual kitchen conducted within the period. These findings wer Director, the Maint	9:10 a.m. to 12:45 p.m. on eater than seven months in all kitchen exhaust system ted within the most recent d. Based on interview at the ew, the Maintenance Director Maintenance Director agreed it wen months in between exhaust system inspections are most recent twelve month the ereviewed with the Executive tenance Director and the enance Director during the exit		inspected semiannually to safety and proper operation 4: How the corrective acti will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into p	ensure ns on re the recur ce blace? ce will . This e Tels enders ill be	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on observational fire Alarm 1.3 requires a firested, and maintained in accord 9.6.1.3 requires a firested, and maintain 70, National Electric National Fire Alarm 14.2.1.2.2 requires to malfunctions shall be practice could affect visitors. Findings include: Based on observation Director during the facility from 8:50 at main fire alarm con Maintenance Office was silenced. Based the initial walk throstated dust from the renovation of the facility for th	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? 1. The Director of Maintenanch has called Elwood Fire Protecto clear the trouble from the pand ensure normal operations. 2. Elwood has inspected the missed smoke dectors in room C11 to C 19 3. Elwood has preformed a sensivity test on smoke dector rooms C11 to C 19 2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be taked This deficient practice could a all residents, staff, and visitors 3: What measures will be purint place or what systemic changes will be made to ensure that the deficient practice does not recur?	e tion anel . ms rs in ng yy vill en. ffect s.

4CYK21

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155077	B. W	ING		01/30	/2024
		l		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			CHWAY DR		
ENIVIVE A	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVE '	OI INDIANAFOLIS			INDIAN	AI OLIO, IIV 40224		
(X4) ID	SUMMARY	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		but he did not know why the			The Director of Maintenance h		
		t was illuminated. Based on			been educated by the Executi		
		ne Maintenance Director and			Director on K345 Fire Alarm m		
	•	tenance Director during a tour			be in proper working order, pro	oper	
		1:10 p.m. to 3:50 p.m. on			time and no trouble or faults		
		fire alarm control panel for the			indicated. All smoke dectors a		
	•	the trouble mode and was			required to be inspected per c	ode.	
	silenced. Based on interview at the time of the				4: How the corrective action		
	observations, the Maintenance Director and the				will be monitored to ensure t		
	Corporate Maintenance Director stated the fire				deficient practice will not red	ur	
	alarm is operable and would function but the				i.e., what quality assurance		
	facility is working with the fire alarm system				program will be put into plac	e?	
	monitoring company to determine why the panel				The Director of Maintenance v		
	is in the trouble mode.				perform monthly review X6. To	0	
					ensure correct information on		
		e reviewed with the Executive			panel display. This audit will b		
	· ·	enance Director and the	placed into the Tels system for				
	-	ance Director during the exit			scheduled reminders and		
	conference.				documentation.		
					Results of these reviews will b	e	
	3.1-19(b)				presented by the Executive		
					Director to the QAPI committe	e for	
		review, observation and			further recommendations.		
	· ·	ty failed to ensure 1 of 1 fire					
	-	maintained in accordance with					
		3 requires a fire alarm system to					
		and maintained in accordance					
		ional Electrical Code and NFPA					
		larm Code. NFPA 72, 2010					
	· ·	4.5 requires testing shall be					
	-	dance with Table 14.4.5 Testing					
		14.4.5 at 15.(h) states fire					
	•	e detectors shall be functional					
	•	ction 14.6.2.4 states a record of					
	all inspections, testing and maintenance shall be						
	provided that includes all applicable information						
	requested in Figure 14.6.2.4. This deficient						
	_	t over 20 residents, staff and					
	visitors in the C Wi	ng.					
1	l		1		l e e e e e e e e e e e e e e e e e e e		1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	
ENVIVE	OF INDIANAPOLIS		INDIAN	NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
	Based on review of inspection contracted documentation date. Director, the Maintenareview from 9:10 a. smoke detector test most recent twelve detectors installed it through C19 was no 01/05/24 testing documentation areas in the C Wing resident sleeping roothe time of record resident sleeping roothe time of record resident sleeping roothe tested the C Wing was not detectors because of the C Wing were tested to the C Wi	the fire alarm system or's "Fire Alarm Report" d 01/05/24 with the Executive enance Director and the ance Director during record m. to 12:45 p.m. on 01/30/24, ing documentation within the month period for smoke in resident sleeping rooms C11 of available for review. The cumentation did include six is but it did not include the oms. Based on interview at eview, the Corporate for stated the facility is ion, the contractor may not awase of the renovation but farm system smoke detectors in steed on 01/05/24 and agreed mentation for fire alarm stors installed in resident through C19 within the most in period was not available for observations with the for and the Corporate for during a tour of the facility is 50 p.m. on 01/30/24, the C Wing in the core installed in resident through C19. The reviewed with the Executive enance Director and the ence Director during the exit			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WI	NG		01/30/	/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			CHWAY DR		
ENIVIVE (OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVL	OI INDIANAI OLIO			IINDIAIN	AI OLIO, III 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		review, observation and					
		ty failed to ensure 1 of 1 fire					
	alarm systems was maintained in accordance with						
	9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to						
		and maintained in accordance					
	with NFPA 70, National Electrical Code and NFPA						
	72, National Fire Alarm Code. NFPA 72, 2010						
	Edition, Section 14.4.5 requires testing shall be						
	performed in accordance with Table 14.4.5 Testing						
	Frequencies. Section 14.4.5.3.1 states sensitivity						
	shall be checked within 1 year after installation.						
	Section 14.4.5.3.2 states sensitivity shall be						
	checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3.						
	-	oke detectors or smoke alarms					
		sitivity outside the listed and					
		range shall be cleaned and					
	-	eplaced. Section 14.6.2.4 states					
	a record of all inspe	-					
	_	be provided that includes all					
		ion requested in Figure					
		cient practice could affect over					
		nd visitors in the C Wing.					
	20 residents, starr a	nd visitors in the C wing.					
	Findings include:						
		the fire alarm system					
	•	or's "Fire Alarm Report"					
		ed 10/17/23 with the Executive					
	· ·	enance Director and the					
	_	ance Director during record					
		m. to 12:45 p.m. on 01/30/24,					
		sitivity testing documentation					
		s installed in resident sleeping					
	rooms C11 through C19 was not available for						
		23 sensitivity testing					
		include six areas in the C Wing					
		le the resident sleeping rooms.					
	Based on interview	at the time of record review,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		JILDING	01	COMPL 01/30/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	the Corporate Maint facility is undergoin may not have sensitives in the resident sleeping roo of the renovation but system smoke detect sensitivity tested on sensitivity testing do system smoke detect sleeping rooms C11 recent two year perioreview. Based on of Maintenance Direct from 1:10 p.m. to 3: is currently occupied system smoke detect sleeping rooms C11. These findings were Director, the Maintenance Director, the Maintenance Director, the Maintenance Director, the Maintenance Corporate Maintenance Director.	grenovation, the contractor ivity tested the C Wing om smoke detectors because it agreed other fire alarm tors in the C Wing were 10/17/23 and agreed ocumentation for fire alarm tors installed in resident through C19 within the most od was not available for bservations with the or and the Corporate or during a tour of the facility 50 p.m. on 01/30/24, the C Wing d by residents. Fire alarm tors are installed in resident				
V 0252	3.1-19(b)					
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing ar and standpipe systems and, and maintained in IFPA 25, Standard for the ag, and Maintaining of Protection Systems. And design, maintenance, and are maintained in a and readily available. System last checked ———————————————————————————————————				

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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 01/30/2024 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 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 K 0353 02/29/2024 1: What corrective action(s) will interview; the facility failed to provide written be accomplished for those documentation or other evidence the sprinkler residents found to have been system components had been inspected and affected by the deficient tested for 1 of 4 quarters. Sprinkler systems shall practice? be properly maintained in accordance with NFPA 1. The Director of Maintenance 25, Standard for the Inspection, Testing, and has contacted Elwood fire Maintenance of Water-Based Fire Protection protection and scheduled future Systems, 2011 Edition. NFPA 25, Section 5.2.5 timely compliant inspections requires that waterflow alarm devices shall be 2. All ceiling holes have been inspected quarterly to verify they are free of repaired and all missing tiles were physical damage. NFPA 25, Section 5.3.3.1 replaced. requires the mechanical waterflow alarm devices 2: How other residents having including, but not limited to, water motor gongs, the potential to be affected by shall be tested quarterly. NFPA 25, Section 4.3.1 the same deficient practice will requires records shall be made for all inspections, be identified and what tests, and maintenance of the system components corrective action will be taken. and shall be made available to the authority This deficient practice could affect having jurisdiction upon request. NFPA, 25 all residents, staff and visitors. Section 4.3.2 requires that records shall indicate 3: What measures will be put the procedure performed (e.g., inspection, test, or into place or what systemic maintenance), the organization that performed the changes will be made to work, the results, and the date. This deficient ensure that the deficient practice could affect all residents, staff and practice does not recur? visitors in the facility. The Director of Maintenance has been educated by the Executive Findings include: Director on K353. Sprinkler inspections must be conducted Based on review of the sprinkler system quarterly and documented. All inspection contractor's "Sprinkler System Test ceiling penetrations must be Report" documentation dated 05/25/23, 08/03/23 sealed to prevent the passage of

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and 01/05/24 with the Executive Director, the

Maintenance Director and the Corporate

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smoke and fire.

4: How the corrective action

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ì í	UILDING	onstruction 01	(X3) DATE COMPL 01/30	ETED	
	OF PROVIDER OR SUPPLIEI E 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		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	Maintenance Direct 9:10 a.m. to 12:45 quarter (October, N sprinkler system in was available for rewith the Maintenan Maintenance Direct from 1:10 p.m. to 3 sprinkler system in a hanging tag to the system risers located indicating fourth quarter in the contractor on 12/18 time of the observation of	tor during record review from p.m. on 01/30/24, no fourth lovember, and December) 2023 spection report documentation eview. Based on observations are Director and the Corporate tor during a tour of the facility :50 p.m. on 01/30/24, the spection contractor had affixed a facility's two dry sprinkler and in the Laundry Room parter 2023 water flow alarming was performed by the stone, the Maintenance or porate Maintenance Director more than 90 days in between system inspection and testing			will be monitored to ensure deficient practice will not redice., what quality assurance program will be put into place The Director of Maintenance perform monthly review X6. The audit will be placed into the Total system for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	cur ce? will his els ers		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			JILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED		
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 DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ATE	(X5) COMPLETION DATE	
	Findings include:							
	Director and the Coduring a tour of the p.m. on 01/30/24, the ceiling smoke barria. numerous suspens in the main dining in the two suspended codietary office in the c. the attic access p. Wing short hall want there were numerous panels installed on exposed the attic and d. panels installed of storage room for a supartially detached we. a three inch in disceiling of the room Wing exit door vest detector had been in Based on interview observations, the M. Corporate Maintena aforementioned open maintain ceiling comments. These findings were Director, the Maintena for the control of the c	ded ceiling tiles were missing froom. ceiling tiles were missing in the kitchen. anel was not in place in the B feer heater room. In addition, as gaps in between drywall the ceiling in the room which force. In the ceiling of the B Wing from the ceiling of the B Wing from the ceiling of the attic above. In the ceiling of the attic above, at the corridor near the C fibule where a former smoke finitely at the time of the faintenance Director and the faintenance Director agreed the fenings in the ceiling did not						
K 0363 SS=E	NFPA 101 Corridor - Doors							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		l í	JILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS				45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
				<u> </u>	,		
(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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Corridor - Doors						
		orridor openings in other					
	•	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	•	g fire for at least 20					
		fully sprinklered smoke					
	•	only required to resist the					
	. •	. Corridor doors and doors					
	to rooms containing	•					
		rials have positive latching atches are prohibited by					
		hese requirements do not					
	•	spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
		ceeding 1 inch. Powered					
	_	vith 7.2.1.9 are permissible					
		device capable of keeping					
	-	nen a force of 5 lbf is					
		no impediment to the					
		rs. Hold open devices that					
	-	door is pushed or pulled are					
		ed protective plates of					
	•	re permitted. Dutch doors					
	meeting 19.3.6.3.6	are permitted. Door					
	frames shall be lat	peled and made of steel or					
	other materials in	compliance with 8.3,					
	unless the smoke	compartment is					
	sprinklered. Fixed	fire window assemblies are					
	allowed per 8.3. In	sprinklered compartments					
		ctions in area or fire					
		s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR I	Parts 403, 418, 460, 482,					
	483, and 485						
	Show in REMARK	S details of doors such as					
	fire protection ratir	ngs, automatics closing					

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AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155077	B. W	B. WING 01/30/2024				
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	2			CHWAY DR			
FN\/I\/F	OF INDIANAPOLIS				IAPOLIS, IN 46224			
V.V	J. 11121/11/11 OLIO				CLIO, III 10227			
(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	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	devices, etc.						0.0 (0.0 (0.0)	
		on and interview, the facility	K 0	363	1: What corrective action(s)	will	02/29/2024	
		f over 60 corridor doors had no			be accomplished for those			
	_	ing and latching into the door			residents found to have been	n		
		sist the passage of smoke.			affected by the deficient			
	_	ice could affect over 20			practice?			
	residents, staff and	VISITORS.			The Director of Maintenance h	nas		
					repaired this door.			
	Findings include:				2: How other residents havi	_		
	D 1	tal at the section			the potential to be affected b	- 1		
		ons with the Maintenance			the same deficient practice v	vill		
		orporate Maintenance Director			be identified and what			
	_	facility from 1:10 p.m. to 3:50			corrective action will be take			
	-	he latching plate and latching			This deficient practice could a	ffect		
		corridor door to resident			over 20 residents, staff and			
		was loose and partially			visitors.			
		loor which prevented the door			3: What measures will be pu	t		
		and latching into the door frame			into place or what systemic			
		e multiple times. In addition, a			changes will be made to			
		ted around the door handle for			ensure that the deficient			
		the D Wing Housekeeping			practice does not recur?			
		hich would not resist the			The Director of Maintenance h			
		Based on interview at the time			been educated by the Executi			
		s, the Corporate Maintenance			Director on K363 fire doors m			
		corridor door to resident			shut and latch to prevent smo	ке		
		mpediment to closing and			and fire from spreading.			
	_	or frame and each of the two			4: How the corrective action			
	uoors would not res	sist the passage of smoke.			will be monitored to ensure to			
	Those fir dince	a ravioused with the Everentine			deficient practice will not red	cur		
	_	e reviewed with the Executive enance Director and the			i.e., what quality assurance			
	, , , , , , , , , , , , , , , , , , ,				program will be put into place. The Director of Maintenance was a second control of the program will be put into place.			
	conference.	ance Director during the exit				WIII		
	conference.				perform monthly review X6.			
	3.1-19(b)				Results of these reviews will be	ਮਦ 		
	3.1-19(0)				presented by the Executive	o for		
					Director to the QAPI committe further recommendations.	E IOF		
					iuither recommendations.			
K 0374	NFPA 101							
SS=E		ilding Spaces - Smoke						
	I OUDUIVIDIUII UI DUI	namy opaces - omere	1		i .			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 01/30/2024					
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 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)	(X5) COMPLETION DATE			
Bldg. 01	Barrier Doors 2012 EXISTING Doors in smoke basolid bonded wood construction that r Nonrated protective are permitted. Doof fixed fire window as are self-closing or require latching, a in the direction of provides a minimulation of for swinging or ho 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 2 of would restrict the management of 20 minutes. LSC, So doors in smoke barriers to only the minimum of operation which is of the movement of sn could affect over 40. Findings include: Based on observation Director and the Co during a tour of the p.m. on 01/30/24, th B Wing short hall a D17 each swing to of were equipped with but the coordinator which caused the do	esists fire for 20 minutes. The plates of unlimited height one are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening arm clear width of 32 inches rizontal doors.	K 0374	1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice? The Director of Maintenance replaced the door coordinator the door now shuts properly 2: How other residents havi the potential to be affected to the same deficient practice to be identified and what corrective action will be take This deficient practice could a 40 residents, staff and visitors 3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance been educated by the Execut Director on K374 All fire and smoke doors must close fully	nas and ng y will en. ver s. t			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
155077		B. WII	NG		01/30/	2024	
	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)	TE	(X5) COMPLETION DATE
K 0511 SS=E	coordinator and cau inch when tested to on interview at the t Maintenance Direct Maintenance Direct cross corridor smok fully close when tes would not resist the These findings were Director, the Mainte	sed a gap of greater than 1/8 close multiple times. Based time of the observations, the or and the Corporate or agreed the aforementioned ted to close multiple times and passage of smoke. The reviewed with the Executive tenance Director and the time Director during the exit			prevent smoke and fire from spreading. 4: How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The Director of Maintenance was perform monthly review X6. The audit will be placed into the Tesystem for scheduled reminder and documentation. 'Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	e? vill is els ers	
Bldg. 01	complies with NFF Code, electrical with NFF Code, electrical with NFF Code. Existing instance provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 3 of were protected in an NFPA 70, National Article 406.5, states so that live wiring to contact. NFPA 70, Receptacle Faceplate receptacle faceplate completely cover the mounting surface.	gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.	K 05	511	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance have replaced the broken GFCI outland replaced missing outlet covers. 2: How other residents having the potential to be affected by the same deficient practice where identified and what	n nas let ng y	02/29/2024

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		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		JILDING	01	COMPLETED		
		155077	B. W	ING		01/30/	2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
me	`		TAG		corrective action will be taken. This deficient practice could affect all residents, staff and visitors. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance has been educated by the Executive Director on K511 all electrical fixtures must be protected in accordance with LSC 19.5.1.1. to prevent accidental access. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The Director of Maintenance will perform monthly review X6. Results of these reviews will be		BALL	
K 0712 SS=C Bldg. 01	Director, the Mainted Corporate Maintena conference. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills conditions, at leass The staff is familia	che reviewed with the Executive enance Director and the enance Director during the exit when the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is the part of established			presented by the Executive Director to the QAPI committe further recommendations.	e for		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	1 1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155077	B. Wl	ING		01/30/2024	
NAME OF	PROVIDER OR SUPPLIEF	3	-		ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS	i 		INDIAN	IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION rills are conducted between	+	TAG	DEFICIENCT)	DATE	
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	a, 20 dood motodd or					
	19.7.1.4 through 1	19.7.1.7					
		review and interview, the	K 0	712	1: What corrective action(s)	will 02/29/2024	
		nduct quarterly fire drills at			be accomplished for those		
	-	nder varying conditions on the			residents found to have bee	n	
	first shift for 3 of 4	quarters. This deficient			affected by the deficient		
	1 -	et all residents, staff and			practice?		
	visitors.				1. The Director of Maintenance		
					has scheduled random times	for	
	Findings include:				future drills.		
					2. Moving forward the director	of	
	Based on review of	-			maintenance will have		
		the Executive Director, the			partisapants sign the back of	the	
		tor and the Corporate			actual drill sheet.		
		tor during record review from			2: How other residents havi		
	_	p.m. on 01/30/24, first shift fire			the potential to be affected by	=	
		thin the most recent twelve 1/07/23, 07/28/23 and 10/11/23			the same deficient practice value identified and what	VIII	
	_	respectively, 8:30 a.m., 8:00			corrective action will be take	an l	
		Based on interview at the time			This deficient practice could a		
		ne Maintenance Director and			all residents, staff and visitors		
	· ·	itenance Director stated the			3: What measures will be pu		
	_	ree shifts per day and agreed			into place or what systemic	-	
		first shift fire drills were not			changes will be made to		
	conducted at unexp	ected times under varying			ensure that the deficient		
	conditions.				practice does not recur?		
					The Director of Maintenance I		
	_	e reviewed with the Executive			been educated by the Executi		
	1	enance Director and the			Director on K712 fire drill mus		
	_	ance Director during the exit			random and unannounced. A	ll	
	conference.				participants must sign to		
	2 1 10(1) 12 1 5	1()			document the were trained		
	3.1-19(b) and 3.1-5	1(c)			4: How the corrective action		
	2 Daged 1				will be monitored to ensure		
		review and interview, the			deficient practice will not rec	cur	
	•	cument all staff who terly fire drills on the third shift			i.e., what quality assurance		
	i participated in duar	terry the drins on the third shift			i program will be but into blac	er i	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		, ,	UILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED	
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 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
	drills to be conduct under varied condit states employees of be instructed in life	LSC Section 19.7.1.6 requires ed quarterly on each shift ions. LSC Section 19.7.1.8 health care occupancies shall safety procedures and ient practice affects all visitors.			The Director of Maintenance perform monthly review X6. Taudit will be placed into the Tsystem for scheduled remindand documentation. Results of these reviews will presented by the Executive Director to the QAPI committed further recommendations.	This els ers pe	
	Maintenance Direct Maintenance Direct 9:10 a.m. to 12:45 p for the third shift fin on 03/20/23 did not participated in the f the time of record re Director and the Co stated the facility op and agreed docume third shift fire drill op participated in the f These findings were Director, the Mainte	the Executive Director, the for and the Corporate for during record review from form on 01/30/24, documentation for drill conducted at 3:00 a.m. include the staff who fire drill. Based on interview at eview, the Maintenance from the Maintenance for Director for the aforementioned did not include all staff who					
	conference. 3.1-19(b) and 3.1-5						
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall						

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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 01/30/2024 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 liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and K 0741 1: What corrective action(s) will 02/29/2024 interview; the facility failed to ensure smoking be accomplished for those materials were deposited into ashtrays and metal residents found to have been containers with self-closing cover devices into affected by the deficient which ashtrays can be emptied of noncombustible practice? material and safe design in 2 of 2 outdoor areas The Director of Maintenance has where smoking was taking place. This deficient cleaned up the cigarette butts in practice could affect over 5 residents, staff and both areas. Ashtray and metal visitors. closing can will be in each smoking location. Findings include: 2: How other residents having the potential to be affected by Based on review of smoking policy the same deficient practice will

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documentation with the Executive Director, the

Maintenance Director during record review from

Maintenance Director and the Corporate

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be identified and what

corrective action will be taken.

This deficient practice could affect

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l '		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
155077		B. W	ING		01/30/2	2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L .			CHWAY DR		
ENVIVE (OF INDIANAPOLIS				APOLIS, IN 46224		
			1		, T	Г	~~~
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		toro	DATE
	-	o.m. on 01/30/24, assessed are allowed to smoke in			over 5 residents, staff and visi		
					3: What measures will be put	ا ا	
	_	smoking areas. Based on			into place or what systemic		
		ne Maintenance Director and			changes will be made to		
		tenance Director during a tour			ensure that the deficient		
		1:10 p.m. to 3:50 p.m. on			practice does not recur?		
		igarette butts were strewn on			The Director of Maintenance h		
	_	the facility by the D Wing			been educated by the Executi		
		garette butts were also			Director on K741 We must en	I .	
	_	wer pot which contained			smoking materials are deposit		
		utside the D Wing Activity			into ashtrays and metal contai	I .	
		over 20 cigarette butts were			with self-closing cover devices		
	_	id outside the staff breakroom			which ashtrays can be emptie		
		utdoor resident smoking area			noncombustible material and	sate	
	_ _	by the main dining room exit			design		
		erview at the time of the			4: How the corrective action	.	
		aintenance Director and the			will be monitored to ensure t		
	-	ance Director agreed cigarette			deficient practice will not rec	ur	
	-	d on the ground at the			i.e., what quality assurance		
		locations and were not			program will be put into place		
		ed into the ashtrays and			The Director of Maintenance v		
		th self-closing cover devices			perform weekly review X8. Th	IS	
	_	ed at these two outdoor			audit will be placed into the	_	
	location where smol	king was taking place.			Results of these reviews will b	e	
	Those findings	raviawad with the Ever-			presented by the Executive	o for	
	_	e reviewed with the Executive			Director to the QAPI committe	e ior	
		enance Director and the			further recommendations.		
	_	ance Director during the exit					
	conference.						
	2 1 10/1						
	3.1-19(b)						
K 0754	NFPA 101						
SS=E	Soiled Linen and	Trash Containers					
Bldg. 01	Soiled Linen and	-					
Diag. 01		sh collection receptacles					
		2 gallons in capacity. The					
		f container capacity in a					
	room or space sha						
		et. A total container					
	yalions/square lee	a. A total containel					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155077	B. W	ING	_	01/30	/2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ACHWAY DR		
ENVIVE	OF INDIANAPOLIS	;		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	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 APPROPRIATE DEFICIENCY)		DATE
		lons shall not be exceeded					
		are feet area. Mobile soiled					
		ection receptacles with					
		than 32 gallons shall be					
	located in a room protected as a hazardous						
	area when not attended.						
	Containers used solely for recycling are						
	permitted to be excluded from the above						
	requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7						
		on and interview, the facility	K 0	754	1: What corrective action(s)	will	02/29/2024
		ttended trash receptacles			be accomplished for those		
		ans of egress were stored in a		residents found to have been		า	
	_	hazardous area in accordance			affected by the deficient		
		.7. This deficient practice could			practice?		
		ents, staff and visitors in the			The Director of Maintenance	_	
	vicinity of resident	sleeping Room C22.			removed the trash containers	trom	
	F' 1' ' 1 1				the hall.		
	Findings include:				2: How other residents having	_	
	D1				the potential to be affected b	-	
		ons with the Maintenance			the same deficient practice v	VIII	
		orporate Maintenance Director facility from 1:10 p.m. to 3:50			be identified and what corrective action will be take	n	
	_	wo separate unattended 20			This deficient practice could a		
		eptacles were partially filled			over 20 residents, staff and vis		
		e stored next to one another in			3: What measures will be put		
		Room C22. The combined			into place or what systemic	•	
		ptacles exceeded 32 gallons.			changes will be made to		
	Based on interview	-			ensure that the deficient		
		Iaintenance Director stated the			practice does not recur?		
		e stored in the corridor and			The Director of Maintenance h	nas	
	_	ntioned receptacles were not			been educated by the Executi		
	-	om protected as a hazardous			Director on K754 Mobile soile		
	area when unattend	-			linen or trash collection		
					receptacles with capacities		
	These findings were	e reviewed with the Executive			greater than 32 gallons shall b	e	

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STATEMENT OF DEFICIENCIES X1) 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 01/30/2024	
	PROVIDER OR SUPPLIER		STREET 45 BEA INDIAN		
(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)	(X5) COMPLETION DATE
K 0791 SS=F Bldg. 01	Director, the Mainted Corporate Maintena conference. 3.1-19(b) NFPA 101 Construction, Rep Operati Construction, repa operations Scanstruction, repair construction, repair inspected daily to used instantly in compliance with N 18.7.9, 19.7.9, 4.6 Based on observation failed to ensure the construction, repair comply with LSC 1 states construction,	air, and Improvement	K 0791	located in a room protected a hazardous area when not attended. 4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into place The Director of Maintenance perform weekly review X8. The audit will be placed into the Tourist system for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committed further recommendations. 1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice?	the cur ce? will his els ers be ee for will 02/29/2024
	19.7.9.2 states the n	neans of egress in any area etion, repair, or improvements aily for compliance with		The Director of Maintenance check and document for clear egress in construction areas construction is taking place.	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155077	B. W			01/30/	
				_			-
NAME OF 1	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS	i		INDIAN	APOLIS, 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		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	'E	DATE
	7.1.10.1 and shall a	lso comply with NFPA 241,			2: How other residents having	ng	
	Standard for Safegu	arding Construction,			the potential to be affected b	_	
	_	nolition Operations. LSC			the same deficient practice v	- 1	
	Section 4.6.10.1 states buildings, or portions of				be identified and what		
	buildings, shall be permitted to be occupied				corrective action will be take	n.	
		, repair, alterations, or			This deficient practice could a		
	_	re required means of egress			over 20 residents, staff and vis		
		otection features are in place			3: What measures will be put		
		naintained for the portion			into place or what systemic		
	occupied or where alternative life safety measures				changes will be made to		
	acceptable to the authority having jurisdiction are				ensure that the deficient		
	_	ion 7.1.10.1 states the means of			practice does not recur?		
	egress shall be continuously maintained free of all				The Director of Maintenance h	nas	
	obstructions or impediments to full instant use in				been educated by the Executi	ve	
	the case of fire or other emergency. This deficient				Director on K791. We must		
		et all residents, staff and			ensure the means of egress ir	1	
	visitors.	,			adjoining construction, repair and		
					improvement operations comp		
	Findings include:				with state regulations		
					4: How the corrective action		
	Based on observation	ons with the Executive			will be monitored to ensure t	he	
	Director, the Maint	enance Director and the			deficient practice will not red		
	Corporate Maintena	ance Director during a tour of			i.e., what quality assurance		
	_	10 p.m. to 3:50 p.m. on 01/30/24,			program will be put into place	e?	
		rrently undergoing facility			The Director of Maintenance v		
		Wing, C Wing and D Wing			perform weekly review X8. This	is	
		nostly completed. All wings			audit will be placed into the Te		
		exit with an exit sign. Based on			system for scheduled reminde		
		e of the observations, the			and documentation.		
	Executive Director	stated facility renovations			Results of these reviews will b	е	
	began in the Spring	of 2023. Based on interview			presented by the Executive		
		oservations, the Corporate			Director to the QAPI committe	e for	
	Maintenance Direct	tor stated the facility might			further recommendations.		
		heck documentation in Direct					
		was not available for review at					
	the time of the surv						
	These findings were	e reviewed with the Executive					
	_	enance Director and the					
	· ·	ance Director during the exit					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155077	B. W	ING		01/30/	2024
	ROVIDER OR SUPPLIER		•	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY S	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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.2	DATE
	3.1-19(b)						
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems Electrical Systems List in the REMAR Chapter 6 Electric that are not addres K-Tags, but are de along with the app NFPA standard cit on Form CMS-256 Chapter 6 (NFPA Based on observatio failed to ensure accomaintained in enclo apparatus in 1 of 1 I NFPA 99, Health C Edition, Section 6.3 shall be in accordan Electric Code. NFP 110.26 states workin operating at 600 vol to require examinati maintenance while of dimensions of 110.2 shall be measured fi are exposed or from opening if such are states the working s shall not be used for practice could affect visitors in the D Wi Findings include: Based on observation	Secondary NFPA 99 al Systems requirements seed by the provided efficient. This information, blicable Life Safety Code or tation, should be included 67. 99) on and interview, the facility ess and working space was sures housing electrical D Wing electrical rooms. are Facilities Code, 2012 2.2.1 states electrical installation are with NFPA 70, National PA 70, 2011 Edition, Article and space for equipment lts, nominal, or less and likely ion, adjustment, servicing, or energized shall comply with the 26(A)(1), (2) and (3). Distances from the live parts if such parts in the enclosure front or enclosed. Article 110.26(B) pace required by this section in storage. This deficient it over 20 residents, staff and	K 0	911	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance will cleared the areas in front of all breaker panels. 2: How other residents having the potential to be affected by the same deficient practice will be taked to be identified and what corrective action will be taked to a corrective action will be taked to a corrective action will be put into place or what systemic changes will be made to the ensure that the deficient practice does not recur? The Director of Maintenance in the been educated by the Executive Director on K911. We must clumobstructed access to breaked panels at all times.	vill I ng y vill en. ffect sitors t	02/29/2024

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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	COME	E SURVEY PLETED 0/2024	
	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 C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 0014	p.m. on 01/30/24, p two wall mounted e Panel Location roor underneath the elect indicate no storage space under and in t items were stored in space. Based on int observations, the Co stated the D Wing h and agreed picture f feet of the working panels in the D Win room. These findings were Director, the Mainte Corporate Maintena conference. 3.1-19(b)	facility from 1:10 p.m. to 3:50 icture frames were stored under lectrical panels in the Electrical in in the D Wing. The flooring trical panels was painted to should be in the working front of the panels but the in the painted area working erview at the time of the proporate Maintenance Director and been recently renovated frames were stored within three space in front of electrical g Electrical Panel Location ereviewed with the Executive enance Director and the since Director during the exit		4: How the corrective will be monitored to deficient practice wile., what quality as program will be put. The Director of Main perform monthly reviaudit will be placed is system for scheduler and documentation. Results of these revipresented by the Exp. Director to the QAPI further recommendation.	o ensure the vill not recur surance into place? Internance will item X6. This item X6. This item to the Tels direminders items will be ecutive committee for		
K 0914 SS=E Bldg. 01	Testing Electrical Systems Testing Hospital-grade reclocations and whe anesthesia is adminitial installation, Additional testing defined by docum. Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not oths. Line isolation monitors are tested at intervals of to 1 month by actuating in per 6.3.2.6.3.6, which					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155077	B. W	NG		01/30	/2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			CHWAY DR		
FNVIVE	OF INDIANAPOLIS				IAPOLIS, IN 46224		
LI4VIV L	C. 114D1/114A1 OLIO			וואטואוו	OLIO, III TOZZT		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ual and audible alarm. For					
		utomated self-testing, this					
		formed at intervals less					
	than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or						
		electric distribution system.					
	Records are maintained of required tests and associated repairs or modifications,						
	_	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)				4.3404		
		view, observation and	K 0	914	1: What corrective action(s)	will	02/29/2024
	interview; the facili	-			be accomplished for those		
	nonhospital-grade electrical receptacles that failed				residents found to have been	n	
	_	of over 60 resident rooms were			affected by the deficient		
		tal-grade receptacles. NFPA			practice?		
		lectrical Code, 2011 Edition, at			The Director of Maintenance h	nas	
		tates each patient bed location			replaced the mentioned		
	_	vith a minimum of four			receptacles with hospital grad		
	1 -	hall be permitted to be of the			2: How other residents having	-	
		uadruplex type, or any			the potential to be affected b	_	
		three. All receptacles, whether			the same deficient practice v	VIII	
		be listed "hospital grade" and			be identified and what	_	
		not intended that there be a			corrective action will be take		
		placement of existing receptacles. It is intended,			This deficient practice could a		
		receptacies. It is intended,			over 6 residents, staff and visi		
		ital grade receptacles upon			3: What measures will be put	ι	
		, renovation, or as existing			into place or what systemic		
		placement. This deficient			changes will be made to ensure that the deficient		
		et over 6 residents and staff.					
	practice could affect	a over o residents and stair.			practice does not recur? The Director of Maintenance h	126	
	Findings include:				been educated by the Executi		
	i manigo meiade.				Director on K914 When chang		
	Based on review of	"Receptacle Tests - Annual"			out receptacles in resident are		
		ed 10/01/23 with the Executive			it is required to use hospital gr		
		enance Director and the			receptacle.	au c	
		ance Director during record			4: How the corrective action		
	_	.m. to 12:45 p.m. on 01/30/24,			will be monitored to ensure t	ho	
		es in resident sleeping Room				-	
	electrical receptacie	an resident steeping Koom	1		deficient practice will not rec	ur	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024		
	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 APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
IAU	B1, B4 and B8 faile replaced. Based on review, the Mainten electrical receptacle replaced but he coul replaced with hospir on observations with and the Corporate M tour of the facility from 1/30/24, all electric resident sleeping rown hospital-grade. Base the observations, the Director agreed the three resident sleepin hospital-grade. These findings were Executive Director,	d annual testing and were interview at the time of record ance Director stated the s which failed 10/01/23 were d not ensure that they were tal-grade receptacles. Based in the Maintenance Director during a rom 1:10 p.m. to 3:50 p.m. on the cal receptacle locations in the based on interview at the time of the Corporate Maintenance receptacle locations in the	TAU	i.e., what quality assurance program will be put into place. The Director of Maintenance of perform an annual outlet audited receptacles moving forward. The audit will be placed into the Total system for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committed further recommendations.	ce? will t and This els ers	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the ncess shall be provided to nis capability for the life branches. Maintenance generator and transfer rmed in accordance with e inspected weekly, and 30 minutes 12 times a				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155077	B. W	ING _		01/30/	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
ENIVIVE	OF INDIANAPOLIS						
EINVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	onths for 4 continuous hours.					
	Scheduled test un	nder load conditions include					
	a complete simulated cold start and						
	automatic or manual transfer of all EES						
	loads, and are conducted by competent						
	personnel. Maintenance and testing of stored						
	energy power sources (Type 3 EES) are in						
		NFPA 111. Main and feeder					
		e inspected annually, and a					
	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained						
		ble. EES electrical panels					
	I -	arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for i						
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	· ·					
	1. Based on record	review and interview, the	K 0	918	1: What corrective action(s)	will	02/29/2024
	facility failed to ens	sure a written record of weekly			be accomplished for those		
	inspections for the	generator was maintained for			residents found to have beer	1	
	12 weeks of the mo	est recent 52 week period.			affected by the deficient		
	NFPA 99, 6.4.4.1.3	requires onsite generators shall			practice?		
	be maintained in ac	cordance with NFPA 110,			1.The Director of Maintenance	,	
	Standard for Emerg	gency and Standby Power			documented all weekly		
	Systems. NFPA 11	0, 8.4.1 requires an Emergency			inspections since that date and	d is	
	Power Supply Syste	em (EPSS) including all			not in the Tels system weekly.		
	appurtenant compos	nents, shall be inspected			2.The Director of Maintenance	<u>;</u>	
	weekly and exercise	ed monthly. NFPA 99, Section			called Evapar and had them		
	6.4.4.2 requires a w	ritten record of inspection,			preform the Load bank.		
	performance, exerc	ising period, and repairs for the			3. Evapar has preformed a fue	اد	
	generator to be regularly maintained and available				sample		
	for inspection by th				4. Evapar has changed the		
	l -	leficient practice could affect all			batteries.		
	residents, staff and	visitors.			2: How other residents havir	ıg	
					the potential to be affected b	У	
	Ī		1		Ī		Ī

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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 01 COMPLETED 155077 B. WING 01/30/2024

NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
	OF INDIANADOLIC			ACHWAY DR			
ENVIVE	OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 46224			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	Findings include:			the same deficient practice will			
				be identified and what			
	Based on review of "Emergency Generator			corrective action will be taken.			
	Weekly Load Test" documentation with the			This deficient practice could affect			
	Executive Director, the Maintenance Director and			all residents, staff, and visitors.			
	the Corporate Maintenance Director during record			3: What measures will be put			
	review from 9:10 a.m. to 12:45 p.m. on 01/30/24,			into place or what systemic			
	weekly emergency generator inspection			changes will be made to			
	documentation for January, February and March			ensure that the deficient			
	2023 was not available for review. Based on interview at the time of record review, the			practice does not recur?			
	· · · · · · · · · · · · · · · · · · ·			The Director of Maintenance has			
	Corporate Maintenance Director stated the facility has one diesel fired emergency generator and			been educated by the Executive Director on K918 The Generator is			
	agreed weekly emergency generator inspection						
	documentation for January, February and March			required to be inspected weekly and documented, Monthly load			
	2023 was not available for review.			test documented, along with fuel			
	2023 was not available for review.			sampling yearly to ensure it will			
	These findings were reviewed with the Executive			work in an emergency.			
	Director, the Maintenance Director and the			4: How the corrective action			
	Corporate Maintenance Director during the exit			will be monitored to ensure the			
	conference.			deficient practice will not recur			
				i.e., what quality assurance			
	3.1-19(b)			program will be put into place?			
				The Director of Maintenance will			
	2. Based on record review, observation and			perform monthly X6. This audit will			
	interview; the facility failed to exercise the			be placed into the Tels system for			
	generator for 12 of 12 months and failed to			scheduled reminders and			
	exercise the generator annually to meet the			documentation.			
	requirements of NFPA 110, 2010 Edition, the			Results of these reviews will be			
	Standard for Emergency and Standby Powers			presented by the Executive			
	Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2			Director to the QAPI committee for			
	states diesel generator sets in service shall be			further recommendations.			
	exercised at least once monthly, for a minimum of						
	30 minutes, using one of the following methods:						
	(1) Loading that maintains the minimum exhaust						
	gas temperatures as recommended by the						
	manufacturer						
	(2) Under operating temperature conditions and at						
	not less than 30 percent of the EPS (Emergency						
	Power Supply) nameplate kW rating.						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	l í	UILDING	nstruction 01	(X3) DATE COMPI 01/30	LETED
NAME OF I	PROVIDER OR SUPPLIEI	.	•		DDRESS, CITY, STATE, ZIP COD	•	
ENVIVE	OF INDIANAPOLIS	;			APOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	
IAG	 	es diesel-powered EPS		IAG	BENEEMEN		DATE
		o not meet the requirements of					
		ised monthly with the available					
		Power Supply System) load and					
		nnually with supplemental					
		Test) at not less than 50 percent					
		ate kW rating for 30 continuous					
	_	less than 75 percent of the EPS					
		ng for 1 continuous hour for a					
	total test duration o	f not less than 1.5 continuous					
	hours. This deficien	nt practice could affect all					
	residents, staff and	visitors.					
	Findings include:						
	Based on review of	"Emergency Generator					
	Weekly Load Test"	documentation with the					
	Executive Director	, the Maintenance Director and					
	the Corporate Main	tenance Director during record					
		.m. to 12:45 p.m. on 01/30/24,					
		entation for January, February					
		as not available for review. In					
		ng documentation for load					
		ekly for the period of 04/05/23					
	_	id not indicate the actual load					
		d for the diesel powered e test. Based on interview at					
	1	e test. Based on interview at eview, the Corporate					
		tor stated the facility has one					
		ncy generator, load testing is					
		reekly basis, the generator is					
		acility acknowledges load					
		eve at least 30 % of the name					
	_	do not record the load					
		load test. The Corporate					
		tor stated an annual load bank					
		it agreed supplemental load					
	_	nentation for the most recent					
	_	d was not available for review.					
		ons with the Maintenance					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155077	B. W	ING		01/30	2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION orporate Maintenance Director		TAG	DEFICIENC!		DATE
		facility from 1:10 p.m. to 3:50					
		he facility has one diesel fired					
	1 ~	or located outside the building					
		le of the property. The					
	manufacturer's nam	ne plate affixed to the generator					
	indicated it was rated at 600 kW.						
	These findings were reviewed with the Executive						
		enance Director and the					
	Corporate Maintena	ance Director during the exit					
	conference.						
	3.1-19(b)						
	3. Based on record	review, observation and					
		ty failed to ensure an annual					
		s performed for the facility's					
		ergency generator. NFPA 99,					
		ies Code, 2012 Edition, Section					
	· ·	ype 2 EES (Essential Electrical					
		sets shall be inspected and e with Section 6.4.4.1.1.3.					
		states maintenance shall be					
		dance with NFPA 110, Standard					
	_	Standby Power Systems, 2010					
		NFPA 110, Section 8.3.8 states					
		hall be performed at least					
		s approved by ASTM					
		icient practice could affect all					
	residents, staff and	visitors.					
	Findings include:						
	Based on review of	"Fuel Analysis Report"					
		ed 12/19/22 with the Executive					
	Director, the Mainte	enance Director and the					
	Corporate Maintena	ance Director during record					
		.m. to 12:45 p.m. on 01/30/24,					
	documentation of a	n annual fuel quality test for					

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPL 01/30/	ETED		
	PROVIDER OR SUPPLIED		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	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ.	(X5) COMPLETION DATE		
	within the most recent available for retime of record revier. Director stated the emergency generat of an annual fuel qualities of fired emmost recent twelve available for review. Based on observati Director and the Coduring a tour of the p.m. on 01/30/24, the emergency generat on the northeast side manufacturer's namindicated it was rate. These findings were Director, the Maint Corporate Maintenconference. 3.1-19(b) 4. Based record review interview; the facility emergency generated operating mode in Standard for Emergy Systems. NFPA 11 states the Emergency (EPSS) shall be manufactured for the specified for the duration specified fo	fuel fired emergency generator ent twelve month period was view. Based on interview at the ew, the Corporate Maintenance facility has one diesel fired or and agreed documentation hality test for the facility's ergency generator within the month period was not wat the time of the survey. Ons with the Maintenance Director facility from 1:10 p.m. to 3:50 the facility has one diesel fired for located outside the building fle of the property. The five plate affixed to the generator end at 600 kW. The reviewed with the Executive enance Director and the fance Director during the exit friew, observation and fity failed to ensure 1 of 1 fle ors was kept in reliable faccordance with NFPA 110, gency and Standby Power 10, 2010 Edition, Section 8.3.1 by Power Supply Systems intained to ensure that the fit supplying service within the fit type and for the time for the class. This deficiency dents, staff and visitors.							

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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 01/30/2024			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Based on review of the emergency generator inspection contractor's "Generator Maintenance Report" documentation dated 11/21/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, the emergency generator batteries need to be replaced. The "Comments/Remarks" section of the 11/21/23 report stated "batteries failed load test and need replaced (dated 2018)". Based on interview at time of the observations, the Maintenance Director and the Corporate Maintenance Director stated the emergency generator is tested weekly and will operate, the batteries are scheduled to be replaced on 02/05/23 but agreed emergency generator battery replacement documentation on or after 11/21/23 was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. Documentation affixed to each of the two starting batteries indicated they were manufactured in October 2018. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference.						
K 9999							
Bldg. 01	State Findings	K 9999	1: What corrective action(s)	will 02/29/2024			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 01/30/2024 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 be accomplished for those 3.1-19 ENVIRONMENT AND PHYSICAL residents found to have been STANDARDS affected by the deficient practice? 3.1-19(a) The facility must be designed, The Maintenance Director has constructed, equipped and maintained to protect installed/reinstalled any/all smoke the health and safety of residents, personnel, and detectors in all resident rooms. the public. 2: How other residents having the potential to be affected by the same deficient practice will This State Rule has not been met as evidenced by: Based on observation and interview, the facility be identified and what failed to provide smoke detectors in 2 of over 60 corrective action will be taken. resident sleeping rooms. This deficient practice This deficient practice could affect could affect over 20 residents, staff and visitors. over 20 residents, staff and visitors 3: What measures will be put Findings include: into place or what systemic changes will be made to Based on observations with the Maintenance ensure that the deficient Director and the Corporate Maintenance Director practice does not recur? during a tour of the facility from 1:10 p.m. to 3:50 The Director of Maintenance has p.m. on 01/30/24, all resident sleeping rooms were been educated by the Executive equipped with a smoke detector except resident Director on the requirement to sleeping Room B22 and D9. The facility was maintain any/all in-room safety currently being renovated but resident rooms B22 designed equipment designed to and D9 were occupied by residents. Based on protect the health and safety of interview at the time of the observations, the residents. Personnel and the Maintenance Director and the Corporate Maintenance Director agreed resident sleeping 4: How the corrective action Room B22 and D9 were not provided with a smoke will be monitored to ensure the detector. deficient practice will not recur i.e., what quality assurance These findings were reviewed with the Executive

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conference.

3.1-19(b)

Director, the Maintenance Director and the

Corporate Maintenance Director during the exit

Event ID:

4CYK21

Facility ID: 000032

documentation.

If continuation sheet

program will be put into place?

The Director of Maintenance will

resident rooms. This audit will be placed into the Tels system for

Results of these reviews will be presented by the Executive

perform monthly X6 audits or

scheduled reminders and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155077	B. WING			01/30/2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					Director to the QAPI committee further recommendations.	e for	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4CYK21 Facility ID: 000032 If continuation sheet Page 51 of 51