DEPARTMENT OF HEALTH AND HUM	MAN SERVICES		FORM APPR
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED
	155077	B. WING	11/02/2022

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BU B. WI	JILDING ING	<del></del>	COMPL 11/02	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR 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
E 0000							
Bldg	conducted by the laccordance with 4  Survey Date(s): 11  Facility Number: Provider Number: AIM Number: 10  At this Emergency of Indianapolis was Emergency Preparameter and Medicare and Medicare and Medicare and Suppliers, 42  The facility has 18 the survey, the certain the survey of Quality Review conductive accordance with the survey of the survey o	000032 155077 0273330 Preparedness survey, Envive as found not in compliance with redness Requirements for dicaid Participating Providers CFR 483.73.	E 00	000	PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the far alleged or conclusions set for on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitt to respond to the allegation of noncompliance cited during the Recertification and State Licensure completed on November 2, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 24, 2022. The provider respectfully requested desk review with paper compliance to be considered establishing that the provide in substantial compliance.	te cts orth ed of	
E 0031 SS=F Bldg	441.184(c)(2), 48 483.73(c)(2), 484 485.68(c)(2), 485	16.54(c)(2), 418.113(c)(2), 32.15(c)(2), 483.475(c)(2), 4.102(c)(2), 485.625(c)(2), 5.727(c)(2), 485.920(c)(2), 91.12(c)(2), 494.62(c)(2)					

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

TITLE (X6) DATE

KAVITA BERI **HFA** 11/22/2022

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE (COMPL 11/02/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
TAG	Emergency Officia §403.748(c)(2), §4 §441.184(c)(2), §4 §483.73(c)(2), §48 §485.68(c)(2), §48 §485.920(c)(2).  [(c) The [facility] man emergency prepain that complies local laws and muat least every 2 yet facilities]. The coninclude all of the form (i) Federal, State, emergency prepain (ii) Other sources  *[For LTC Facilities Contact information (i) Federal, State, emergency prepain (ii) The State Lice Agency.  (iii) The Office of the Ombudsman.  (iv) Other sources  *[For ICF/IIDs at § information for the (i) Federal, State, emergency prepain (ii) Other sources	als Contact Information 416.54(c)(2), §418.113(c)(2), 460.84(c)(2), §482.15(c)(2), 33.475(c)(2), §484.102(c)(2), 486.360(c)(2), §485.727(c)(2), 486.360(c)(2), §491.12(c)(2), 486.360(c)(2), §485.727(c)(2), 486.360(c)(2), §485.727(c)(2), 486.360(c)(2), §485.727(c)(2), 486.360(c)(2), §481.10(c)(2), 486.360(c	TAG	DEFICIENCY		DATE		
	(iv) The State Pro Agency.	tection and Advocacy						

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	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE COMPL 11/02/	ETED
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR				
ENVIV	E OF INDIANAPOLIS			INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
TAG	Based on record reversible to ensure the communication plat sources of assistance could affect all occurs. Findings include:  Based on review of documentation date. Director, the Direct Corporate Maintenareview from 9:20 at emergency prepared contacting the India (IDOH) by telephone emergency incident evacuation. The enalso did not include the Gateway link at the primary method when the IDOH Gate completing the Incideral emergency Contact plan stated to contact State/Phone #" at 3 "IPLA". Based on review, the Executithe Indiana Profess:  This finding was re Director, the Director, the Director.	view and interview, the facility emergency preparedness in included all applicable e. This deficient practice	E 0		POC- Life Safety  Tag E0031 SS-F What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents have been affect by the deficient practice, but the emergency preparedness plan now includes contacting the Indiana Department of Health (IDOH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. The emerging preparedness plan also include the contact for IDOH using the Gateway link at https://gateway.isdh.in.gov as primary method or by the secondary method when the I Gateway is nonoperational by completing the Incident Report form and e-mailing it to incidents@isdh.in.gov.  How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.  No residents have been affect by the deficient practice, but the emergency preparedness plant.	ted he n ency les e the DOH eting the ne ce ted he e ted he	DATE 11/24/2022

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/02/2022
	ROVIDER OR SUPPLIEF DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				now been updated in all the binders located at several diffications in the building.	erent
				What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.	nto
				The Emergency Preparednes book will be Audited every more once a month by the Maintenar Director/designee. Maintenar director /Designee will bring the audit sheets back in the morn meeting next day to be review. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100%complaince is achief for 3 consecutive months. The committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated.	onth ance nce ne ing yed. II be e s or eved e QA nds
				How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and	the
				Maintenance Director/designed will be Auditing the EPP every month once a month.  Maintenance director /Designed	/

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI  A. BUILDING COMPLETI				
		155077	B. W	ING		11/02/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
E 0041 SS=F Bldg	482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.0 (e) Emergency and The [LTC facility and implement emergency and The [LTC facility and implement emergency generated on forth in paragraph §482.15(e)(1), §48 Emergency generated emergency generated em	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section.		TAG	will bring the audit sheets back the morning meeting next day be reviewed. The results of the audits will be reviewed in Qua Assurance meeting monthly for months or until 100% complain is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated.  Date of compliance November 24th, 2022	to ese lity or 6 nce ill and	DATE

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	OF CORRECTION	IDENTIFICATION NUMBER  155077	A. BUILDING B. WING		COM	TE SURVEY MPLETED 02/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101 and TIA 12-4), and structure is built or structure or building 482.15(e)(2), §483 Emergency generating The [hospital, CAI-implement the eminspection, testing requirements foun Facilities Code, NIC Code.  482.15(e)(3), §483 Emergency generating and LTC facilities] source to power end LTC facilities] source to power end and LTC facilities] source to power end wave a plan for hopower systems opemergency, unless \$483.73(g), and CThe standards ince this section are appreference by the Enderal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resource (NARA). For information for the standards and Recounty and the Source to power enderal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resource (NARA). For information Resource (NARA). For information for information for information Resource (NARA). For information for inf	and is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] d in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency erational during the s it evacuates.  §482.15(h), LTC at AHs §485.625(g):] orporated by reference in eproved for incorporation by birector of the Office of the in accordance with 5 U.S.C. part 51. You may obtain the sources listed below.					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE S COMPLI 11/02/2	ETED	
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	of_federal_regular life any changes in a incorporated by redocument in the Fannounce the characteristic (1) National Fire FBatterymarch Parl Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issued (iii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (vi) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Litedition, issued Au (viii) TIA 12-1 to Nf 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Syincluding TIAs to C2009.	rotection Association, 1 K, 2, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued March 3, FPA 99, issued March 3, FPA 101, issued August FPA 101, issued August FPA 101, issued October FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,	E 0041	DOC Life Sefety		11/24/2022	
	interview; the facili	riew, observation and ty failed to implement the system inspection, testing and	E 0041	POC- Life Safety Tag E0041		11/24/2022	

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Facility ID: 000032

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/02/2022
NAME OF I	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF INDIANAPOLIS		INDIAN	NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) COMPLETION OPRIATE DATE
mo	maintenance require Care Facilities Code	ements found in the Health e, NFPA 110, and Life Safety	ing	F Level	BATE
	This deficient pract staff and visitors.  a. Based on record facility failed to ens	with 42 CFR 483.73(e)(2). ice could affect all residents, review and interview, the sure an annual fuel quality test		What corrective action(s be accomplished for tho residents found to have affected by the deficient practice?	se been
	generator. NFPA 9 2012 Edition, Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be	the facility's diesel-powered  9, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES  I System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and		No residents have been a by the deficient practice, k facility has performed ann quality test for the facility's diesel-powered generator	out the qual fuel s
	Standby Power Sys NFPA 110, Section shall be performed approved by ASTM	tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient t all residents, staff and		How other residents hav potential to be affected be same deficient practice widentified and what correaction(s) will be taken.	by the will be
	Findings include:			No residents have been a by the deficient practice, by facility has performed an a	out the audit on
	Director, the Direct Corporate Maintena 1:45 p.m. on 11/01/ fuel quality test for generator was not a	riew with the Executive or of Maintenance and the since Director from 9:20 a.m. to 22, documentation of an annual the diesel fired emergency vailable for review. Based on the of record review, the Director		annual fuel quality test for facility's diesel-powered g The annual fuel quality test facility's diesel-powered g is updated now.	enerator. st for the
	of Maintenance stat fired emergency ged documentation of a	ed the facility has one diesel nerator and agreed n annual fuel quality test for rgency generator was not		What measures will be p place and what systemic changes will be made to ensure that the deficient practice does not recur.	:
	_	viewed with the Executive or of Maintenance and the		Annual fuel quality test on diesel-powered generator	

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE COMPL 11/02	LETED		
NAME OF I	PROVIDER OR SUPPLIER	3	•	45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	•	
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.	ance Director during the exit			Audited every month once a		
	conference.				month by the Maintenance	200	
	h Based on record	review, observation and			Director/designee. Maintena director /Designee will bring the		
		ity failed to document 36 month			audit sheets back in the morn		
		generator testing for 1 of 1			meeting next day to be review	•	
		ors in accordance with NFPA			The results of these audits wil		
		NFPA 99, Health Care Facilities			reviewed in Quality Assurance		
	Code, 2012 Edition, Section 6.4.1.1.6.1 states Type				meeting monthly for 6 months		
	1 and Type 2 essential electrical system power				until 100%complaince is achie	eved	
	sources (EPSS) shall be classified as Type 10,				for 3 consecutive months. The	e QA	
	Class X, Level 1 generator sets per NFPA 110.				committee will identify any tre	nds	
	NFPA 110, the Standard for Emergency and				or patterns and make		
	Standby Powers Systems, 2010 Edition, Section				recommendations to revise th		
		EPSS shall be tested at least			plan of correction as indicated		
	-	36 months. Section 8.4.9.1					
		S shall be tested continuously					
		its assigned class (See Section .2 states where the assigned					
		14 hours, it shall be permitted			How the corrective action(s) will be monitored to ensure		
	_	t after 4 continuous hours.			deficient practice will not	ine	
		es the minimum load for this			recur, i.e., what quality		
		ed in 8.4.9.5.1, 8.4.9.5.2, or			assurance program will be p	ut	
	_	8.4.9.5.3 states for spark-ignited			into place; and		
		l be the available EPSS load.					
		ice could affect all residents,			Annual fuel quality test on the		
	staff and visitors.				diesel-powered generator will	be	
					Audited every month once a		
	Findings include:				month by the Maintenance		
					Director/designee. Maintena		
		view with the Executive			director /Designee will bring the		
	·	tor of Maintenance and the			audit sheets back in the morn	-	
		ance Director from 9:20 a.m. to			meeting next day to be review		
		/22, thirty-six month period or testing documentation for			The results of these audits will		
		or testing documentation for urs for the diesel fired			reviewed in Quality Assurance		
		or was not available for review.			meeting monthly for 6 months until 100%complaince is achie		
		at the time of record review,			for 3 consecutive months. The		
		ntenance stated the facility has			committee will identify any tre		
		ergency generator and agreed			or patterns and make		
	1	6 7 6	1		J. Pattorno ana matto		I

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` ′		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING			COMPLETED	
		155077	B. W	ING		11/02/	2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	documentation of su	applemental load testing for			recommendations to revise the	е		
	four hours within th	e most recent three year			plan of correction as indicated	ı		
	period was not avail	lable for review. Based on						
		ne Executive Director, the						
		ance and the Corporate			Date of compliance			
		for during a tour of the facility			November 24th , 2022			
		1:50 a.m. on 11/02/22, the facility						
		emergency generator located						
	outside the building	Manufacturer's nameplate						
	_	ator stated it was rated at 600						
	kW.	ator stated it was rated at 000						
	This finding was rev	viewed with the Executive						
	Director, the Director	or of Maintenance and the						
	-	ance Director during the exit						
	conference.							
K 0000								
K 0000								
Bldg. 01								
Diag. 01	A Life Safety Code	Recertification and State	K O	000	PLAN OF CORRECTION FOR	₹		
	-	as conducted by the Indiana	110	000	ENVIVE OF INDIANAPOLIS	`		
		th in accordance with 42 CFR			F000 INITIAL			
	483.90(a).				COMMENTS Preparation or			
					execution of this plan of			
	Survey Date(s): 11/	01/22 & 11/02/22			correction does not constitu	te		
		00022			admission or agreement of			
	Facility Number: 0				provider of the truth of the fa			
	Provider Number: 1002				alleged or conclusions set fo	ortn		
	Alivi Nuilloef: 1002	21333U			on the Statement of Deficiencies. The Plan of			
	At this Life Safety (	Code survey, Envive of			Correction is prepared and			
		und not in compliance with			executed solely because it is	,		
	Requirements for Pa	-			required by the position of			
	-	, 42 CFR Subpart 483.90(a),			Federal and State Law. The			
	Life Safety from Fi	re and the 2012 Edition of the			Plan of Correction is submitt	ted		
		ction Association (NFPA) 101,			to respond to the allegation	of		
		SC), Chapter 19, Existing			noncompliance cited during			
	Health Care Occupa	ancies and 410 IAC 16.2			the Recertification and State			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	This one story facil Type III (211) cons sprinklered. The fa with smoke detection open to the corrido the C Wing. The fa smoke detectors in rooms. The facility a census of 94 at the All areas where res were sprinklered. buildings providing detached building fi generator which we Quality Review con NFPA 101 Means of Egress Means of Egress Aisles, passagew discharges, exit fo in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7. Based on observatif failed to maintain to obstructions in 1 of deficient practice of	lity was determined to be of struction and was fully acility has a fire alarm system on in the corridors, in all areas r and in rooms 11 through 19 in acility has battery operated all other resident sleeping y has a capacity of 184 and had be time of this survey.  Sidents have customary access The facility has four detached g storage services and one mousing an emergency ere each not sprinklered.  Impleted on 11/09/22  - General	K 0211	Licensure completed on November 2, 2022.Please accept this Plan of Correction as the provider's credible allegation of compliance as November 24, 2022. The provider respectfully request desk review with paper compliance to be considered establishing that the provider in substantial compliance.  POC- Life Safety  Tag K211 E Level	n of ts
	Findings include:	e main dining room.  ons with the Executive		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

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Event ID:

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Facility ID: 000032

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/02/2022
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		45 BE	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	TON (X5) D BE OPRIATE COMPLETION DATE
	Corporate Maintena	or of Maintenance and the ance Director during a tour of		practice?	
	the exit door to the east side of the mai facility exit with an keypad at the exit d	15 a.m. to 11:50 a.m. on 11/02/22, outside of the facility on the n dining room was marked as a exit sign. The door also had a oor to release the door to open ase the door to open was not		No residents have been a by the deficient practice, be facility has no obstructions means of egress now./p>	out the
	as a delayed egress delayed egress sign the time of the obse Maintenance stated	oor. The door was not marked door with the necessary age. Based on interview at revations, the Director of the keypad was not operable was on order. The Director of		How other residents have potential to be affected be same deficient practice videntified and what correaction(s) will be taken.	by the vill be
	egress door but agre	the door may be a delayed eed the door was not posted delayed egress signage.		No residents have been a by the deficient practice, a hallways are audited and times to ensure that there	all the different
	Director, the Direct	viewed with the Executive or of Maintenance and the ance Director during the exit		obstructions in the means egress./p>	of
	3.1-19(b)			What measures will be p place and what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance director /Des will complete random audi Monday through Sunday f times a week on random s including weekends for for weeks, then three times a for two weeks, then two tir week for the two weeks, o week for one weeks to ensure mean of egress are obstructive. Maintenance director /Designee will review the awith the IDT during morning	signee its daily four shifts ur week mes a nce a sure that uction or

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Event ID:

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Facility ID: 000032

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PRINTED: 11/30/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE							
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPL	LETED
		155077	B. WI	NG		11/02/	/2022
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
				45 BEA	CHWAY DR		
ENVIVE (	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)

ENVIVE C	OF INDIANAPOLIS	INDIANAPOLIS, 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	
			meeting Monday through Friday.		
			The results of these audits will be		
			reviewed in Quality Assurance		
			meeting monthly for 6 months or		
			until 100%complaince is achieved		
			for 3 consecutive months. The QA		
			committee will identify any trends		
			or patterns and make		
			recommendations to revise the		
			plan of correction as indicated.		
			promote some some some some some some some som		
			How the corrective action(s)		
			will be monitored to ensure the		
			deficient practice will not		
			recur, i.e., what quality		
			assurance program will be put		
			into place; and		
			Maintenance director /Designee		
			will complete random audits daily		
			Monday through Sunday four		
			times a week on random shifts		
			including weekends for four		
			weeks, then three times a week		
			for two weeks, then two times a		
			week for the two weeks, once a		
			week for one weeks to ensure that		
			mean of egress are obstruction		
			free. Maintenance director		
			/Designee will bring the audit		
			sheets back in morning meeting		
			every day to be reviewed. The		
			results of these audits will be		
			reviewed in Quality Assurance		
			meeting monthly for 6 months or		
			until 100%complaince is achieved		
			for 3 consecutive months. The QA		
			committee will identify any trends		
			or patterns and make		
			- Fatterne and many		

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Event ID: 0Z2N21 Facility ID: 000032

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/02/2022	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	
ENVIVE (	OF INDIANAPOLIS			NAPOLIS, 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
ing	KLGCL/HOKT OK	ESC IDENTIFICATION	1710	recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022	е
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors				
Bidg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lockinical security new used, only one lock permitted on each be made for the result of the such reliable staff at all times.  18.2.2.5.1, 18.2.19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the Clinical or Security needs of the Clinical or Security needs of the Clinical locks that release upon loss building is protected automatic sprinkle space is protected detection system (	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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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155077	B. WING		11/02/2022
	PROVIDER OR SUPPLIER		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S BLANGE CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	space); and both	the sprinkler and detection			
	systems are arran	nged to unlock the doors			
	upon activation.				
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4			
	DELAYED-EGRE	SS LOCKING			
	ARRANGEMENT				
		lelayed-egress locking			
	1 -	in accordance with			
		permitted on door			
		ig low and ordinary hazard			
		ngs protected throughout by			
an approved, supervised automatic fire detection system or an approved, supervised					
	automatic sprinkle				
	18.2.2.2.4, 19.2.2	-			
	ACCESS-CONTR				
	LOCKING ARRAN				
		d Egress Door assemblies			
		lance with 7.2.1.6.2 shall			
	be permitted.				
	18.2.2.2.4, 19.2.2	.2.4			
	ELEVATOR LOB	BY EXIT ACCESS			
	LOCKING ARRAI				
	-	t access door locking in			
		7.2.1.6.3 shall be permitted			
		es in buildings protected			
		approved, supervised			
		ection system and an			
	1	ised automatic sprinkler			
	system. 18.2.2.2.4, 19.2.2	2.4			
		ation and interview, the facility	K 0222	POC- Life Safety	11/24/2022
		means of egress through 2 of	IX UZZZ	Life Galety	11/24/2022
		accessible for residents		Tag K222	
		iagnosis requiring specialized		E Level	
		Doors within a required means		What corrective action(s) w	iii
	•	be equipped with a latch or		be accomplished for those	
		ne use of a tool or key from the		residents found to have bee	n
	_	otherwise permitted by LSC		affected by the deficient	
	-	Door-locking arrangements		practice?	

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Facility ID: 000032

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(7/2) 7.5	III TIPLE CO	NCTRICTION	(Y2) DATE SUBVEY			
		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		155077	B. W	ING		11/02	/2022	
NAME OF P	ROVIDER OR SUPPLIER				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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	shall be permitted in	n accordance with 19.2.2.2.5.2.						
	This deficient pract	ice could affect over 40			No residents have been affect	ted		
	residents, staff and	visitors if needing to exit the			by the deficient practice, but the	he		
	facility.	-			facility doors have the code po			
	-				now at each exit door in all wi			
	Findings include:				Delayed egress signs are now	_		
	S				posted./p>			
		ons with the Executive						
	ŕ	or of Maintenance and the						
		ance Director during a tour of			How other residents having	the		
	the facility from 9:1	15 a.m. to 11:50 a.m. on 11/02/22,			potential to be affected by the	ne		
	the exit door to the	outside of the facility in the			same deficient practice will I	be		
	vestibule for the A	Wing and in the vestibule for			identified and what corrective	re		
	the B Wing were ea	ach marked as a facility exit with			action(s) will be taken.			
	an exit sign and cou	ald be opened by entering a						
	_	at the door. However, the			No residents have been affect	ted		
		d at each exit door. Based on		by the deficient practice, all the				
	_	e of the observations, the			hallway door and exits are au			
	Executive Director				at different times to ensure that			
		residents who have a clinical			there is code posted at each			
		secure wing are in the C Wing			and delayed egress signs are			
	-	I residents in the A Wing and			posted./p>			
		ical diagnosis to be in a secure						
		e keypad code to release the						
		the vestibule for the A Wing			What measures will be put in	nto		
	_	s not posted at the keypad.			place and what systemic			
		1			changes will be made to			
	This finding was re	viewed with the Executive			ensure that the deficient			
	_	for of Maintenance and the			practice does not recur.			
		ance Director during the exit			Maintenance director /Designo	<b>66</b>		
	conference.	and Director during the Cart			will complete random audits d			
	23110101100				Monday through Sunday four	чи		
	3.1-19(b)				times a week on random shifts	9		
	5.1 17(0)				including weekends for four			
	2 Based on observe	ation and interview, the facility			weeks, then three times a wee	ak		
		means of egress through 1 of						
		cks were readily accessible for			for two weeks, then two times week for the two weeks, once			
		nd visitors. LSC 7.2.1.6.1,			•			
					week for one weeks to ensure			
		cks allows approved, listed,			the facility doors have the cod			
	delayed egress lock	s shall be permitted to be			posted now at each exit door	ın all		

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

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER A. BUILDING 01  B. WING			COMPLI 11/02/2		
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on observation Director, the Director the Director Corporate Maintenathe facility from 9:1 the exit door to the east side of the main facility exit with an keypad at the exit do but the code to releast a delayed egress delayed egress delayed egress signs the time of the observation of the ob	ons with the Executive for of Maintenance and the fance Director during a tour of 15 a.m. to 11:50 a.m. on 11/02/22, outside of the facility on the in dining room was marked as a facility sign. The door also had a floor to release the door to open fase the door to open was not foor. The door was not marked door with the necessary fage. Based on interview at factorial structures are also and the floor may be a delayed floor may be a delayed floor floor was not posted floor floor was not posted floor was not p		meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.  Date of compliance November 24th, 2022	eved : QA nds	
K 0291 SS=F Bldg. 01		_				

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155077	B. WING		11/02/2022	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	l	
				ACHWAY DR		
ENVIVE	OF INDIANAPOLIS		INDIAN	NAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
	accordance with 7					
	18.2.9.1, 19.2.9.1	.0.				
		riew, observation and	K 0291	POC- Life Safety	11/24/2022	
		ty failed to document monthly	K 0271	Life dulety	11/24/2022	
		or all battery backup lights in		Tag K291		
	_	C 7.9. Section 7.9.3.1.1 states		E Level		
		y lighting systems shall be		L LCVCI		
	permitted to be con-					
	1 ~	ng shall be conducted monthly,		What corrective action(s) wil	.	
		3 weeks and a maximum of 5		be accomplished for those	'	
		s, for not less than 30		residents found to have been	,	
		otherwise permitted by		affected by the deficient	•	
	7.9.3.1.1(2).	otherwise permitted by		practice?		
	` ′	shall be permitted to be		practice:		
		days with the approval of the		No residents have been affect	her	
	authority having jur			by the deficient practice, but the		
		ng shall be conducted annually		facility had now started to	ic	
		1/2 hours if the emergency		document and check the test		
	lighting system is ba			Emergency operated light insi	de	
		lighting equipment shall be		the walk-in weatherproof shell		
		r the tests required by		emergency generator location		
	7.9.3.1.1(1) and (3).			monthly and annually.		
		of visual inspections and tests		Thornting and annually.		
	1 1	owner for inspection by the				
	authority having jur			How other residents having	tho	
		ice could affect all residents,		potential to be affected by th		
	staff and visitors.	tee could arreet air residents,		same deficient practice will be		
	starr and visitors.			identified and what correctiv		
	Findings include:			action(s) will be taken.		
	i maniga metude.			action(s) will be taken.		
	Based on review of	"Emergency Exit		No residents have been affect	red	
		Lights" documentation with		by the deficient practice, there		
	the Executive Direc	-		only one emergency operated		
		e Corporate Maintenance		on the generator which is aud	_	
		ord review from 9:20 a.m. to		checked and documented.	nicu,	
		22, monthly and annual battery		oncorea ana accumented.		
		g documentation for the most				
	` ~	n period did not include the		What measures will be put in	nto.	
		ht inside the walk-in weather		place and what systemic		
I	oanci y operancu iigi	in morae the want-ill weather	i	Piace and what systemic	1	

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proof shell for the emergency generator location.

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changes will be made to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155077	B. WING		11/02/2022	
NAME OF	DDOMDED OF GUIDE TE	n.	STREE	T ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF	PROVIDER OR SUPPLIE	K	45 BE	EACHWAY DR		
ENVIVE	OF INDIANAPOLIS	8	INDIA	ANAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	D BE COMPLETION	
TAG	+	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		v at the time of record review,		ensure that the deficient		
		intenance stated he mainly		practice does not recur.		
		ighting but agreed monthly and		Maintenance director /Des	-	
		esting documentation for the		will complete random audi	-	
		ght inside the walk-in weather		Monday through Sunday fo		
		emergency generator location		times a week on random s		
		twelve month period was not		including weekends for fou		
		w. Based on observations with		weeks, then three times a		
		ctor, the Director of		for two weeks, then two tin		
		he Corporate Maintenance our of the facility from 9:15 a.m.		week for the two weeks, or		
	_	1/02/22, only one battery		week for one weeks to ens		
		ystem was noted in the facility		emergency exit lights on the generator are checked and		
		weather proof shell location for		documented. Maintenance		
		erator which functioned when		director /Designee will brin		
	its respective test b			audit sheets back in morni	-	
	ns respective test of	atton was pushed.		meeting every day to be re	_	
	This finding was re	eviewed with the Executive		The results of these audits		
		tor of Maintenance and the		reviewed in Quality Assura		
	· ·	ance Director during the exit		meeting monthly for 6 mor		
	conference.	S		until 100%complaince is a		
				for 3 consecutive months.		
	3.1-19(b)			committee will identify any	trends	
				or patterns and make		
				recommendations to revise	e the	
				plan of correction as indica	ated	
				How the corrective action	n(s)	
				will be monitored to ensu	• •	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will b	pe put	
				into place; and		
				Maintenance director /Des	ignee	
				will complete random audi	ts daily	
				Monday through Sunday for	our	
				times a week on random s	hifts	
				including weekends for fou		
				weeks, then three times a		
				for two weeks, then two tin	nes a	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155077	B. WI	NG		11/02/	/2022
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				CHWAY DR		
FN\/I\/F (	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVE V	CI INDIANAI OLIO			אואטואוו	7.1 OLIO, IIV 70224		
(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
					week for the two weeks, once		
					week for one weeks to ensure	that	
					emergency exit lights on the		
					generator are checked and		
					documented. Maintenance		
					director /Designee will bring th	e	
					audit sheets back in morning		
					meeting every day to be review		
					The results of these audits will		
					reviewed in Quality Assurance		
					meeting monthly for 6 months		
					until 100%complaince is achie		
					for 3 consecutive months. The		
					committee will identify any tren	nas	
					or patterns and make recommendations to revise the	•	
					plan of correction as indicated		
					Date of compliance November 24th , 2022		
					November 24tif, 2022		
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
		RKS section any LSC					
	Section 18.3 and	-					
		are not addressed by the					
		out are deficient. This					
		with the applicable Life					
	-	FPA standard citation,					
	should be included	d on Form CMS-2567.					
	1. Based on observa	ation and interview, the facility	K 0.	300	POC- Life Safety		11/24/2022
	failed to replace bat	tery operated smoke alarms			·		
	installed in 47 of 63	resident sleeping rooms in			Tag K300		
	accordance with NF	FPA 72. NFPA 72, 2010			SS-E		
	· ·	4.8.1 states unless otherwise					
		e manufacturer's published					
		and multiple-station smoke			What corrective action(s) wil	l	
	-	aced when they fail to respond			be accomplished for those		
	to operability tests b	out shall not remain in service			residents found to have beer	1	

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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 11/02/2022	
	PROVIDER OR SUPPLIEI		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	longer than 10 year	s from the date of manufacture.		affected by the deficient	
	This deficient pract	ice could affect all residents,		practice?	
	staff and visitors.				
				No residents have been affected	ed
	Findings include:			by the deficient practice, but	
				resident room battery operated	
	Based on observation	ons with the Executive		smoke detectors documentatio	n is
	Director, the Direct	tor of Maintenance and the		current at this time.	
	Corporate Maintena	ance Director during a tour of			
	the facility from 9:	15 a.m. to 11:50 a.m. on 11/02/22,		How other residents having the	ne
	manufacturer's doc	umentation affixed to the Kidde		potential to be affected by the	
	Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room			same deficient practice will be	e
				identified and what corrective	•
		the unit was manufactured		action(s) will be taken.	
	03/12/12 and to "re	place the unit within 10 years			
		'. The installation date was not		No residents have been affected	ed
		pattery operated smoke alarm.		by the deficient practice, building	_
	Based on interview			wide audit is completed to ensu	
	1	irector of Maintenance stated		battery operated smoke detect	ors
	_	ing room which has a battery		preventive maintenance	
	_	rm has the same type of		documentation is current and	
		noke alarm installed in the room		documented.	
		sleeping room battery		What measures will be put	
	_	rms installed in the facility		into place and what systemic	
	were more than ten	years old.		changes will be made to	
				ensure that the deficient	
	1	viewed with the Executive		practice does not recur.	
		tor of Maintenance and the		Maintenance director /Designe	
	_	ance Director during the exit		will complete random audits da	illy
	conference.			Monday through Sunday four	
	2.1.10(1)			times a week on random shifts	
	3.1-19(b)			including weekends for four	
	2 D1			weeks, then three times a weel	
		review, observation and		for two weeks, then two times a	
	interview; the facili			week for the two weeks, once a	a
		the preventative maintenance		week for one weeks to ensure	
		ted smoke alarms in resident		battery operated smoke detect	ors
	_	te. NFPA 101 in 4.6.12.3 states		documentation is current.	
	existing life safety	features obvious to the public,	İ	Maintenance director /Designe	e

if not required by the Code, shall be maintained.

will bring the audit sheets back in

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155077	B. WING		11/02/2022	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				ACHWAY DR		
ENVIVE	OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	·	Fire Alarm and Signaling Code,		morning meeting every day to	<b>I</b>	
	·	Maintenance and Tests states		reviewed. The results of these		
		ment shall be maintained and		audits will be reviewed in Qua	-	
		e with the manufacturer's		Assurance meeting monthly for	<b>I</b>	
	_	ons and per the requirements		months or until 100%complair	nce	
	_	PA 72, 14.2.1.1.1 Inspection,		is achieved for 3 consecutive		
	<u> </u>	nance programs shall satisfy		months. The QA committee w		
	*	this Code and conform to the		identify any trends or patterns	and	
		eturer's published instructions.		make recommendations to re-		
	_	ice could affect all residents,		the plan of correction as indic	ated.	
	staff, and visitors.					
	Findings include:					
	Based on record rev	view with the Executive		How the corrective action(s)		
		or of Maintenance and the		will be monitored to ensure		
		ance Director from 9:20 a.m. to		deficient practice will not		
	_	22, resident room battery		recur, i.e., what quality		
	_	ector preventive maintenance		assurance program will be p	out	
	_	the most recent twelve month		into place; and		
	period was not avai	lable for review. Based on		Maintenance director /Design	ee	
	_	e of record review, the Director		will complete random audits d	<b>I</b>	
		ted he regularly tests battery		Monday through Sunday four		
		ectors but does not document		times a week on random shift	s	
	_	ed resident room battery		including weekends for four		
		ector testing and cleaning		weeks, then three times a we	ek	
	documentation for t	the most recent twelve month		for two weeks, then two times		
	period was not avai	lable for review. Based on		week for the two weeks, once		
	observations with the	he Executive Director, the		week for one weeks to ensure	;	
	Director of Mainter	nance and the Corporate		battery operated smoke detec	tors	
		tor during a tour of the facility		documentation is current at al	I	
	from 9:15 a.m. to 1	1:50 a.m. on 11/02/22,		times. Maintenance director		
	manufacturer's docu	umentation affixed to the Kidde		/Designee will bring the audit		
	Model i9010 batter	y operated smoke alarm		sheets back in morning meeti	ng	
	installed on the ceil	ing in resident sleeping Room		every day to be reviewed. The	-	
	B11 and D4 stated t	to test the unit weekly and to		results of these audits will be		
	clean the unit annua	ally. Based on interview at the		reviewed in Quality Assurance	e	
	time of the observat	tions, the Director of		meeting monthly for 6 months		
	Maintenance stated	each resident sleeping room		until 100%complaince is achie		
		operated smoke alarm has the		for 3 consecutive months. The		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		l í	JILDING	onstruction 01	(X3) DATE COMPL 11/02/	ETED		
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE	
	installed in the roor  This finding was re Director, the Direct	y operated smoke alarm n. viewed with the Executive or of Maintenance and the ance Director during the exit			committee will identify any tre or patterns and make recommendations to revise th plan of correction as indicated Date of compliance November 24th, 2022	e		
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated is by smoke resisting irs in accordance with 8.4.						
	a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64						

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	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMPLETED		
155077 B. WING 11/02/2022		
NAME OF DROVIDER OR SURBLIER		
NAME OF PROVIDER OR SUPPLIER  45 BEACHWAY DR		
ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG: DEGLIE ATORY OR LSC IDENTIFYING INFORMATION  TAG: DEFICIENCY DEPOSIT		
TAG REGULATOR OR ESCIDENTIFIED INFORMATION TAG DATE	E	
(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces		
(over 50 square feet)		
g. Laboratories (if classified as Severe		
Hazard - see K322)		
Based on observation and interview, the facility K 0321 POC- Life Safety 11/24	2022	
failed to ensure 1 of over 13 hazardous areas such		
as combustible storage rooms over 50 square feet Tag K321		
in size were separated from other spaces by smoke SS-E		
resistant partitions and doors. Doors shall be self		
closing or automatic closing in accordance with		
7.2.1.8. This deficient practice could affect over 10  What corrective action(s) will		
residents, staff and visitors in the vicinity of the be accomplished for those		
Central Supply room. residents found to have been		
Findings include:  affected by the deficient practice?		
Findings include:		
Based on observations with the Executive No residents have been affected		
Director, the Director of Maintenance and the by the deficient practice, but		
Corporate Maintenance Director during a tour of Corridor door to the room now has		
the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22, self-enclosure.		
the Central Supply room is a storage room for  How other residents having the		
combustible boxes and supplies which was potential to be affected by the		
greater than 50 square feet in size. The corridor    document to the greater was not said closing on outcometics		
door to the room was not self closing or automatic closing. Based on interview at the time of the identified and what corrective action(s) will be taken.		
observations, the Director of Maintenance agreed		
the corridor door to the aforementioned hazardous  No residents have been affected		
area was not self closing or automatic closing.  by the deficient practice, building		
wide audit is completed to ensure		
This finding was reviewed with the Executive all the rooms have self-enclosure		
Director, the Director of Maintenance and the where needed.		
Corporate Maintenance Director during the exit  What measures will be put into		
conference. place and what systemic		
changes will be made to		
3.1-19(b) ensure that the deficient		
practice does not recur.		
Maintenance director /Designee will complete random audits daily		
Monday through Sunday four		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/02/2022	
	ROVIDER OR SUPPLIE DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				times a week on random shift including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure self-enclosures are present of the needed doors. Maintenand director /Designee will bring the audit sheets back in morning meeting every day to be revied. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Maintenance director /Design will complete random audits of Monday through Sunday four times a week on random shift including weekends for four weeks, then three times a week for the two weeks, once week for one weeks to ensure self-enclosures are present of the needed doors. Maintenand director /Designee will bring the audit sheets back in morning the audit sheets back in morning	ek ek ea a e n all ce ne wed. Il be e e e QA nds e d.  the  de lailly s ek ea a e n all ce

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
NAME OF I	PROVIDER OR SUPPLIER	<b>\</b>			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)	
						TE	COMPLETION	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking Facilities Cooking equipmer accordance with N Ventilation Contro Commercial Cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under 1 Cooking facilities NFPA 96 per 9.2.3	nt is protected in NFPA 96, Standard for ol and Fire Protection of ting Operations, unless: ng equipment (i.e., small as microwaves, hot plates, d for food warming or limited ance with 18.3.2.5.2, s open to the corridor in tents with 30 or fewer with the conditions under		PREFIX TAG	meeting every day to be review The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any trenor patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th, 2022	wed. be or ved QA nds	COMPLETION DATE	
	through 19.3.2.5.5 Based on record rev	n 18.3.2.5.4, 19.3.2.5.1	K 0	324	POC- Life Safety		11/24/2022	

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COMPLET			
		155077	B. W	'ING		11/02/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				IAPOLIS, IN 46224		
(X4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	Т	ID	I	1 0	(5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	· ·	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPL	
TAG		to ensure 1 of 1 kitchen range		IAG	Tag K324	DA	115
		ns was maintained in proper			SS-E		
		PA 96, Standard for Ventilation			What corrective action(s) wi		
	-	otection of Commercial			be accomplished for those	"	
		s, 2011 Edition, Section 4.1.3			residents found to have been	,	
		equipment shall be kept in			affected by the deficient	'	
	working condition:				practice?		
	(1) Cooking equipment				practice:		
	(2) Hoods				No residents have been affect	<sub>ed</sub>	
	(3) Ducts (if application	able)			by the deficient practice, but		
	(4) Fans				kitchen range hood exhaust		
	(5) Fire-extinguishing equipment				systems repair documents are		
	(6) Special effluent or energy control equipment				maintained in proper working		
	Section 4.1.3.1 states maintenance and repairs				order.		
		on all components at intervals					
	-	in good working condition.			How other residents having	the	
		ice could affect over two			potential to be affected by the		
	kitchen staff.				same deficient practice will l		
					identified and what corrective		
	Findings include:				action(s) will be taken.		
		the kitchen range hood fire			No residents have been affect	ed	
		inspection contractor's "Fire			by the deficient practice, Audi		
		ocumentation dated 07/18/22		kitchen hood exhaust system had			
		Director, the Director of			been completed./p>		
		e Corporate Maintenance					
	_	ord review from 9:20 a.m. to			What measures will be put ir	ito	
	_	22, the kitchen range hood fire			place and what systemic		
	* *	has deficiencies as a result of			changes will be made to		
	•	omments, Discrepancies of			ensure that the deficient		
		on of the 07/18/22 inspection			practice does not recur.		
	-	ro-switch at A* control box			Maintenance director /Designo		
		vire connection to allow elec			will complete random audits d	ally	
		ivation". Based on interview			Monday through Sunday one		
		d review, the Director of			times a week on random shifts	<b>S</b>	
		he was not aware if any			including weekends for four	,	
	_	ade on or after 07/18/22 and			weeks, then one times a week		
	-	on of any corrections			two weeks, then one times a		
	-	er 07/18/22 was not available			for the one week to ensure bu	t	
	for review at the tin	for review at the time of the survey.			kitchen range hood exhaust		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  11/02/2022			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE			
	Director, the Direc	eviewed with the Executive stor of Maintenance and the sance Director during the exit		systems repair document maintained in proper wo order. Maintenance directly Designee will bring the sheets back in morning revery day to be reviewed results of these audits were viewed in Quality Assumeeting monthly for 6 muntil 100% complaince is for 3 consecutive months committee will identify an or patterns and make recommendations to rever plan of correction as individual to the corrective active will be monitored to endeficient practice will necur, i.e., what quality assurance program will into place; and Maintenance director /Dowill complete random aud Monday through Sunday times a week on random including weekends for feweeks, then one times at two weeks, then one times at two weeks, then one times are main proper working order. Maintenance director /Dowill bring the audit sheet morning meeting every creviewed. The results of audits will be reviewed in Assurance meeting mon months or until 100% corrections.	rking ctor audit meeting d. The ill be urance onths or achieved s. The QA ny trends  ise the icated./p>  on(s) sure the ot  I be put  esignee dits daily v one n shifts four week for es a week ure kitchen tems aintained  esignee s back in day to be the Quality thly for 6			

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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 11/02/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				is achieved for 3 consecutive months. The QA committee w identify any trends or patterns make recommendations to retain the plan of correction as indicated as the plan of compliance.  Date of compliance November 24th, 2022	and vise			
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and tes secure location are	<u> </u>						
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record interview; the facili hydrostatic flush for piping systems whitesting. NFPA 25, 3 Testing and Mainter	•	K 0353	POC- Life Safety  Tag K353 SS-F  What corrective action(s) wil	11/24/2022			
	conducted for system	n investigation shall be m piping whenever foreign pipe valves or in check valves.		be accomplished for those residents found to have been affected by the deficient	n			

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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 11/02/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Section 14.3.3, states if an obstruction practice? investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete No residents have been affected flushing program shall be conducted by qualified by the deficient practice, but repair personnel. This deficient practice could affect all for hydrostatic flush for 2 of 2 residents, staff and visitors. automatic sprinkler piping system is in process which failed flow Findings include: testing and trip testing. Based on review of the sprinkler system How other residents having the inspection contractor's "Sprinkler Inspection potential to be affected by the Certificate" documentation dated 07/11/22 with same deficient practice will be the Executive Director, the Director of identified and what corrective Maintenance and the Corporate Maintenance action(s) will be taken. Director during record review from 9:20 a.m. to 1:45 p.m. on 11/01/22, the facility's two dry No residents have been affected sprinkler systems failed flow testing and trip by the deficient practice, Audit for testing. Review of the sprinkler system inspection the facility wide hydrostatic flush contractor's "Service Proposal" documentation had been completed and repair for dated 08/11/22 indicated a quote to "remove and hydrostatic flush for 2 of 2 flush each inspector's test until clean water is automatic sprinkler piping system observed". Based on interview at the time of is in process which failed flow record review, the Director of Maintenance and testing and trip testing. the Corporate Maintenance Director stated the What measures will be put into quote had been approved and the sprinkler place and what systemic system contractor was actively prepping the changes will be made to system for the flush at the time of the survey but ensure that the deficient had not yet started or completed the flush of the practice does not recur. two sprinkler systems. Based on observations Maintenance director /Designee with the Executive Director, the Director of will complete random audits daily Maintenance and the Corporate Maintenance Monday through Sunday one Director during a tour of the facility from 9:15 a.m. times a week on random shifts to 11:50 a.m. on 11/02/22, the sprinkler system including weekends for four contractor was actively prepping the system for weeks, then one times a week for the flush by installing additional sprinkler low two weeks, then one times a week point drains in advance of flushing the two dry for the one week to ensure sprinkler systems for the facility. hydrostatic flush for automatic sprinkler piping system is in

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This finding was reviewed with the Executive

Director, the Director of Maintenance and the

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process which failed flow testing

and trip testing. Maintenance

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155077	B. W	ING		11/02/	2022
		ı		CTPEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
EVI/II/E	OF INDIANAPOLIS				IAPOLIS, IN 46224		
LINVIVE	TINDIANAI OLIO	,		וואטואוו			
(X4) ID	SUMMARY	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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ance Director during the exit			director /Designee will bring th	ne	
	conference.				audit sheets back in morning		
					meeting every day to be revie		
	3.1-19(b)				The results of these audits wil		
					reviewed in Quality Assurance		
		review and interview, the			meeting monthly for 6 months		
		aintain automatic sprinkler			until 100%complaince is achie		
	1 -	nce with NFPA 25. LSC 9.7.5			for 3 consecutive months. The		
		er systems shall be inspected,			committee will identify any tre	nds	
	· ·	ned in accordance with NFPA			or patterns and make		
		e Inspection, Testing, and			recommendations to revise th	-	
	Maintenance of Water-Based Fire Protection				plan of correction as indicated	l.	
	1 -	5, 2011 Edition, Section 4.1.4.1			l		
		owner or designated			How the corrective action(s)		
	_	correct or repair deficiencies			will be monitored to ensure t	the	
	_	t are found during the			deficient practice will not		
	_	maintenance required by this			recur, i.e., what quality		
		ons and repairs shall be			assurance program will be p	ut	
		fied maintenance personnel or			into place; and		
	_	or. NFPA 25, 4.3.1 requires			Maintenance director /Designo		
		de for all inspections, tests,			will complete random audits d	ally	
		f the system components and able to the authority having			Monday through Sunday one	_	
		equest. This deficient practice			times a week on random shifts	5	
		dents, staff, and visitors in the			including weekends for four	for	
	facility.	dents, starr, and visitors in the			weeks, then one times a week two weeks, then one times a weeks.		
	idenity.				for the one week to ensure	WEEK	
	Findings include:				hydrostatic flush for automatic		
	i mamga menade.				sprinkler piping system is in	,	
	Based on review of	the sprinkler system			process which failed flow testi	na	
		or's "Sprinkler Inspection			and trip testing. Maintenance	· ·9	
		entation dated 07/11/22 with			director /Designee will bring the	ne	
		etor, the Director of			audit sheets back in morning		
		ne Corporate Maintenance			meeting every day to be revie	wed.	
		ord review from 9:20 a.m. to			The results of these audits wil		
	_				reviewed in Quality Assurance		
	1:45 p.m. on 11/01/22, deficiencies were noted for the facility's sprinkler system during the				meeting monthly for 6 months		
		acility. The "Notes and			until 100%complaince is achie		
		' section of the 07/11/22			for 3 consecutive months. The		
		spection report stated			committee will identify any tre		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155077			JILDING	01	COMPL 11/02/	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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
IAU	"Accelerator failed A & B Wings" sprin was out of service to C & D Wings". Bo following statement waterflow switch for must have a waterfl maintenance device system must have a System has excessivinterview at the tim of Maintenance and Director provided a documentation date system inspection of each system on or a been performed beet trying to perform sp.  This finding was red Director, the Director Corporate Maintenance of Corporate Maintenance of Systems, 2011 Editionand Maintenance of Systems, 2011 Editionand fire department inspected, tested, ar with Chapter 13. St. 13.1.1.2 shall be utimaintenance of valutrim. Section 4.3.1 all inspections, tests	to activate" for the "west side nkler system and "Accelerator apon arrival" for the "east side th sprinkler systems had the tes "systems have 1 PS10 or 2 dry systems. Each system ow switch. Systems have 1 air of for 2 dry systems, each dry an air maintenance device. We air pressure". Based on the corporate Maintenance of the Corporate Maintenance of the Corporate Maintenance of approved "Service Proposal" do 8/11/22 from the sprinkler contractor but stated repairs to a fter 08/11/22 have not yet the facility was actively brinkler flushing first.  In the Corporate Maintenance of Maintenance and the same Director during the exit the facility was actively brinkler flushing first.  In the Corporate Maintenance and the same Director during the exit the facility was actively brinkler flushing first.  In the Maintenance and the same Director during the exit the facility of the Inspection, Testing, and the maintenance of the formation of the same for inspection, testing and wes, valve components and states records shall be made for so, and maintenance of the conents and shall be made		IAU	or patterns and make recommendations to revise the plan of correction as indicated Date of compliance November 24th , 2022		DATE	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	01	COMPL	
		155077	B. WING			11/02/	2022
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS				CHWAY DR APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	·	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
IAU		nority having jurisdiction upon	TAG				DATE
		ent practice could affect all					
	-	visitors in the facility.					
	Findings include:						
	Based on record review with the Executive						
	Director, the Director of Maintenance and the						
	Corporate Maintena	nce Director during record					
		m. to 1:45 p.m. on 11/01/22,					
	monthly sprinkler system valve inspection						
	documentation for August, September and October 2022 was not available for review. Based on interview at the time of record review, the						
		ance said he documents					
	sprinkler system ga	uge inspections but agreed					
	monthly sprinkler sy	ystem valve inspection					
		August, September and					
		not available for review. Based					
		h the Executive Director, the					
		ance and the Corporate or during a tour of the facility					
		1:50 a.m. on 11/02/22, the facility					
	has supervised dry s						
	This finding was	viewed with the Executive					
	_	or of Maintenance and the					
	· ·	ince Director during the exit					
	conference.	C					
	3.1-19(b)						
K 0355	NFPA 101						
SS=F	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extir	<del>-</del>					
		guishers are selected,					
	· ·	d, and maintained in					
		IFPA 10, Standard for					
	Portable Fire Extir	_					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIER 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		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
PREFIX	REGULATORY OF  1. Based on observation failed to ensure 3 or had documented an accordance with NI portable fire exting installed, inspected with NFPA 10. NF Fire Extinguishers, states fire extinguishmaintenance at interpretation of specifically indicate electronic notification fire extinguisher shattached that indicate maintenance was performing the worth agency perform practice could affect visitors.  Findings include:  Based on observation of the ABC type portation the Medical Receiphall, the Central Su		K 0		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ed ble ve ecord auty cal the e e e e e e e e e e e e e e e e e e	COMPLETION
	inspection contractor recent annual main January 2021. Base the observations, the agreed it had been a since the most recent	or indicating the date the most tenance was performed was ed on interview at the time of e Director of Maintenance greater than twelve months int annual maintenance was aforementioned three portable			documentations have been completed for medical record room, central supply room, be shop and main shut off electric and water room.	•	
					What measures will be put in	ito	

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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	B. WING 11/		11/02/	11/02/2022	
		l		STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ACHWAY DR			
ENI\/I\/E	OF INDIANAPOLIS	•			IAPOLIS, IN 46224			
LINVIVE	OI INDIANAFOLIS	,		INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	viewed with the Executive			place and what systemic			
		tor of Maintenance and the			changes will be made to			
	-	ance Director during the exit			ensure that the deficient			
	conference.				practice does not recur.			
					Maintenance director /Design	ee		
	3.1-19(b)				will complete random audits of	laily		
					Monday through Sunday one			
		ation and interview, the facility			times a week on random shift	s		
		f 18 portable fire extinguishers			including weekends for four			
	_	east monthly and the			weeks, then one times a weel			
	-	ocumented including the date			two weeks, then one times a	week		
	and initials of the person performing the				for the one week to ensure			
	inspection in accordance with NFPA 10. LSC				portable fire extinguisher mor	ithly		
	_	ole fire extinguishers shall be			inspection and documentation	n are		
		inspected and maintained in			complete. Maintenance direct	or		
		FPA 10. NFPA 10, the			/Designee will bring the audit			
		ble Fire Extinguishers, 2010			sheets back in morning meeti	ng		
		2.1.2 states fire extinguishers			every day to be reviewed. The	е		
	_	either manually or by means of			results of these audits will be			
		oring device/system at a			reviewed in Quality Assurance	е		
	1	y intervals. Where monthly			meeting monthly for 6 months	or		
	_	are conducted, the date the			until 100%complaince is achie	eved		
		was performed and the initials			for 3 consecutive months. The	e QA		
		rming the inspection shall be			committee will identify any tre	nds		
		nanual inspections are			or patterns and make			
		for manual inspections shall			recommendations to revise th	е		
		label attached to the fire			plan of correction as indicate			
		inspection checklist						
		or by an electronic method.						
		ept to demonstrate that at least			How the corrective action(s)			
		inspections have been			will be monitored to ensure	the		
	_	eficient practice could affect all			deficient practice will not			
	residents, staff and	visitors.			recur, i.e., what quality			
					assurance program will be p	ut		
	Findings include:				into place; and			
					Maintenance director /Design			
		ons with the Executive			will complete random audits of	laily		
		tor of Maintenance and the			Monday through Sunday one			
	_	ance Director during a tour of			times a week on random shift	s		
	the facility from 9:15 a.m. to 11:50 a.m. on 11/02/22,				including weekends for four			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ í	UILDING	onstruction  01	(X3) DATE COMPL 11/02/	ETED
	PROVIDER OR SUPPLIEF			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ABC type portable missing monthly in a. in the Medical Reshort hall for Augus 2022. b. in the Central Su September and October 2022. d. in the Beauty Sho October 2022. d. in the Main Shut September and October and October 2022. d. in the Main Shut September and October 2022. d. in the Main Shut September and October 2022. d. in the Main Shut September and October 2022. d. in the Main Shut September and October 2022. This finding was re Director, the Director, the Director	op for August, September and Off Electrical & Water for ober 2022.			weeks, then one times a week two weeks, then one times a week to ensure portable fire extinguisher moninspection and documentation complete. Maintenance directly Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance November 24th, 2022	thly are or eved e QA ands	
K 0362 SS=E Bldg. 01	walls constructed resistance rating. compartments, paresist the transfer nonsprinklered buunderside of the floceiling. Corridor wunderside of ceiling permitted by Code	arated from use areas by with at least 1/2-hour fire In fully sprinklered smoke artitions are only required to of smoke. In wildings, walls extend to the loor or roof deck above the valls may terminate at the ngs where specifically					

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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  11/02/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	sprinklered comparestrictions in area or frames.  If the walls have a the ratingterminate at the uprief description in ceiling throughout 19.3.6.2, 19.3.6.2.  Based on observation failed to ensure constructions	7 on and interview, the facility ridor walls in 1 of 9 smoke	K 0362	POC- Life Safety	11/24/2022		
	compartments were transfer of smoke. assemblies and their including all frames and sills shall be in requirements of NF and Other Openings Edition, Section 4.8 fire doors, sills shall door assembly. Sec constructed of none 4.8.2.5 states for speliding accordion on having a jamb deptl width shall be equal 5.2.5.2 states no ope surfaces of either the practice could affect	constructed to resist the LSC 8.3.3.1 states fire window r accompanying hardware, s, closing devices, anchorage accordance with the PA 80, Standard for Fire Doors is Protectives. NFPA 80, 2010 1.2.11 states for service counter is be provided as part of the fire exting 4.8.2.2 states sills shall be combustible materials. Section ecial-purpose horizontally rolding doors with frames in of 4 inches or less, the sill is to the jamb depth. Section en holes or breaks shall exist in e door or frame. This deficient it over 20 residents, staff and the of the main dining room.		Tag K362 SS-E  What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice?  No residents have been affect by the deficient practice, but the rolling fire door for the kitcher the west wall of main dining resis now on track within the rolling opening to resist the transfer smoke now.  How other residents having	eted the n is in oom ing door		
	Findings include:  Based on observation Director, the Direct Corporate Maintenathe facility from 9:1 the main dining roo	ons with the Executive or of Maintenance and the unce Director during a tour of 5 a.m. to 11:50 a.m. on 11/02/22, m was open to the corridor. r for the kitchen is in the west		potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken.  No residents have been affect by the deficient practice, Aud the all the fire-resistant doors the facility had been made. N	ne be ve  sted it for in		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/02/2022
	PROVIDER OR SUPPLIER		45 BI	ET ADDRESS, CITY, STATE, ZIP COD EACHWAY DR	
ENVIVE	OF INDIANAPOLIS		INDI	ANAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR wall of the main dir	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ning room. The rolling fire door	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)  other doors have the same	PRIATE COMPLETION DATE
	wall of the main dir was off track and w for the rolling door opening to not resis Director of Maintendoor back on track of frame at the time of interview at the time Director of Maintenhad been off track a passage of smoke.	LSC IDENTIFYING INFORMATION		DEFICIENCY)	gnee s daily ne hifts r eek for a week fire ansfer e g the ng viewed. will be nce ths or chieved The QA trends e the ited.
1			1	Maintenance director /Desi	ignee

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ICHWAY DR IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	5.112	
				will complete random audits da Monday through Sunday one times a week on random shifts including weekends for four weeks, then one times a week two weeks, then one times a w for the one week to ensure fire resistant doors resist the trans of the smoke. Maintenance director /Designee will bring th audit sheets back in morning meeting every day to be review. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100%complaince is achie for 3 consecutive months. The committee will identify any trer or patterns and make recommendations to revise the plan of correction as indicated Date of compliance  November 24th, 2022	of for week ended to be ended	
K 0363 SS=E Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containir	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in its grire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in its fave positive latching				

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hardware. Roller latches are prohibited by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       11/02/2022			
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		45	EET ADDRESS, CITY, STATE, ZIP CO BEACHWAY DR DIANAPOLIS, IN 46224	)D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION  MS regulation. These requirements do not		G DEFICIENCY)		DATE
	apply to auxiliary spaces that do not contain flammable or combustible material.					
		en bottom of door and floor				
		ceeding 1 inch. Powered				
		with 7.2.1.9 are permissible				
	•	device capable of keeping				
		hen 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				
	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door					
	_	b are permitted. Door beled and made of steel or				
		compliance with 8.3,				
	unless the smoke					
	•	fire window assemblies are				
	-	n sprinklered compartments				
		ctions in area or fire s or frames in window				
	assemblies.	s of frames in willdow				
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,				
		S details of doors such as				
		ngs, automatics closing				
	devices, etc.	-				
		on and interview, the facility	K 0363	POC- Life Safety		11/24/2022
		f over 75 corridor doors had no ing and latching into the door		Tog K262		
	_	sist the passage of smoke.		Tag K363 SS-E		
		ice could affect over 40		00-L		
	residents, staff and			What corrective action	(s) will	
	Findings include:			be accomplished for the residents found to have affected by the deficient	e been	
	Based on observation	ons with the Executive		practice?		
		or of Maintenance and the				
	Corporate Maintena	ance Director during a tour of		No residents have been	affected	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01  B. WING			COMPLETED	
		155077	B. Wl	NG		11/02/2	2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI 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	<sub></sub>	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	the facility from 9:1	5 a.m. to 11:50 a.m. on 11/02/22,			by the deficient practice, but re	oom		
	the following was n	oted:			no A18, B23,C10 and the entr	y		
	a. the corridor door to Room A18 didn't latch into the door frame when tested to close multiple times				door to the kitchen are all the			
					doors are now fixed and can la	atch		
	because a hasp was	affixed to the door and the			properly now.			
	door frame which d	idn't allow the latching						
	mechanism on the o	loor to protrude into the			How other residents having	the		
	latching plate on the	e door frame. The Director of			potential to be affected by th	ie		
		red the hasp which then			same deficient practice will b	oe		
		latch into the door frame.			identified and what correctiv	e e		
		d out of the face of the			action(s) will be taken.			
	corridor door to Room B23 by the door handle							
	which exposed the latching mechanism on the				No residents have been affect			
		sure the door was 1 3/4 inch			by the deficient practice, Audit	t for		
		vood or other material capable			the all the doors in the facility	had		
	_	at least 20 minutes. Room B23			been made. No other doors ha	ave		
		to a conference room.			the same deficient practice.			
		to Room C10 was propped in						
		ion with a waste basket placed						
	on the floor up agai							
		missing on the metal plate			What measures will be put in	nto		
		g mechanism in place on the			place and what systemic			
		tchen from the Main Dining			changes will be made to			
		n rolling fire door which			ensure that the deficient			
	I	or to the kitchen to not latch			practice does not recur.			
		each time the door was tested			Maintenance director /Designe			
	_	nes. The Main Dining Room			will complete random audits d	ally		
	was open to the cor				Monday through Sunday one			
	Based on interview				times a week on random shifts	S		
		irector of Maintenance and			including weekends for four	,		
		tenance Director agreed the			weeks, then one times a week			
		ridor doors had an impediment			two weeks, then one times a v			
		ing into the door frame or			for the one week to ensure do	ors		
		passage of smoke or were not			latch properly. Maintenance	_		
		nded core wood or other			director /Designee will bring th	ie		
		resisting fire for at least 20			audit sheets back in morning			
	minutes.				meeting every day to be revie			
	TE1 ' C' 1'				The results of these audits wil			
		viewed with the Executive			reviewed in Quality Assurance			
I	Director, the Direct	or of Maintenance and the			I meeting monthly for 6 months	or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077		A. BUILDING <u>01</u> B. WING			COMPLETED 11/02/2022	
		133077	В. W.			11/02/	ZUZZ	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
FN\/I\/F	OF INDIANAPOLIS				CHWAY DR IAPOLIS, IN 46224			
					I OLIO, II <b>V</b> 70224			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE	
1710		ance Director during the exit		1710	until 100%complaince is achie	ved	DATE	
	conference.				for 3 consecutive months. The			
					committee will identify any tre	nds		
	3.1-19(b)				or patterns and make			
					recommendations to revise the			
					plan of correction as indicated			
					How the corrective action(s)			
					will be monitored to ensure t	:he		
					deficient practice will not			
					recur, i.e., what quality	4		
					assurance program will be p into place; and	ut		
					Maintenance director /Designe	ee		
					will complete random audits d			
					Monday through Sunday one	,		
					times a week on random shifts	6		
					including weekends for four			
					weeks, then one times a week			
					two weeks, then one times a way for the one week to ensure do			
					latch properly. Maintenance	013		
					director /Designee will bring th	ne		
					audit sheets back in morning			
					meeting every day to be revie	wed.		
					The results of these audits wil			
					reviewed in Quality Assurance			
					meeting monthly for 6 months until 100%complaince is achie			
					for 3 consecutive months. The			
					committee will identify any trea	-		
					or patterns and make			
					recommendations to revise the			
					plan of correction as indicated			
					Data of second			
					Date of compliance November 24th, 2022			
					11076111061 24111, 2022			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	COM	e survey pleted 2/2022
	ROVIDER OR SUPPLIEI		45 BE	T ADDRESS, CITY, STATE, Z EACHWAY DR ANAPOLIS, IN 46224	IP COD	
(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 (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	alarm signal and so conditions. Fire drand unexpected to conditions, at least The staff is familia aware that drills a routine. Where draware that drills aroutine. The sased on record facility failed to do staff training documentation that the sased on review of documentation. "En In" documentation with Director of Mainten Maintenance Director of Mainten Maintenance Director of Mainten as econd shift find documentation on frourth quarter (Octo 2021 and in the section 2022 was not available interview at the timestal staff in the same conditions.	ay be used instead of	K 0712	POC- Life Safety Tag K712  What corrective ac be accomplished for residents found to affected by the defipractice?  No residents have be by the deficient practice in the defi	ction(s) will or those have been dicient deen affected ctice, but fire empleted on described by the cted by the ctice will be t corrective ken.	11/24/2022

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 ${\it Facility ID:} \quad 000032$ 

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155077 B. WING 11/02/2022

	100077	B. WING	11/02/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD	
<b></b>	05 10 10 10 10	45 BEACHWAY DR	
ENVIVE	OF INDIANAPOLIS	INDIANAPOLIS, 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
	shifts per day and agreed documentation of a fire		
	drill or staff training on fire drill procedures for the	What measures will be put into	
	second shift in the aforementioned calendar	place and what systemic	
	quarters was not available for review.	changes will be made to	
		ensure that the deficient	
	This finding was reviewed with the Executive	practice does not recur.	
	Director, the Director of Maintenance and the	Maintenance director /Designee	
	Corporate Maintenance Director during the exit	will complete random audits daily	
	conference.	Monday through Sunday one	
		times a week on random shifts	
	3.1-19(b)	including weekends for four	
		weeks, then one times a week for	
	2. Based on record review and interview, the	two weeks, then one times a week	k
	facility failed to document the staff who	for the one week to ensure fire	
	participated in quarterly fire drills or staff training	drills are completed on every shift	1
	documentation on fire drill procedures on the	per regulations. Maintenance	
	second shift for 2 of 4 quarters. LSC Section	director /Designee will bring the	
	19.7.1.6 requires drills to be conducted quarterly	audit sheets back in morning	
	on each shift under varied conditions. LSC	meeting every day to be reviewed	
	Section 19.7.1.8 states employees of health care	The results of these audits will be	
	occupancies shall be instructed in life safety	reviewed in Quality Assurance	
	procedures and devices. This deficient practice	meeting monthly for 6 months or	
	affects all residents, staff and visitors.	until 100%complaince is achieved	
	Findings includes	for 3 consecutive months. The QA	
	Findings include:	committee will identify any trends	
	Based on review of "Fire/Disaster Drill"	or patterns and make recommendations to revise the	
	documentation, "Envive Healthcare Inservice Sign		
	In" documentation and "2022 Fire Drill Schedule"	plan of correction as indicated.	
	documentation with the Executive Director, the		
	Director of Maintenance and the Corporate	How the corrective action(s)	
	Maintenance Director during record review from	will be monitored to ensure the	
	9:20 a.m. to 1:45 p.m. on 11/01/22, documentation	deficient practice will not	
	of the staff who participated in the second shift	recur, i.e., what quality	
	fire drills conducted on 03/31/22 at 6:00 p.m. and	assurance program will be put	
	on 06/21/22 at 2:00 p.m. was not available for	into place; and	
	review. Based on interview at the time of record	Maintenance director /Designee	
	review, the Director of Maintenance stated the	will complete random audits daily	
	facility operates two shifts per day and agreed	Monday through Sunday one	
	documentation of the staff who participated in the	times a week on random shifts	
	accumulation of the start who participated in the	unics a week on failuoin stills	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ	JILDING	onstruction 01	(X3) DATE COMPL 11/02/	ETED
	PROVIDER OR SUPPLIEI			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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	aforementioned two review.  This finding was re Director, the Direct Corporate Maintena conference.  3.1-19(b)  3. Based on record facility failed to do fire drills were conwithin the most record the second secon	o fire drills was not available for eviewed with the Executive for of Maintenance and the ance Director during the exit eview and interview, the cument the date second shift ducted for one of four quarters ent twelve month period. This ffects all residents, staff and			including weekends for four weeks, then one times a week two weeks, then one times a week for the one week to ensure fire drills are completed on every sper regulations. Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be reviee. The results of these audits will reviewed in Quality Assurance meeting monthly for 6 months until 100% complaince is achief for 3 consecutive months. The committee will identify any treat	veek shift  wed. I be or eved eQA	
	documentation, "En In" documentation documentation with Director of Mainter Maintenance Direc 9:20 a.m. to 1:45 p. documentation for	F"Fire/Disaster Drill" nvive Healthcare Inservice Sign and "2022 Fire Drill Schedule" in the Executive Director, the mance and the Corporate tor during record review from i.m. on 11/01/22, fire drill the second shift fire drill ' for "Jan-Dec" 2022 did not			or patterns and make recommendations to revise the plan of correction as indicated.  Date of compliance November 24th, 2022		
	record the day the control interview at the time of Maintenance starshifts per day and a second shift fire driver record the date the This finding was red Director, the Director	drill was conducted. Based on the of record review, the Director ted the facility operates two agreed the aforementioned tell documentation did not drill was conducted.  Eviewed with the Executive the tor of Maintenance and the sance Director during the exit					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/02/2022
	PROVIDER OR SUPPLIER 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 0761	3.1-19(b)				
SS=F Bldg. 01	Based on record rev	riew, observation and	K 0761	POC- Life Safety	11/24/2022
	inspection and testin were completed in a Communicating oper required by 19.1.1.4	ty failed to ensure annual ng of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers 1.1 shall be permitted only in		Tag K761 F Level	
	self-closing fire doc 8.3.) LSC 8.3.3.1 O protection rating by protected by approv	pe protected by approved or assemblies. (See also Section penings required to have a fire Table 8.3.4.2 shall be red, listed, labeled fire door window assemblies and their		What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice?	
	accompanying hard closing devices, and accordance with the Standard for Fire De	ware, including all frames,		No residents have been affect by the deficient practice, but the facility annual inspection documentation of fire door	
	Code. NFPA 80 5.2 shall be inspected a annually, and a writ shall be signed and	.1 states fire door assemblies nd tested not less than ten record of the inspection kept for inspection by the .3.1 states functional testing of		assembly in the facility now includes all the doors in the fa which were missed in the reportance Like kitchen rolling fire door, oxygen containing room	-
	fire door and windo performed by indivi understanding of the the type of door bei	w assemblies shall be iduals with knowledge and e operating components of ng subject to testing. NFPA e door assemblies shall be		How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.	e De
	visually inspected fi overall condition of NFPA 80, Section 5	rom both sides to assess the door assembly.  5.2.4.2 states as a minimum, the		No residents have been affect by the deficient practice, but a of the document is made to	
	either the door or fr	r breaks exist in surfaces of		ensure that all the required factors are inspected and documented.	cility

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		ULTIPLE CONSTRUCTION (X3) DATE SURVEY (ILDING 01 COMPLETED			SURVEY LETED
	PROVIDER OR SUPPLIE		•	45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	are intact and secure equipped.  (3) The door, frame noncombustible the and in working ord damage.  (4) No parts are mi (5) Door clearance listed in 4.8.4 and (6) The self-closing the active door confrom the full open (7) If a coordinator closes before the active door when it is in t (9) Auxiliary hardward prohibit operation a frame.  (10) No field modi have been perform (11) Gasketing and inspected to verify This deficient prac staff and visitors.  Findings include:  Based on review of Doors, Explanation documentation with Director of Mainter and inspector and inspector of Mainter and inspector and inspe	e, hinges, hardware, and reshold are secured, aligned, er with no visible signs of ssing or broken. It is do not exceed clearances 6.3.1.7. It is device is operational; that is, appletely closes when operated position. It is installed, the inactive leaf extive leaf. It is are operates and secures the he closed position. It is installed on the door or are not installed on the door or are not installed on the door or fications to the door assembly the deficition of the door assembly the door ass		TAG	What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.  Maintenance director /Designa will complete random audits of Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure the facility annual inspection documentation of fire door assembly in the facility now includes all the door.  Maintenance director /Designa will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly for months or until 100%complair is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to reviewed in or correction as indicated.	ee lailly s ek a a that ee k in be ality or 6 nce ill and vise ated	DATE
	9:20 a.m. to 1:45 p	tor during record review from .m. on 11/01/22, annual ntation of fire door assemblies			How the corrective action(s) will be monitored to ensure to deficient practice will not		

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in the facility within the most recent twelve month period did not include all fire doors in the facility.

Doors to oxygen storage rooms were not included

in the listing of "Fire Door Location" in "Fire"

documentation. In addition, the fire door

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recur, i.e., what quality

into place; and

assurance program will be put

Maintenance director /Designee

will complete random audits daily

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	r í	UILDING	onstruction 01	(X3) DATE COMPL 11/02/	ETED
	PROVIDER OR SUPPLIEF			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, 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
	explanation and insitems in NFPA 80, inspection documer fire door was also non interview at the Director of Mainter doors in the facility items stated in the edocumentation. Batexecutive Director, and the Corporate Mour of the facility for 11/02/22, the facility transfilling room in entrance to the main oxygen containers a cylinders were store to the room had a label affixed to the addition, the rolling 3-hour fire resistant door. A contractor inspection sticker to date of the most recent based on interview and of the observation Maintenance agreed fire door locations in the inspection documentation inclination. This finding was reduced the Director, the Director of the process of the inspection, the Director of the process of the	tructions did not include all Section 5.2.4.2. Annual natation for the kitchen rolling not available for review. Based time of record review, the nance stated he checks fire on a monthly basis for the explanation and instruction used on observations with the nather Director of Maintenance Maintenance Director during a from 9:15 a.m. to 11:50 a.m. on ty has one oxygen storage and side the facility near the n dining room. Five liquid and fifteen 'E' type oxygen ed in the room. The entry door hour fire resistance rating hinge side of the door. In g fire door in the kitchen had a tee rating label affixed to the had affixed an annual to the door assembly but the teent inspection was not legible. at the time of record review tions, the Director of d it could not be ensured all in the facility were included in mentation and the inspection uded all items in NFPA 80.  viewed with the Executive tor of Maintenance and the ance Director during the exit			Monday through Sunday four times a week on random shift including weekends for four weeks, then three times a week for two weeks, then two times week for the two weeks, once week for one weeks to ensure the facility annual inspection documentation of fire door assembly in the facility now includes all the doors.  Maintenance director /Design will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Quales Assurance meeting monthly formonths or until 100% complair is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to rethe plan of correction as indictional designation.  Date of compliance November 24th, 2022	ek a a that ee k in be eliity or 6 nce iill and	
K 0918 SS=F	NFPA 101 Electrical Systems	s - Essential Electric Syste					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155077	A. BUILDING B. WING	01	COMPLETED  11/02/2022
	ROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	
LINVIVL	OI INDIANAI OLIS		INDIAN		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENC!)	DATE
Bldg. 01	-	s - Essential Electric			
	System Maintenar	•			
	-	other alternate power			
		ated equipment is capable se within 10 seconds. If the			
		n is not met during the			
		ocess shall be provided to			
		nis capability for the life			
	•	branches. Maintenance			
_		generator and transfer			
		rmed in accordance with			
	NFPA 110.				
	Generator sets are	e inspected weekly,			
	exercised under lo	ad 30 minutes 12 times a			
year in 20-40 day intervals, and exercised		intervals, and exercised			
	once every 36 months for 4 continuous hours.				
	Scheduled test un	der load conditions include			
	a complete simula	ted cold start and			
	automatic or manu	ıal transfer of all EES			
		iducted by competent			
	·	nance and testing of stored			
		rces (Type 3 EES) are in			
		IFPA 111. Main and feeder			
		e inspected annually, and a			
		lically exercising the			
	•	ablished according to			
	=	irements. Written records			
		nd testing are maintained ole. EES electrical panels			
	_	arked, readily identifiable,			
		normal power circuits.			
	•	ssibility of damage of the			
	emergency power				
	consideration for r	•			
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,			
	NFPA 111, 700.10	•			
	1. Based on record r	review and interview, the	K 0918	POC- Life Safety	11/24/2022
	facility failed to ens	ure an annual fuel quality test			
	_	he facility's diesel-powered		Tag K918	
	generator. NFPA 99	9, Health Care Facilities Code,		F Level	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB	NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155077	B. WING		11/02/2	2022
NAME OF	PROVIDER OR SUPPLIEI		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIED		45 BEA	ACHWAY DR		
ENVIVE	OF INDIANAPOLIS	S	INDIAN	IAPOLIS, 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 APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	2012 Edition, Secti	on 6.5.4.1.1.2 states Type 2 EES				
	(Essential Electrica	l System) generator sets shall				
	be inspected and te	sted in accordance with		What corrective action(s) will	ı	
	Section 6.4.4.1.1.3.	Section 6.4.4.1.1.3 states		be accomplished for those		
	maintenance shall b	pe performed in accordance		residents found to have been	ı	
		andard for Emergency and		affected by the deficient		
		stems, 2010 Edition, Chapter 8.		practice?		
	1 .	8.3.8 states a fuel quality test		Processor		
		at least annually using tests		No residents have been affecte	ed	
	_	I standards. This deficient		by the deficient practice, but the		
	practice could affect all residents, staff and visitors.			facility has started annual fuel	.	
				quality test for diesel fired		
	visitors.			emergency generator and four	.	
	Findings include:			continuous hour supplemental		
	Findings include.			1		
	Dogod on mooned may	view with the Executive		load testing has been started.		
				How other residents having t		
	· ·	tor of Maintenance and the		potential to be affected by the		
	_	ance Director from 9:20 a.m. to		same deficient practice will b		
	_	/22, documentation of an annual		identified and what corrective	e	
		the diesel fired emergency		action(s) will be taken.		
	_	vailable for review. Based on				
		e of record review, the Director		No residents have been affect	ed	
		ted the facility has one diesel		by the deficient practice, but		
	fired emergency ge	_		facility had inspected the		
	documentation of a	n annual fuel quality test for		generator and started the work	king	
	the diesel fired eme	ergency generator was not		on missing documentation.		
	available for review	v.				
				What measures will be put in	to	
	This finding was re	viewed with the Executive		place and what systemic		
	Director, the Direct	tor of Maintenance and the		changes will be made to		
	Corporate Maintena	ance Director during the exit		ensure that the deficient		
	conference.			practice does not recur.		
				Maintenance director /Designe	ee l	
	3.1-19(b)			will complete random audits da		
				Monday through Sunday four	, l	
	2. Based on record	review, observation and		times a week on random shifts	,	
		ity failed to document 36 month		including weekends for four		
		generator testing for 1 of 1		_	,	
	Period emergency §	generator testing for 1 of 1		weeks, then three times a wee	r.	

emergency generators in accordance with NFPA

99 and NFPA 110. NFPA 99, Health Care Facilities

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for two weeks, then two times a

week for the two weeks, once a

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	TE SURVEY PLETED 02/2022	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155077	B. W	ING		11/02/	2022	
				CTDEET A	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD			
END //\/E	OF INDIANABOLIO				CHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE 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)	тс	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Code, 2012 Edition	, Section 6.4.1.1.6.1 states Type			week for one weeks to ensure	the		
		ial electrical system power			diesel fired emergency genera			
		ll be classified as Type 10,			documents are maintained pe			
		nerator sets per NFPA 110.			regulation. Maintenance direc			
	_	ndard for Emergency and			/Designee will bring the audit			
		stems, 2010 Edition, Section			sheets back in morning meetir	าต		
		EPSS shall be tested at least			every day to be reviewed. The	-		
		6 months. Section 8.4.9.1			results of these audits will be			
		S shall be tested continuously			reviewed in Quality Assurance	2		
		ts assigned class (See Section			meeting monthly for 6 months			
		2 states where the assigned			until 100%complaince is achie			
	class is greater than 4 hours, it shall be permitted				for 3 consecutive months. The			
	to terminate the test after 4 continuous hours.				committee will identify any trei			
	Section 8.4.9.5 states the minimum load for this				or patterns and make	ius		
	test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or				recommendations to revise the	0		
	-	3.4.9.5.3 states for spark-ignited			plan of correction as indicated			
		be the available EPSS load.			pian of correction as indicated			
	_	ice could affect all residents,			How the corrective action(s)			
	staff and visitors.	ice could affect all festdents,			How the corrective action(s) will be monitored to ensure t			
	starr and visitors.					.rre		
	Findings include:				deficient practice will not			
	Findings include.				recur, i.e., what quality			
	Rosed on record rev	view with the Executive			assurance program will be p	uı		
		or of Maintenance and the			into place; and			
	· ·	ance Director from 9:20 a.m. to			Maintenance director /Designe			
	-	22, thirty-six month period			will complete random audits d	ally		
	-	-			Monday through Sunday four			
		or testing documentation for			times a week on random shifts	5		
		ars for the diesel fired			including weekends for four	a la		
		or was not available for review.			weeks, then three times a wee			
		at the time of record review,			for two weeks, then two times			
		ntenance stated the facility has			week for the two weeks, once			
		ergency generator and agreed			week for one weeks to ensure	that		
		applemental load testing for			the diesel fired emergency			
		ne most recent three year			generator documents are			
	_	lable for review. Based on			maintained per			
		ne Executive Director, the			regulation.Maintenance direct	or		
		ance and the Corporate			/Designee will bring the audit			
		or during a tour of the facility			sheets back in morning meetir	-		
		1:50 a.m. on 11/02/22, the facility			every day to be reviewed. The	;		
	has one diesel fired	emergency generator located			results of these audits will be			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155077	B. W	NG		11/02/	2022	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				CHWAY DR			
ENVIVE	OF INDIANAPOLIS				NDIANAPOLIS, IN 46224			
(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	
	outside the building				reviewed in Quality Assurance			
		Manufacturer's nameplate			meeting monthly for 6 months			
		ntor stated it was rated at 600			until 100%complaince is achie			
	kW.				for 3 consecutive months. The			
	TT1 ' C' 1'	· 1 M A P A			committee will identify any tren	nds		
	_	viewed with the Executive			or patterns and make			
		or of Maintenance and the			recommendations to revise the			
	conference.	nce Director during the exit			plan of correction as indicated			
	conterence.				Date of compliance			
	3.1-19(b)				November 24th, 2022			
	3.1-17(0)							
K 0920	NFPA 101							
SS=E	1							
Bldg. 01	Extens							
, i		ent - Power Cords and						
	Extension Cords							
	Power strips in a p	patient care vicinity are only						
	used for compone	nts of movable						
	patient-care-relate	d electrical equipment						
	(PCREE) assembl	es that have been						
	assembled by qua	lified personnel and meet						
	the conditions of 1	0.2.3.6. Power strips in						
	the patient care vid	cinity may not be used for						
	non-PCREE (e.g.,	personal electronics),						
		n care resident rooms that						
		E. Power strips for PCREE						
		UL 60601-1. Power strips						
		the patient care rooms						
		) meet UL 1363. In						
	•	ooms, power strips meet						
		s. All power strips are						
	-	precautions. Extension						
		d as a substitute for fixed						
	-	re. Extension cords used						
	•	moved immediately upon						
		purpose for which it was						
		ts the conditions of 10.2.4.						
	•	9), 10.2.4 (NFPA 99), 400-8						
l	(NFPA 70), 590.3(	(D) (NFPA 70), TIA 12-5	1					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING <u>01</u> COMP		(X3) DATE S COMPL 11/02/	ETED		
	ROVIDER OR SUPPLIER DF 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)	TE	(X5) COMPLETION DATE
TAG	Based on observation failed to ensure 1 of used as a substitute requires utilities to 6 9.1.2 requires electromply with NFPA 2011 Edition. NFP unless specifically proceed to be used to be	on and interview, the facility I extension cords were not for fixed wiring. LSC 19.5.1 comply with Section 9.1. LSC ical wiring and equipment to 70, National Electrical Code, A 70, Article 400.8 requires that, bermitted, flexible cords and used as a substitute for fixed be. LSC Section 4.5.7 states any supprent or safeguard provided be designed, installed and ance with all applicable NFPA ficient practice could affect saff and visitors in the vicinity be's station pantry.  ons with the Executive or of Maintenance and the since Director during a tour of 5 a.m. to 11:50 a.m. on 11/02/22, lugged into an extension cord B Wing nurse's station. Based time of the observations, the sance agreed an extension cord substitute for fixed wiring at	K 09		POC- Life Safety  Tag K920 E Level  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents have been affect by the deficient practice, but the facility has removed the extendance of in the pantry in B wing ar replaced it with fix wiring.  How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.  No residents have been affect by the deficient practice, but facility had audited all the area ensure there is no extension of in any other areas of the facility.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.  Maintenance director /Designowill complete random audits of Monday through Sunday four	nted the sion and the ee ted the sords try.	11/24/2022
					times a week on random shifts	S	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  ENVIVE OF INDIANAPOLIS  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FU  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  OF THE PROVIDER OF THE PROVIDER OF THE PROPERTY O	AID SERVICES			OMB	8 NO. 0938-039
			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SI COMPLE 11/02/2	ETED
			45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	.TE	(X5) COMPLETION DATE
				including weekends for four weeks, then three times a week for two weeks, then two times week for the two weeks, once week for one weeks to ensure there is no extension cords in building per regulations.  Maintenance director /Designed will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly for months or until 100% complaint is achieved for 3 consecutive months. The QA committee wite identify any trends or patterns make recommendations to reviewe the plan of correction as indicated.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; and Maintenance director /Designed will complete random audits day Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times week for one weeks to ensure that there are no extension continued in the building per regulations.	a a that the ee k in be eliity or 6 ill and vise ated the eaily sek a a a that ords	

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Maintenance director /Designee will bring the audit sheets back in morning meeting every day to be

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	onstruction  01	(X3) DATE COMPI 11/02			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO ACHWAY DR	OD			
ENVIVE	OF INDIANAPOLIS		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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE		
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - 0 Storag Gas Equipment - 0 Storage Greater than or eo Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 o Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamms from combustibles sprinklered) or encontrocombustibles sprinklered) or encontrocombustible of minimum 1/2 hr. fi Less than or equa In a single smoke cylinders available patient care areas of less than or equa	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.	TAG	reviewed. The results of audits will be reviewed. Assurance meeting more months or until 100% of is achieved for 3 consermonths. The QA commidentify any trends or promake recommendation the plan of correction at Date of compliance. November 24th, 2022	of these in Quality onthly for 6 complaince ocutive nittee will atterns and s to revise s indicated	DATE		
		handled with precautions						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155077	B. WI	NG		11/02	/2022	
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR			
ENI\/I\/E	OF INDIANAPOLIS				APOLIS, IN 46224			
			_	INDIAN				
(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	
	as specified in 11.							
		ign readable from 5 feet is						
		ate of a cylinder storage						
		sign includes the wording as						
	a minimum "CAUTION: OXIDIZING GAS(ES							
	STORED WITHIN							
		d so cylinders are used in						
	order of which they are received from the supplier. Empty cylinders are segregated							
	I	. When facility employs						
	1	gral pressure gauge, a						
		e considered empty is						
	established. Empty cylinders are marked to							
	avoid confusion. Cylinders stored in the open							
	are protected from weather.							
		.3.3, 11.3.4, 11.6.5 (NFPA						
	99)	1					1.1/2.1/2.00	
		on and interview, the facility	K 0	923	POC- Life Safety		11/24/2022	
		f 15 cylinders of nonflammable			T 1000			
		en were properly secured from			Tag K923			
		/gen storage areas. NFPA 99,			E Level			
		ies Code, 2012 Edition, Section e for nonflammable gases						
		than 85 cubic meters (3000			NA/In at a compaction a cation (a) will			
		mply with 5.1.3.3.2 and 5.1.3.3.3.			What corrective action(s) will	ı		
		5.1.3.3.2(7) requires cylinders be			be accomplished for those residents found to have been	_	ne	
	· ·	s, chains, or other fastenings to				1		
		from falling, whether			affected by the deficient			
	1	ected, full or empty. This			practice?			
		ould affect over 20 residents,			No residents have been affect	-bd		
	_	the vicinity of the oxygen			by the deficient practice, but the			
		ling room near the main dining			facility has secured one of tha			
	room.	g non main anning			nonflammable gases oxygen			
	150111				storage cylinders properly			
	Findings include:				atalaga dymiadia proporty			
	- mamas morado.				How other residents having t	the		
	Based on observation	ons with the Executive			potential to be affected by th			
		for of Maintenance and the			same deficient practice will k			
	· ·	ance Director during a tour of			identified and what correctiv			
	-	15 a.m. to 11:50 a.m. on 11/02/22,			action(s) will be taken.	-		

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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	construction 01	(X3) DATE SURVEY COMPLETED 11/02/2022		
		ROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BE	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	TAG	one of fifteen 'E' type freestanding on the the oxygen storage main dining room a from falling. Five I fifteen 'E' type oxyge room. Based on into observations, the Coagreed the oxygen of a cylinder stand or of in the oxygen storage placed it in a cylinder this finding was reduced to the original or of the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed the oxygen storage placed it in a cylinder this finding was reduced to the oxygen storage placed the oxygen storag	the control of the corridor door to and transfilling room near the nd was not properly secured iquid oxygen containers and gen cylinders were stored in the erview at the time of the corporate Maintenance Director cylinder was not supported in otherwise secured from falling ge and transfilling room and er storage rack in the room.  Wiewed with the Executive or of Maintenance and the time Director during the exit	TAG		ted he as to en n the  nto  ee laily s ek a a e that ee k in b be e lility or 6 nce rill s and vise ated
					recur, i.e., what quality	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022			
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
					assurance program will be pinto place; and Maintenance director /Designation will complete random audits of Monday through Sunday four times a week on random shift including weekends for four weeks, then three times a weefor two weeks, then two times week for the two weeks, once week for one weeks to ensure that there are no unsecured oxygen cylinders in the buildir Maintenance director /Designation will bring the audit sheets back morning meeting every day to reviewed. The results of these audits will be reviewed in Qual Assurance meeting monthly formonths or until 100% complain is achieved for 3 consecutive months. The QA committee widentify any trends or patterns make recommendations to rethe plan of correction as indictional patterns and the plan of correction as indictional patterns are plant and the plant and t	ee laily s ek a a e that ng. ee k in be elility or 6 nce fill and			

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