PRINTED: 02/21/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPI	LETED
		155077	B. WI	NG		01/30	/2024
			-	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	.R	45 BEACHWAY DR				
ENVIVE	OF INDIANAPOLIS	3		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Distan							
Bldg	A E		F 00	200	D	L.:.	
		eparedness Survey was	E 00)00	Preparation or execution of t	nis	
	accordance with 42	ndiana Department of Health in			plan of correction does not		
	accordance with 42	2 CFR 483./3.			constitute admission or agree		
	G D 01/2/	0/24			of provider of the truth of the		
	Survey Date: 01/30	0/24			alleged or conclusions set fo		
	E- :: 114- Novelous	000022			the Statement of Deficiencies		
	Facility Number: Provider Number:				Plan of Correction is prepare		
					executed solely because it is required by the position of Fe		
	AIM Number: 100273330				and State Law. The Plan of	euerai	
	At this Emergency	Preparedness survey, Envive			Correction is submitted to res	cnond	
		s found not in compliance with			to the allegation of noncomp	-	
	_	edness Requirements for			cited during the Annual Surv		
		licaid Participating Providers			conducted January 30, 2024	-	
	and Suppliers, 42 (Please accept this Plan of	•	
	and supplies, 12	0111 1001/01			Correction as the provider's		
	The facility has 18	4 certified beds. At the time of			credible allegation of complia	ance	
	the survey, the cen				as of February 29, 2024. The		
]				provider respectfully request		
	Quality Review co	ompleted on 02/05/24			review with paper complianc		
		•			be considered in establishing		
	The requirement at	t 42 CFR Subpart 483.73 is NOT			the provider is in substantial	,	
	MET as evidenced	by:			compliance.		
E 0041	482.15(e), 483.73	2(a) 495 625(a)					
SS=F	` '	d LTC Emergency Power					
Bldg		ition for Participation:					
Diag	- , ,	nd standby power systems.					
		it implement emergency and					
		stimplement emergency and stems based on the					
		set forth in paragraph (a) of					
		n the policies and					
		set forth in paragraphs (b)(1)					
	(i) and (ii) of this						
		0000011.					
	§483.73(e), §485	625(e)					

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

(e) Emergency and standby power systems.

(X6) DATE

TITLE

Gregory Otter Executive Director 02/17/2024

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		JILDING	NSTRUCTION	(X3) DATE COMPI 01/30	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 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency generator must be the location required Care Facilities Colliterim Amendment 12-4, TIA 12-5, are Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or buildi 482.15(e)(2), §48 Emergency generator the eminspection, testing requirements four Facilities Code, NCode. 482.15(e)(3), §48 Emergency generation and LTC facilities source to power end have a plan for hor systems and the control of the control	and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The elocated in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim in 12-1, TIA 12-2, TIA 12-3, ind NFPA 110, when a new or when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must inergency power system ig, and [maintenance] ind in the Health Care in IFPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs ig that maintain an onsite fuel emergency generators must ow it will keep emergency overational during the				IATE			
	§483.73(g), and 0 The standards ind this section are a	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in pproved for incorporation by Director of the Office of the							

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Event ID:

4CYK21 Facility ID: 000032

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTI A. BUILDI B. WING		NSTRUCTION	(X3) DATE : COMPL 01/30/	ETED		
	DF PROVIDER OR SUPPLIED E OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	Federal Register 552(a) and 1 CFF the material from You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at Nogo to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characterymarch Par Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (viii) NFPA 101, Liedition, issued Au (viii) TIA 12-1 to NI 11, 2011. (ix) TIA 12-2 to NI 30, 2012.	in accordance with 5 U.S.C. R part 51. You may obtain the sources listed below. In copy at the CMS purce Center, 7500 Security pore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to langes. Protection Association, 1 kk, 9, www.nfpa.org, Ith Care Facilities Code, ed August 11, 2011. Irim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 1, FPA 99, issued March 7, FPA 99, issued March 3, Ife Safety Code, 2012							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	, _{TE} C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\i=	DATE
	22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to c 2009 Based on record rev interview; the facili emergency power sy maintenance require Care Facilities Code Code in accordance	tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view, observation and ty failed to implement the ystem inspection, testing and ements found in the Health e, NFPA 110, and Life Safety with 42 CFR 483.73(e)(2). ice could affect all residents,	E 00)41	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? a. Weekly and monthly general inspections have been added	n ator	02/29/2024
	staff and visitors. Findings include:	ice could affect all residents,			the Tels workorder system for time reminders and document requirements	ron	
	Weekly Load Test" Executive Director, the Corporate Main review from 9:10 a. weekly emergency documentation for J 2023 was not availa interview at the tim Corporate Maintena has one diesel fired agreed weekly emergency.	of "Emergency Generator documentation with the the Maintenance Director and tenance Director during record m. to 12:45 p.m. on 01/30/24, generator inspection fanuary, February and March able for review. Based on the of record review, the same Director stated the facility temergency generator and regency generator inspection fanuary, February and March able for review.			b. The Director of Maintenance called Evapar and had them preform the Load bank. c. Evapar has preformed a fue sample. d. Evapar has changed the batteries. 2: How other residents have the potential to be affected by the same deficient practice where identified and what corrective action will be take. This deficient practice could a all residents, staff, and visitors 3: What measures will be purinto place or what systemic	ng oy will en. uffect s.	
	Weekly Load Test" Executive Director, the Corporate Main review from 9:10 a. load testing docume and March 2023 wa	of "Emergency Generator documentation with the the Maintenance Director and tenance Director during record m. to 12:45 p.m. on 01/30/24, entation for January, February is not available for review. In g documentation for load			changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance here been educated by the Executi Director on E 041 The General is required to be inspected we and documented, Monthly loa	ive ator eekly	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDI B. WING	ING	COMPLETED 01/30/2024					
	OF PROVIDER OR SUPPLIEF E OF INDIANAPOLIS		45	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 PREI TA	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE				
IAU	tests conducted were through 01/17/24 dispercentage achiever generator during the the time of record record for Maintenance Direct diesel fired emerged documented on a woversized, and the from testing cannot achieved plate rating so they percentage for each Maintenance Direct test is performed but bank testing document twelve month periodec. based on review documentation date Director, the Maintenance Director, the most reconduction of a the facility's diesel within the most reconduction of a nannual fuel qualities of an annual fuel qualities of the facility of the demension of the facility of the demension of the facility of the demension of the facility of	ckly for the period of 04/05/23 dd not indicate the actual load of for the diesel powered et test. Based on interview at the eview, the Corporate for stated the facility has one for generator, load testing is eachly basis, the generator is facility acknowledges load for at least 30 % of the name do not record the load load test. The Corporate for stated an annual load bank at agreed supplemental load entation for the most recent dd was not available for review. The Fuel Analysis Report dd 12/19/22 with the Executive enance Director and the fine Director during record for the most recent dwas not available for review. The first emergency generator for the dwas fired emergency generator ent twelve month period was firew. Based on interview at the first, the Corporate Maintenance facility has one diesel fired or and agreed documentation fallity test for the facility's ergency generator within the month period was not at the time of the survey. The first emergency generator within the month period was not at the time of the survey. The first emergency generator for the facility with the time of the survey.		test documented, along with sampling yearly to ensure it work in an emergency. 4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plathed The Director of Maintenance perform monthly X6. This aude be placed into the Tels systes scheduled reminders and documentation. Results of these reviews will presented by the Executive Director to the QAPI committed further recommendations.	fuel vill the cur ce? will dit will m for				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/30/2024				
NAME OF I	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP COD EACHWAY DR	•			
ENVIVE	OF INDIANAPOLIS		INDIANAPOLIS, IN 46224					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE COMPLETION			
TAG	emergency generated replaced. The "Conthe 11/21/23 report test and need replaced interview at time of Maintenance Direct Maintenance Direct Generator is tested to batteries are scheduled but agreed emergent replacement document was not available for Based on observation Director and the Conduring a tour of the p.m. on 01/30/24, the emergency generated on the northeast side manufacturer's name indicated it was rate affixed to each of the indicated they were 2018. These findings were Director, the Maintenance Director tests and the "Control of the post	or batteries need to be mments/Remarks" section of stated, "batteries failed load red (dated 2018)". Based on the observations, the for and the Corporate for stated the emergency weekly and will operate, the filed to be replaced on 02/05/23 for generator battery entation on or after 11/21/23 for review. Ons with the Maintenance Director facility from 1:10 p.m. to 3:50 fine facility has one diesel fired for located outside the building fine of the property. The file plate affixed to the generator red at 600 kW. Documentation fine two starting batteries manufactured in October The reviewed with the Executive finance Director and the fine Director during the exit	TAG		DATE			
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000	Preparation or execution of plan of correction does not constitute admission or agr of provider of the truth of the alleged or conclusions set the Statement of Deficienci Plan of Correction is preparation.	eement e facts forth on es. The			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155077	B. W	ING		01/30	/2024
		l		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	2			CHWAY DR		
FNVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
	- 114D1/114A1 OLIO			INDIAN	7.1 OLIO, III 70227		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Facility Number: 0				executed solely because it is		
	Provider Number:				required by the position of Fed	deral	
	AIM Number: 100	273330			and State Law. The Plan of		
					Correction is submitted to resp		
	-	Code survey, Envive of			to the allegation of noncomplia		
	Indianapolis was found not in compliance with				cited during the Annual Surve	у	
	Requirements for P	-			conducted January 30, 2024.		
		, 42 CFR Subpart 483.90(a),			Please accept this Plan of		
	-	re and the 2012 Edition of the			Correction as the provider's		
		ction Association (NFPA) 101,			credible allegation of compliar	ice	
		LSC), Chapter 19, Existing			as of February 29, 2024. The		
	Health Care Occupa	ancies and 410 IAC 16.2.			provider respectfully requests		
					review with paper compliance		
	-	ity was determined to be of			be considered in establishing	that	
		truction and was fully			the provider is in substantial		
	_	cility has a fire alarm system			compliance.		
		on in the corridors, in all areas					
	_	and in rooms 11 through 19 in					
	_	ncility has battery operated					
		all other resident sleeping					
	-	has a capacity of 184 and had					
	a census of 96 at the	e time of this survey.					
	A 11 1 1						
		idents have customary access					
	_	The facility has four detached					
		storage services and one tousing an emergency					
	T						
	generator which we	ere each not sprinklered.					
	Quality Paviany con	mpleted on 02/05/24					
	Quality Keview Con	iipieted 011 02/03/24					
K 0100	NFPA 101						
SS=E	General Requirem	nents - Other					
Bldg. 01	General Requirem						
J. J.	•						
	List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements						
		ssed by the provided					
		ficient. This information,					
	-	olicable Life Safety Code or					
		tation, should be included					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on Form CMS-2567. Based on observation and interview, the facility K 0100 1: What corrective action(s) will 02/29/2024 failed to ensure fire resistance rating labels on 1 of be accomplished for those 12 cross corridor door sets were not painted. In residents found to have been addition, the facility failed to ensure 2 of 12 cross affected by the deficient corridor door sets would self close and latch into practice? the door frame per 4.6.12.3. LSC 4.6.12.3 requires The Director of Maintenance existing life safety features obvious to the public repaired has repaired the doors to if not required by the Code, shall be either latch when closed. maintained or removed. This deficient practice 2: How other residents having could affect over 20 residents, staff and visitors. the potential to be affected by the same deficient practice will Findings include: be identified and what corrective action will be taken. Based on observations with the Maintenance This deficient practice could affect Director and the Corporate Maintenance Director over 20 residents, staff, and during a tour of the facility from 1:10 p.m. to 3:50 visitors. p.m. on 01/30/24, the south door in the cross 3: What measures will be put corridor door set in the A Wing by Room 10 was into place or what systemic not equipped with a fire resistance rating label. changes will be made to The north door in the cross corridor door set was ensure that the deficient equipped with a 3-hour fire resistance rating label. practice does not recur? Each door in the cross corridor door set in the B The Director of Maintenance has Wing was equipped with a 3-hour fire resistance been educated by the Executive rating label and latching hardware to latch each Director on K100. All smoke and door into the door frame but the door set failed to fire doors shall shut and latch on latch into the door frame when tested to close their own power to prevent smoke multiple times. In addition, the north door in the and fire from spreading. cross corridor door set in the D Wing by Room D8 4: How the corrective action was equipped with a 3-hour fire resistance rating will be monitored to ensure the label and latching hardware to latch the door into deficient practice will not recur the door frame but the door failed to latch into the i.e., what quality assurance door frame when tested to close multiple times. program will be put into place? Based on interview at the time of the The Director of Maintenance will observations, the Maintenance Director and the perform monthly review X6. This Corporate Maintenance Director agreed the doors audit will be placed into the Tels in the aforementioned cross corridor door sets system for scheduled reminders would not fully self close and latch into the door and documentation. frame when tested to close or were not equipped Results of these reviews will be with a fire resistance rating label. presented by the Executive

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE COMPL 01/30,	LETED
	PROVIDER OR SUPPLIEI		45 B	ET ADDRESS, CITY, STATE, ZIP (EACHWAY DR ANAPOLIS, IN 46224	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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Means of Egress - General		TAG	Director to the QAPI of	Director to the QAPI committee for further recommendations.	
			K 0211	1: What corrective ac be accomplished for residents found to ha affected by the defici practice? 1. The Director of Mai has removed all furnit obstructions to allow e	those ave been ient ntenance ure/	02/29/2024
				 2. All key knobs were from resident rooms 2: How other resider the potential to be aff the same deficient probe identified and what corrective action will This deficient practice over 40 residents, starvisitors. 3: What measures wi 	2. All key knobs were removed from resident rooms 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. This deficient practice could affect over 40 residents, staff and visitors. 3: What measures will be put into place or what systemic	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WI	NG		01/30/	
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS	i		INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWIDER'S BY AN OF 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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	the A Wing corrido	r near Room A1. In addition,	İ		ensure that the deficient		
	_	l in the east exit vestibule of			practice does not recur?		
	the C Wing which interfered with exit access.				The Director of Maintenance h	nas	
	Based on interview at the time of the				been educated by the Executiv		
	observations, the Maintenance Director agreed				Director on K211 maintaining		
	the aforementioned means of egress were not				clear path of egress for emerg		
	continually maintained free of all obstructions or				evacuation purposes.	or log	
	impediments to full instant use in the case of fire				4: How the corrective action		
	or other emergency				will be monitored to ensure t	ho	
	or other emergency	•			deficient practice will not rec		
	These findings were	e reviewed with the Executive			i.e., what quality assurance	ui	
	_	enance Director and the			program will be put into plac	• • • •	
	· ·				The Director of Maintenance v		
	Corporate Maintenance Director during the exit					VIII	
	conference.				perform monthly review X6.	_	
	2.1.10(%)				Results of these reviews will b	e	
	3.1-19(b)				presented by the Executive	- f	
	2 D 1 1	4. 1.4 . 4 6 714			Director to the QAPI committe	e for	
		ation and interview, the facility			further recommendations.		
		ridor doors to 2 of over 60					
		ooms were not provided with a					
		nich required a key to unlock					
		This deficient practice could					
	affect four residents	s and staff.					
	F' 1' ' 1 1						
	Findings include:						
	Dagad on abasement	ons with the Maintenance					
		orporate Maintenance Director facility from 1:10 p.m. to 3:50					
	~						
		he corridor door to resident					
		and D15 was equipped with a					
		ndle which required a key to					
		rridor side of the door. The					
		st mechanism to unlock the					
		de of the door. The exit from					
		be through a shared restroom					
	with the adjoining resident sleeping room. Based						
		time of the observations, the					
	Corporate Maintena	ance Director stated the rooms					
	were recently renov	vated, the rooms were probably					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155077		ľ í	UILDING	nstruction 01	-	ESURVEY LETED 0/2024			
	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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
IAU	used for renovation probably has the ke contractor forgot to agreed the aforeme not continually mai	supplies and the contractor y to unlock the door, the change out the lock and ntioned means of egress were ntained free of all obstructions full instant use in the case of		IAU			DATE		
	Director, the Maint	e reviewed with the Executive enance Director and the ance Director during the exit							
	3.1-19(b)								
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special lockinical security needs	S OR SECURITY THREAT king arrangements for the eds of the patient are							
	permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks								

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ì í	JILDING	01	COMPL 01/30/	ETED
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		curity Locking requirements					
	are being met. In a	addition, the locks must be					
	electrical locks tha	at fail safely so as to					
	-	of power to the device; the					
		ed by a supervised					
		r system and the locked					
		by a complete smoke					
		or is constantly monitored ation within the locked					
		he sprinkler and detection					
		ged to unlock the doors					
	upon activation.	904 10 41110011 4110 40010					
	18.2.2.2.5.2, 19.2.	2.2.5.2, TIA 12-4					
	DELAYED-EGRES						
	ARRANGEMENTS	8					
	Approved, listed d	elayed-egress locking					
	systems installed i	in accordance with					
	7.2.1.6.1 shall be _l						
		g low and ordinary hazard					
		gs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle	-					
	18.2.2.2.4, 19.2.2. ACCESS-CONTR						
	LOCKING ARRAN						
		Egress Door assemblies					
		ance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2.	2.4					
	ELEVATOR LOBE	BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
		.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		sed automatic sprinkler					
	system. 18.2.2.2.4, 19.2.2.	2.4					
	10.2.2.2.4, 13.2.2.	4. 7					

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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	COMPLE	ETED
		155077	B. W.	ING		01/30/2	2024
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	3		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on and interview, the facility	K 0	222	1: What corrective action(s)	will	02/29/2024
		means of egress through 2 of			be accomplished for those		
		ly accessible for residents			residents found to have bee	n	
	without a clinical diagnosis requiring specialized				affected by the deficient		
	security measures. Doors within a required means				practice?		
	1 -	be equipped with a latch or			The Maintenance Director has	s	
	•	ne use of a tool or key from the			placed the code next to each		
		otherwise permitted by LSC			keypad		
		ection 7.2.1.5.3 states locks, if			2: How other residents havi	•	
	*	require the use of a key, a tool,			the potential to be affected b	-	
		ge or effort for operation from			the same deficient practice v	will	
	_	oor-locking arrangements shall			be identified and what		
	_	ordance with 19.2.2.2.5.2. This			corrective action will be take		
	_	ould affect over 20 residents,			This deficient practice could a		
	staff and visitors.				over 20 resident, staff and vis		
					3: What measures will be pu	it	
	Findings include:				into place or what systemic		
					changes will be made to		
		ons with the Maintenance			ensure that the deficient		
		orporate Maintenance Director			practice does not recur?		
	_	facility from 1:10 p.m. to 3:50			The Director of Maintenance I		
	1 ~	he corridor door set in the C			been educated by the Execut		
	1	was equipped with magnetic			Director on K222 maintaining	the	
	_	keep the doors closed when			posting of the code at each		
		the fully closed position. The			keypad required to allow egre	ess in	
		eleased to open by entering a			the event of an emergency		
		by Room C2 but the code was			4: How the corrective action		
		eypad. The corridor door set at			will be monitored to ensure		
		D Wing from the center lobby			deficient practice will not re-	cur	
		with magnetic locking devices			i.e., what quality assurance		
		was in the fully closed position.			program will be put into place		
		be released to open by			The Director of Maintenance	will	
		he keypad but the code was			perform monthly review X6.		
	_	on interview at the time of the			Results of these reviews will be	oe	
		orporate Maintenance Director			presented by the Executive		
	_	houses residents with the			Director to the QAPI committe	ee for	
	_	be in a secure but agreed the			further recommendations.		
	code to release the	door set to open by the					
	entrance to the D W	Ving and at the C Wing exit by					
	Room C2.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIER 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0293 SS=E Bldg. 01	Director, the Mainter Corporate Maintena conference. 3.1-19(b) NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directiona accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of e1. Based on observation facility in accordance 7.10.1.2.1 states exit doors that obviously as exits, shall be mais readily visible from LSC 7.10.1.2.2 state egress path within a marked by approved where the continuat obvious. This defice 20 residents, staff at Findings include: Based on observation Director and the Conduring a tour of the	less than 30 occupants exit travel is obvious.) ation and interview; the facility signage in 1 of 5 wings in the ce with LSC 7.10. LSC ats, other than main exterior exit by and clearly are identifiable arked by an approved sign that om any direction of exit access. The exit of the center of the	K 0293	1: What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? 1. The Director of Maintenance replaced the missing exit signate. 2. Not an exit signage placed of proper door. 2: How other residents having the potential to be affected by the same deficient practice we be identified and what corrective action will be taken This deficient practice could affected by the same deficient practice which is deficient practice could affected by the same deficient practice could affected by the same deficient practice could affected by the deficient practice could affected by the deficient practice could affected by the deficient practice could affect be deficient practice could affect by the same deficient practice by the same deficient practice by the same deficient practice.	ge. gg / ill

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		155077	B. WING 01/30/2024			2024	
				CED FEET	DDDEGG OVER OT LEE TID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
	OF INDIANIADOLIO				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI TAG DEFICIENCY)		TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	the corridor door se	et by Room D3 was not marked			ensure that the deficient		
	as a facility exit wit	th an exit sign. Based on			practice does not recur?		
	interview at the tim	e of the observations, the			The Director of Maintenance h	nas	
	Corporate Maintena	ance Director stated the D			been educated by the Executi	ve	
	Wing had recently l	been renovated, the exit sign			Director on K293. The requirm	nents	
	may not have been	put back in place after the			of exit signage along with the		
	renovation and agre	eed the path of egress was not			importance of marking No exit		
	obvious with the co	rridor door set closed.			doors.		
					4: How the corrective action		
	These findings were reviewed with the Executive				will be monitored to ensure t	:he	
	Director, the Maintenance Director and the				deficient practice will not rec	ur	
	Corporate Maintenance Director during the exit				i.e., what quality assurance		
	conference.				program will be put into plac	:e?	
					The Director of Maintenance v	vill	
	3.1-19(b)				perform monthly review X6. The	nis	
					audit will be placed into the Te	els	
		ation and interview, the facility			system for scheduled reminde	rs	
		f 1 doors to the outside of the			and documentation.		
	_	ng Activities Room was not			Results of these reviews will b	e	
		ty exit. LSC 7.10.8.3.1 states			presented by the Executive		
		or stairway that is neither an			Director to the QAPI committe	e for	
	_	tit access and that is located or			further recommendations.		
	_	s likely to be mistaken for an					
		ied by a sign that reads as					
		The NO EXIT sign shall have					
		ers 2 inches high, with a stroke					
		h, and the word EXIT below					
		s such sign is an approved					
		deficient practice could affect					
	5 residents, staff an	d Visitors.					
	Findings :11						
	Findings include:						
	Rosed on absorbed	ons with the Maintenance					
		ons with the Maintenance orporate Maintenance Director					
		facility from 1:10 p.m. to 3:50					
	_	-					
		he exit door to the courtyard in ies Room was not posted with					
	_	•					
	_	NO EXIT sign. Based on					
	interview at the tim	e of the observations, the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077			UILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Maintenance Direct courtyard is not an a agreed the aforement did not have a NO I These findings were Director, the Mainte	or and the Corporate for stated the door to the exit to the public way and ntioned door to the courtyard EXIT sign posted. The reviewed with the Executive enance Director and the ance Director during the exit					
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-he (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 5.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4.					
	a. Boiler and Fuelbb. Laundries (large	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops					

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155077	B. W	ING		01/30/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	5			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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	d. Soiled Linen Rooms (exceeding 64						
	gallons)	_					
	e. Trash Collection Rooms						
	(exceeding 64 gallons)						
		orage Rooms/Spaces					
	(over 50 square fe	•					
		classified as Severe					
	Hazard - see K32	,	17.0	221	4. Miles a suma estre a estre ()		02/20/2024
		on and interview, the facility	K 0	3 21	1: What corrective action(s)	WIII	02/29/2024
	failed to ensure 4 of over 15 hazardous areas such as combustible storage rooms/spaces (over 50				be accomplished for those		
					residents found to have bee	n	
	square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall				affected by the deficient		
	-				practice?	haa	
	be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect				The Director of Maintenance		
	over 20 residents, s	-			had the dining room emptied construction/combustible	oi ali	
	over 20 residents, s	tall and visitors.			materials.		
	Findings include:				2: How other residents havi	na	
	i manigs merade.				the potential to be affected by	_	
	Based on observation	ons with the Maintenance			the same deficient practice	_	
		orporate Maintenance Director			be identified and what	•••••	
		facility from 1:10 p.m. to 3:50			corrective action will be take	en.	
		he main dining room was being			This deficient practice could a		
	_	of combustible materials and			over 20 residents, staff, and		
	_	ridor. Combustible supplies			visitors.		
	were stored on over	r 10 wooden pallets in the room			3: What measures will be pu	ıt	
		e and supplies stockpiled from			into place or what systemic		
	areas being renovat	ed in the facility. In addition,			changes will be made to		
	panels installed on	the ceiling of the B Wing			ensure that the deficient		
	combustible supply	storage room for a water leak			practice does not recur?		
	repair had become	partially detached which			The Director of Maintenance I	has	
	exposed the attic ab	pove. Resident sleeping rooms			been educated by the Execut	ive	
		en converted to combustible			Director on K321. Hazardous	6	
		ns as part of the facility			areas such as combustible		
		rridor door to each of the two			storage rooms/spaces (over 5		
	_	pped with a self closing or			square feet) must be separate	ed	
		levice. Based on interview at			from other spaces by smoke		
		ervations, the Maintenance			resistant partitions and doors.		
		orporate Maintenance Director			Doors shall be self-closing or	•	
	agreed the aforeme	ntioned hazardous areas were			automatic closing.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	resistant partitions a These findings were Director, the Mainte	other spaces with smoke and doors. e reviewed with the Executive enance Director and the ance Director during the exit		4: How the corrective action will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place. The Director of Maintenance was perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	cur e? vill
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cookin residential cookin appliances such a toasters) are used cooking in accordance 19.3.2.5.2 cooking facilities smoke compartment patients comply wind 18.3.2.5.3, 19.3.2. cooking facilities with 30 or fewer part conditions under 1 Cooking facilities patients are patients comply wind 19.3.2.5.1 through 19.3.2.5.5 Based on record rev	nt is protected in NFPA 96, Standard for old and Fire Protection of sing Operations, unless: ng equipment (i.e., small as microwaves, hot plates, of for food warming or limited ance with 18.3.2.5.2, as open to the corridor in the ents with 30 or fewer with the conditions under 1.5.3, or the in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not pridor. In 18.3.2.5.4, 19.3.2.5.1 of 9.2.3, TIA 12-2 view and interview, the facility	K 0324	1: What corrective action(s) who accomplished for those	will 02/29/2024
	failed to ensure 1 of	f 1 kitchen fire suppression ted semiannually. NFPA 96,	1 0321	be accomplished for those residents found to have been	

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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 ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		45 BEA	ACHWAY DR IAPOLIS, IN 46224	
ENVIVE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF 2011 Edition, Stand Fire Protection of C Operations, Section the fire-extinguishin hoods containing a water system that is the grease removal plenums, and the ex properly trained, qu acceptable to the au lease every six mor	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION lard for Ventilation Control and Commercial Cooking 11.2.1 states maintenance of Ing systems and listed exhaust constant or fire-activated Is listed to extinguish a fire in devices, hood exhaust chaust ducts shall be made by Italified, and certified person(s) Ithority having jurisdiction at Iths. This deficient practice Ithority is a staff and visitors in the			nas ion ng by will en. iffect sitors.
	suppression system "Kitchen Fire Supp documentation date the Executive Direct and the Corporate M record review from 01/30/24, it was gre between semiannual inspections conduct twelve month perio time of record revie and the Corporate M was greater than ses semiannual kitchen conducted within th period. These findings wer Director, the Maint	the kitchen range hood fire inspection contractor's ression Report"" dd 05/23/23 and 01/05/24 with stor, the Maintenance Director Maintenance Director during 9:10 a.m. to 12:45 p.m. on eater than seven months in all kitchen exhaust system ted within the most recent dd. Based on interview at the two, the Maintenance Director Maintenance Director agreed it twen months in between exhaust system inspections are most recent twelve month. The reviewed with the Executive enance Director and the ance Director during the exit		ensure that the deficient practice does not recur? The Director of Maintenance is been educated by the Execution Director on K324. Kitchen hosuppression systems are to be inspected semiannually to ensafety and proper operations 4: How the corrective action will be monitored to ensure deficient practice will not recise, what quality assurance program will be put into place The Director of Maintenance operform monthly review X6. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	the cur ce? will This els ers

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	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 01/30/2024	
	PROVIDER OR SUPPLIER		45 BE <i>A</i>	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarn Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on observation failed to ensure 1 of maintained in accord 9.6.1.3 requires a fir tested, and maintain 70, National Electrical National Fire Alarm 14.2.1.2.2 requires a malfunctions shall be practice could affect visitors. Findings include: Based on observation Director during the facility from 8:50 a main fire alarm condition Maintenance Office was silenced. Base the initial walk throstated dust from the renovation of the facility from 6:50 and facility from 8:50 a main fire alarm conditions of the facility from the renovation of the facility form the renovation of the facility from the renovation facility from the renovation facility from the renovation facility fro	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? 1. The Director of Maintenanch has called Elwood Fire Protect to clear the trouble from the prand ensure normal operations. 2. Elwood has inspected the missed smoke dectors in room C11 to C 19 3. Elwood has preformed a sensivity test on smoke dector rooms C11 to C 19 2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be taken This deficient practice could a all residents, staff, and visitors 3: What measures will be pur into place or what systemic changes will be made to	n ee etion anel s. ms rs in ng by will en. ffect s.	

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is scheduled to be shut down for repairs today

and so the fire alarm system was put on the test

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ensure that the deficient

practice does not recur?

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIER		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR mode and silenced be system trouble light observations with the Corporate Main of the facility from 01/30/24, the main facility was still in the silenced. Based on observations, the M Corporate Maintena alarm is operable are facility is working when we would be sufficiently in the trouble mode. These findings were directly in the trouble mode. These findings were directly in the main tension of the main tension of the mode. 3.1-19(b) 2. Based on record interview; the facility alarm systems was supposed in the systems was supposed in th	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION but he did not know why the was illuminated. Based on the Maintenance Director and tenance Director during a tour 1:10 p.m. to 3:50 p.m. on fire alarm control panel for the the trouble mode and was interview at the time of the aintenance Director and the ince Director stated the fire and would function but the with the fire alarm system by to determine why the panel	STREET 45 BE.	ACHWAY DR	(X5) COMPLETION DATE has ive must roper are code. the cur ce? will fo fire oe or
	performed in accord Frequencies. Table alarm system smoke tested annually. See all inspections, testi provided that include requested in Figure	lance with Table 14.4.5 Testing 14.4.5 at 15.(h) states fire detectors shall be functional ction 14.6.2.4 states a record of ng and maintenance shall be les all applicable information 14.6.2.4. This deficient t over 20 residents, staff and			
	visitors in the C Wi				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPL	ETED
		155077	B. WING	G		01/30/	2024
			<u> </u>	CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENIVIVE A	OF INDIANAPOLIS				APOLIS, IN 46224		
EINVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	,	TAG	DEFICIENCY)		DATE
	Findings include:						
		the fire alarm system					
	inspection contractor's "Fire Alarm Report"						
		d 01/05/24 with the Executive					
	Director, the Mainto	enance Director and the					
		ance Director during record					
		m. to 12:45 p.m. on 01/30/24,					
		ing documentation within the					
		month period for smoke					
		n resident sleeping rooms C11					
	-	ot available for review. The					
		cumentation did include six					
		but it did not include the					
		oms. Based on interview at					
		eview, the Corporate					
		for stated the facility is					
		ion, the contractor may not					
		ing resident sleeping room					
		cause of the renovation but					
		arm system smoke detectors in					
		sted on 01/05/24 and agreed					
		mentation for fire alarm					
		ctors installed in resident					
		through C19 within the most					
		h period was not available for					
	review. Based on o	bservations with the					
		or and the Corporate					
		for during a tour of the facility					
	-	:50 p.m. on 01/30/24, the C Wing					
		d by residents. Fire alarm					
	-	etors are installed in resident					
	sleeping rooms C11	through C19.					
	_	e reviewed with the Executive					
	· ·	enance Director and the					
		ance Director during the exit					
	conference.						
	3.1-19(b)						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	E CONSTRUCTION D1	COMPI 01/30	LETED	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 B	ET ADDRESS, CITY, STATE, ZIP COD EACHWAY DR ANAPOLIS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	Ε	(X5) COMPLETION DATE
	interview; the facilial alarm systems was 9.6.1.3. LSC 9.6.1. be installed, tested, with NFPA 70, Nat 72, National Fire A Edition, Section 14. performed in accord Frequencies. Sections hall be checked with Section 14.4.5.3.2 schecked every alter otherwise permitted 14.4.5.3.5 states sm found to have a sen marked sensitivity is recalibrated or be rearecord of all inspermaintenance shall be applicable informat 14.6.2.4. This defication was a sensitivity of the sensit	review, observation and ty failed to ensure 1 of 1 fire maintained in accordance with 3 requires a fire alarm system to and maintained in accordance ional Electrical Code and NFPA larm Code. NFPA 72, 2010 4.5 requires testing shall be dance with Table 14.4.5 Testing on 14.4.5.3.1 states sensitivity thin 1 year after installation. states sensitivity shall be nate year thereafter unless 1 by compliance with 14.4.5.3.3. soke detectors or smoke alarms sitivity outside the listed and range shall be cleaned and explaced. Section 14.6.2.4 states actions, testing and the provided that includes all ion requested in Figure cient practice could affect over and visitors in the C Wing. The fire alarm system or's "Fire Alarm Report" of 10/17/23 with the Executive tenance Director and the sance Director during record m. to 12:45 p.m. on 01/30/24, sitivity testing documentation installed in resident sleeping C19 was not available for 23 sensitivity testing include six areas in the C Wing te the resident sleeping rooms. at the time of record review,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077			ILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
K 0353 SS=F	facility is undergoin may not have sensitive resident sleeping roof the renovation by system smoke detect sensitivity tested on sensitivity testing do system smoke detect sleeping rooms C11 recent two year perion review. Based on of Maintenance Direct Maintenance Direct from 1:10 p.m. to 3 is currently occupie system smoke detect sleeping rooms C11. These findings were Director, the Maintenance Director, the Maintenance Corporate Maintenance Corporate Maintenance Corporate Maintenance Corporate Maintenance Silver Maintenance Ma	e reviewed with the Executive enance Director and the ance Director during the exit					
SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location and	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a nd readily available. system last checked					
	b) Who provided	system test					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and K 0353 02/29/2024 1: What corrective action(s) will interview; the facility failed to provide written be accomplished for those documentation or other evidence the sprinkler residents found to have been system components had been inspected and affected by the deficient tested for 1 of 4 quarters. Sprinkler systems shall practice? be properly maintained in accordance with NFPA 1. The Director of Maintenance 25, Standard for the Inspection, Testing, and has contacted Elwood fire Maintenance of Water-Based Fire Protection protection and scheduled future Systems, 2011 Edition. NFPA 25, Section 5.2.5 timely compliant inspections requires that waterflow alarm devices shall be 2. All ceiling holes have been inspected quarterly to verify they are free of repaired and all missing tiles were physical damage. NFPA 25, Section 5.3.3.1 replaced. requires the mechanical waterflow alarm devices 2: How other residents having including, but not limited to, water motor gongs, the potential to be affected by shall be tested quarterly. NFPA 25, Section 4.3.1 the same deficient practice will requires records shall be made for all inspections, be identified and what tests, and maintenance of the system components corrective action will be taken. and shall be made available to the authority This deficient practice could affect having jurisdiction upon request. NFPA, 25 all residents, staff and visitors. Section 4.3.2 requires that records shall indicate 3: What measures will be put the procedure performed (e.g., inspection, test, or into place or what systemic maintenance), the organization that performed the changes will be made to work, the results, and the date. This deficient ensure that the deficient practice could affect all residents, staff and practice does not recur? visitors in the facility. The Director of Maintenance has been educated by the Executive Findings include: Director on K353. Sprinkler inspections must be conducted Based on review of the sprinkler system quarterly and documented. All inspection contractor's "Sprinkler System Test ceiling penetrations must be Report" documentation dated 05/25/23, 08/03/23 sealed to prevent the passage of and 01/05/24 with the Executive Director, the smoke and fire. Maintenance Director and the Corporate 4: How the corrective action

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155077)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2024
	PROVIDER OR SUPPLIER OF INDIANAPOLIS	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, no fourth quarter (October, November, and December) 2023 sprinkler system inspection report documentation was available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the sprinkler system inspection contractor had affixed a hanging tag to the facility's two dry sprinkler system risers located in the Laundry Room indicating fourth quarter 2023 water flow alarm inspection and testing was performed by the contractor on 12/18/23. Based on interview at the time of the observations, the Maintenance Director agreed it had been more than 90 days in between quarterly sprinkler system inspection and testing on 08/03/23 and 12/18/23. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents,		will be monitored to ensure to deficient practice will not red i.e., what quality assurance program will be put into place. The Director of Maintenance was perform monthly review X6. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	cur ce? vill his els ers

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			UILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Findings include:							
	staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the following was noted in the ceiling smoke barrier: a. numerous suspended ceiling tiles were missing in the main dining room. b. two suspended ceiling tiles were missing in the dietary office in the kitchen. c. the attic access panel was not in place in the B Wing short hall water heater room. In addition, there were numerous gaps in between drywall panels installed on the ceiling in the room which exposed the attic above. d. panels installed on the ceiling of the B Wing storage room for a water leak repair had become partially detached which exposed the attic above. e. a three inch in diameter hole was noted in the ceiling of the room open to the corridor near the C Wing exit door vestibule where a former smoke detector had been installed. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the aforementioned openings in the ceiling did not maintain ceiling construction. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director and the Corporate Maintenance Director and the Corporate Maintenance Director during the exit conference.							
K 0363 SS=E	NFPA 101 Corridor - Doors							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		JILDING	NSTRUCTION 01	(X3) DATE COMPL 01/30/	ETED
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or come Clearance between covering is not except doors complying with the door closed with a containing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated to the materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glassians assemblies.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,					

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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. BUILDING 01 COMPLETED			LETED	
		155077	B. W	ING		01/30/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	devices, etc.						
		on and interview, the facility	K 0	363	1: What corrective action(s)	will	02/29/2024
		f over 60 corridor doors had no			be accomplished for those		
	impediment to closi	ng and latching into the door			residents found to have been	า	
	frame and would re	sist the passage of smoke.			affected by the deficient		
	This deficient pract	ice could affect over 20			practice?		
	residents, staff and	visitors.			The Director of Maintenance h	nas	
					repaired this door.		
	Findings include:				2: How other residents having	ng	
					the potential to be affected b	У	
	Based on observation	ons with the Maintenance			the same deficient practice v	vill	
	Director and the Corporate Maintenance Director				be identified and what		
	during a tour of the	facility from 1:10 p.m. to 3:50			corrective action will be take	n.	
	p.m. on 01/30/24, tl	ne latching plate and latching			This deficient practice could a	ffect	
	mechanism on the c	corridor door to resident			over 20 residents, staff and		
	sleeping Room C22	was loose and partially			visitors.		
	detached from the d	loor which prevented the door			3: What measures will be put	t	
	from fully closing a	nd latching into the door frame			into place or what systemic		
	when tested to close	e multiple times. In addition, a			changes will be made to		
	circular gap was no	ted around the door handle for			ensure that the deficient		
	the corridor door to	the D Wing Housekeeping			practice does not recur?		
	Employees room w	hich would not resist the			The Director of Maintenance h	nas	
	passage of smoke.	Based on interview at the time			been educated by the Executi	ve	
		s, the Corporate Maintenance			Director on K363 fire doors me		
		corridor door to resident			shut and latch to prevent smo	ke	
		mpediment to closing and			and fire from spreading.		
		or frame and each of the two			4: How the corrective action		
	1	ist the passage of smoke.			will be monitored to ensure t	:he	
					deficient practice will not red	ur	
	These findings were	e reviewed with the Executive			i.e., what quality assurance		
	Director, the Mainte	enance Director and the			program will be put into place	e?	
	Corporate Maintena	ance Director during the exit			The Director of Maintenance v		
	conference.	-			perform monthly review X6.		
					Results of these reviews will b	e	
	3.1-19(b)				presented by the Executive		
					Director to the QAPI committe	e for	
					further recommendations.		
K 0374	NFPA 101						
SS=F	Subdivision of Rui	lding Spaces - Smoke					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	(X3) DATE SURVEY COMPLETED 01/30/2024					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 01	Barrier Doors 2012 EXISTING Doors in smoke basolid bonded wood construction that in Nonrated protective are permitted. Doof fixed fire window as are self-closing or require latching, as in the direction of a provides a minimulation of the self-closing or require latching, as in the direction of a provides a minimulation of the self-closing or for swinging or hour 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 2 of would restrict the in 20 minutes. LSC, Self-close doors in smoke barriers to only the minimum of operation which is of the movement of sin could affect over 40 Findings include: Based on observation Director and the Col during a tour of the p.m. on 01/30/24, the B Wing short hall as D17 each swing to o were equipped with but the coordinator which caused the do	esists fire for 20 minutes. The plates of unlimited height one are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening arm clear width of 32 inches rizontal doors.	K 0374	1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice? The Director of Maintenance replaced the door coordinator the door now shuts properly 2: How other residents havi the potential to be affected to the same deficient practice to be identified and what corrective action will be take This deficient practice could a 40 residents, staff and visitors 3: What measures will be purint practice or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance been educated by the Execut Director on K374 All fire and smoke doors must close fully	nas and ng y vill en. ver t t			

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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	COMPLETED	
155077		155077	B. WI	NG		01/30/	/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	L			CHWAY DR			
ENVIVE (ENVIVE OF INDIANAPOLIS				APOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		sed a gap of greater than 1/8			prevent smoke and fire from			
		close multiple times. Based			spreading.			
		time of the observations, the			4: How the corrective action			
		or and the Corporate			will be monitored to ensure t			
	Maintenance Director agreed the aforementioned				deficient practice will not rec	ur		
		e barrier door sets did not			i.e., what quality assurance	_		
	-	sted to close multiple times and			program will be put into plac			
	would not resist the	passage of smoke.			The Director of Maintenance v			
	TEI (* 1;	· i da p			perform monthly review X6.Th			
		e reviewed with the Executive			audit will be placed into the Te			
	· ·	enance Director and the			system for scheduled reminde	rs		
Corporate Maintenance Director during the exit conference.		ince Director during the exit			and documentation. `Results of these reviews will l			
	conference.					Эе		
	3.1-19(b)				presented by the Executive Director to the QAPI committe	o for		
	3.1-19(0)					e 101		
					further recommendations.			
K 0511	NFPA 101							
SS=E	Utilities - Gas and	Flectric						
Bldg. 01	Utilities - Gas and							
Ŭ		gas or related gas piping						
		PA 54, National Fuel Gas						
	· ·	iring and equipment						
	complies with NFPA 70, National Electric							
	Code. Existing installations can continue in service provided no hazard to life.							
	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2							
	Based on observation	on and interview, the facility	K 0:	511	1: What corrective action(s)	will	02/29/2024	
	failed to ensure 3 of	f over 100 electrical fixtures			be accomplished for those			
	were protected in ac	ecordance with LSC 19.5.1.1.			residents found to have beer	1		
	NFPA 70, National	Electric Code, 2011 Edition,			affected by the deficient			
		receptacles shall be enclosed			practice?			
	_	erminals are not exposed to			The Director of Maintenance h			
	· ·	2011 Edition. Article 406.6,			replaced the broken GFCI out	et		
		tes (Cover Plates), requires			and replaced missing outlet			
		s shall be installed so as to			covers.			
		e opening and seat against the			2: How other residents havir	_		
	_	This deficient practice could			the potential to be affected b	-		
	affect over 10 reside	ents, staff and visitors.			the same deficient practice v	/ill		
			1		he identified and what		I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/30/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		INDIAN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) corrective action will be take. This deficient practice could a all residents, staff and visitors 3: What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance been educated by the Execut Director on K511 all electrical fixtures must be protected in accordance with LSC 19.5.1. prevent accidental access. 4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plat The Director of Maintenance perform monthly review X6. Results of these reviews will presented by the Executive Director to the QAPI committee.	ben. affect s. tt has ive 1. to the cur ce? will			
K 0712 SS=C Bldg. 01	Director, the Mainted Corporate Maintena conference. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills conditions, at leass The staff is familia.	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is repart of established		further recommendations.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155077 B. WING 01/30/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the K 0712 02/29/2024 1: What corrective action(s) will facility failed to conduct quarterly fire drills at be accomplished for those unexpected times under varying conditions on the residents found to have been first shift for 3 of 4 quarters. This deficient affected by the deficient practice could affect all residents, staff and practice? visitors. 1. The Director of Maintenance has scheduled random times for Findings include: future drills. 2. Moving forward the director of Based on review of "Fire Drill Report" maintenance will have documentation with the Executive Director, the partisapants sign the back of the Maintenance Director and the Corporate actual drill sheet. Maintenance Director during record review from 2: How other residents having 9:10 a.m. to 12:45 p.m. on 01/30/24, first shift fire the potential to be affected by drills conducted within the most recent twelve the same deficient practice will month period on 04/07/23, 07/28/23 and 10/11/23 be identified and what were conducted at, respectively, 8:30 a.m., 8:00 corrective action will be taken. a.m. and 8:00 a.m. Based on interview at the time This deficient practice could affect of record review, the Maintenance Director and all residents, staff and visitors. the Corporate Maintenance Director stated the 3: What measures will be put facility operates three shifts per day and agreed into place or what systemic the aforementioned first shift fire drills were not changes will be made to conducted at unexpected times under varying ensure that the deficient conditions. practice does not recur? The Director of Maintenance has These findings were reviewed with the Executive been educated by the Executive Director, the Maintenance Director and the Director on K712 fire drill must be Corporate Maintenance Director during the exit random and unannounced. All conference. participants must sign to document the were trained 3.1-19(b) and 3.1-51(c) 4: How the corrective action will be monitored to ensure the 2. Based on record review and interview, the deficient practice will not recur facility failed to document all staff who i.e., what quality assurance participated in quarterly fire drills on the third shift program will be put into place?

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ì í	UILDING	instruction <u>01</u>	(X3) DATE : COMPL 01/30/	ETED	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	drills to be conducte under varied conditi states employees of be instructed in life	LSC Section 19.7.1.6 requires ed quarterly on each shift ions. LSC Section 19.7.1.8 health care occupancies shall safety procedures and ient practice affects all visitors.			The Director of Maintenance was perform monthly review X6. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	nis Is rs e	
	Maintenance Direct Maintenance Direct 9:10 a.m. to 12:45 p for the third shift fin on 03/20/23 did not participated in the f the time of record re Director and the Co stated the facility op and agreed document third shift fire drill op participated in the f These findings were Director, the Mainte	the Executive Director, the or and the Corporate or during record review from the corporate of the corporate					
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155077 B. WING 01/30/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and K 0741 1: What corrective action(s) will 02/29/2024 interview; the facility failed to ensure smoking be accomplished for those materials were deposited into ashtrays and metal residents found to have been containers with self-closing cover devices into affected by the deficient which ashtrays can be emptied of noncombustible practice? material and safe design in 2 of 2 outdoor areas The Director of Maintenance has where smoking was taking place. This deficient cleaned up the cigarette butts in practice could affect over 5 residents, staff and both areas. Ashtray and metal visitors. closing can will be in each smoking location. Findings include: 2: How other residents having the potential to be affected by Based on review of smoking policy the same deficient practice will documentation with the Executive Director, the be identified and what Maintenance Director and the Corporate corrective action will be taken. Maintenance Director during record review from This deficient practice could affect

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ	UILDING	onstruction 01	(X3) DATE COMPL 01/30/	ETED		
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	residents and staff a designated outdoor observations with the Corporate Main of the facility from 01/30/24, over 20 c the ground outside Activity Room. Cideposited into a flocombustible trash or Room. In addition, strewn on the ground exit door near the oroutside the facility door. Based on into observations, the M Corporate Maintena butts were deposite aforementioned two consistently deposite metal containers with which were provided location where smooth of the Maintena observations, the Maintena containers with the serious metal containers	o.m. on 01/30/24, assessed are allowed to smoke in smoking areas. Based on the Maintenance Director and tenance Director during a tour 1:10 p.m. to 3:50 p.m. on igarette butts were strewn on the facility by the D Wing grarette butts were also wer pot which contained the D Wing Activity over 20 cigarette butts were add outside the staff breakroom autdoor resident smoking area by the main dining room exit the exist of the facility and the facility and the facility and the staff breakroom with the facility and the self-closing cover devices and at these two outdoor king was taking place. The facility by the D Wing area by the main dining room exit for the facility and the facility and the facility and the self-closing cover devices and at these two outdoor king was taking place. The facility by the D Wing area of the facility and the self-closing cover devices and the facility a			over 5 residents, staff and vis 3: What measures will be puinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance is been educated by the Execution Director on K741 We must ensure smoking materials are depositinto ashtrays and metal contawith self-closing cover devices which ashtrays can be emptien noncombustible material and design 4: How the corrective action will be monitored to ensure deficient practice will not recise, what quality assurance program will be put into place in the Director of Maintenance of perform weekly review X8. The audit will be placed into the Results of these reviews will be presented by the Executive Director to the QAPI committed further recommendations.	nas ve sure ted iners s into d of safe the cur ve? will is			
K 0754 SS=E Bldg. 01	shall not exceed 3 average density o room or space sha	Trash Containers sh collection receptacles 32 gallons in capacity. The f container capacity in a							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility K 0754 1: What corrective action(s) will 02/29/2024 failed to ensure unattended trash receptacles be accomplished for those stored in 1 of 7 means of egress were stored in a residents found to have been room protected as a hazardous area in accordance affected by the deficient with Section 19.7.5.7. This deficient practice could practice? affect over 20 residents, staff and visitors in the The Director of Maintenance vicinity of resident sleeping Room C22. removed the trash containers from the hall. Findings include: 2: How other residents having the potential to be affected by Based on observations with the Maintenance the same deficient practice will Director and the Corporate Maintenance Director be identified and what during a tour of the facility from 1:10 p.m. to 3:50 corrective action will be taken. p.m. on 01/30/24, two separate unattended 20 This deficient practice could affect gallon capacity receptacles were partially filled over 20 residents, staff and visitors with trash and were stored next to one another in 3: What measures will be put the corridor outside Room C22. The combined into place or what systemic capacity of the receptacles exceeded 32 gallons. changes will be made to Based on interview at the time of the ensure that the deficient observations, the Maintenance Director stated the practice does not recur? trash receptacles are stored in the corridor and The Director of Maintenance has agreed the aforementioned receptacles were not been educated by the Executive being stored in a room protected as a hazardous Director on K754 Mobile soiled area when unattended. linen or trash collection receptacles with capacities These findings were reviewed with the Executive greater than 32 gallons shall be

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	01	COMPLETED 01/30/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0791 SS=F Bldg. 01	Corporate Maintena conference. 3.1-19(b) NFPA 101 Construction, Reproperations Construction, reparations shall comeans of egress in construction, repairs expected daily to used instantly in compliance with N 18.7.9, 19.7.9, 4.6 Based on observation failed to ensure the construction, repair comply with LSC 19 states construction, operations shall con 19.7.9.2 states the mundergoing construction.		K 0791	located in a room protected as hazardous area when not attended. 4: How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The Director of Maintenance where perform weekly review X8. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations. 1: What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance we check and document for clear egress in construction areas we construction is taking place.	he cur e? vill is els rs e e for vill 02/29/2024		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 01/30	LETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Standard for Safegu Alteration, and Der Section 4.6.10.1 state buildings, shall be puring construction additions only when and required fire properties acceptable to the aurin place. LSC Sectegress shall be controbstructions or impute case of fire or opractice could affect visitors. Findings include: Based on observation Director, the Maintenante facility from 1:15 the A Wing was currenovation. The Brenovations were mover marked as an interview at the time Executive Director began in the Spring at the time of the observation of the observation of the observation of the observation of the survive Director, the Maintenance Director began in the Spring at the time of the observation of the survive Director, the Maintenance Director Director, the Maintenance Director Di	e reviewed with the Executive enance Director and the			2: How other residents havi the potential to be affected in the same deficient practice whe identified and what corrective action will be take. This deficient practice could a over 20 residents, staff and vi 3: What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance is been educated by the Execution Director on K791. We must ensure the means of egress in adjoining construction, repair improvement operations compaired with state regulations. 4: How the corrective action will be monitored to ensure deficient practice will not recive, what quality assurance program will be put into place. The Director of Maintenance operform weekly review X8. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	will en. ffect sitors t nas ive nand oly the cur ce? will is els ers	
	Corporate Maintena	ance Director during the exit					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/30/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0911 SS=E Bldg. 01	Chapter 6 Electric that are not addre K-Tags, but are do along with the app NFPA standard circon Form CMS-256 Chapter 6 (NFPA Based on observation failed to ensure accommaintained in enclos apparatus in 1 of 11 NFPA 99, Health C Edition, Section 6.3 shall be in accordant Electric Code. NFF 110.26 states working operating at 600 voito require examinat maintenance while dimensions of 110.2 shall be measured from opening if such are states the working shall not be used for practice could affect visitors in the D Williams and observation. Based on observation	S - Other 2KS section any NFPA 99 al Systems requirements seed by the provided efficient. This information, dicable Life Safety Code or ration, should be included 67. 999) on and interview, the facility ess and working space was sures housing electrical D Wing electrical rooms. are Facilities Code, 2012 2.2.1 states electrical installation ce with NFPA 70, National PA 70, 2011 Edition, Article and space for equipment test, nominal, or less and likely iton, adjustment, servicing, or energized shall comply with the 26(A)(1), (2) and (3). Distances from the live parts if such parts at the enclosure front or enclosed. Article 110.26(B) pace required by this section in storage. This deficient it over 20 residents, staff and	K 0911	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance of cleared the areas in front of all breaker panels. 2: How other residents have the potential to be affected by the same deficient practice of the same deficient practice of the same deficient practice of the same deficient practice could a cover 20 residents, staff and via. 3: What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance is been educated by the Execution Director on K911. We must companied the panels at all times.	m will ng by will en. iffect sitors t has ive lear		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/30/2024		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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	
	p.m. on 01/30/24, p two wall mounted of Panel Location roo underneath the elec- indicate no storage space under and in items were stored it space. Based on in observations, the Co stated the D Wing I and agreed picture feet of the working panels in the D Win room. These findings wer Director, the Maint	facility from 1:10 p.m. to 3:50 victure frames were stored under electrical panels in the Electrical m in the D Wing. The flooring strical panels was painted to should be in the working front of the panels but the n the painted area working terview at the time of the orporate Maintenance Director had been recently renovated frames were stored within three space in front of electrical hag Electrical Panel Location e reviewed with the Executive enance Director and the ance Director during the exit		4: How the corrective action will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. The Director of Maintenance we perform monthly review X6. The audit will be placed into the Tesystem for scheduled reminder and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	er e? vill nis els rs	
K 0914 SS=E Bldg. 01	Testing Electrical System Testing Hospital-grade re locations and whe anesthesia is adn initial installation, Additional testing defined by docum Receptacles not I these locations an exceeding 12 mon (LIM), if installed, less than or equa	s - Maintenance and s - Maintenance and ceptacles at patient bed ere deep sedation or general ninistered, are tested after replacement or servicing. is performed at intervals nented performance data. isted as hospital-grade at the tested at intervals not nths. Line isolation monitors are tested at intervals of I to 1 month by actuating th per 6.3.2.6.3.6, which				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETE	ED
		155077	B. W	ING		01/30/202	24
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			CHWAY DR		
ENVIVE	ENVIVE OF INDIANAPOLIS				IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRI			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CC CC	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ual and audible alarm. For					
		automated self-testing, this					
	_	formed at intervals less					
	1	2 months. LIM circuits are					
	· ·	.2 after any repair or					
		electric distribution system.					
		tained of required tests and					
	· · · · · · · · · · · · · · · · · · ·	s or modifications,					
	results.	oom or area tested, and					
	6.3.4 (NFPA 99)						
		view, observation and	$ _{K0}$	014	1: What corrective action(s)	will o	2/29/2024
	interview; the facili		K U	71 4	be accomplished for those	WIII 0.	2/29/2024
		electrical receptacles that failed			residents found to have been	n	
		of over 60 resident rooms were			affected by the deficient	"	
	_	ital-grade receptacles. NFPA			practice?		
		lectrical Code, 2011 Edition, at			The Director of Maintenance I	nas	
		tates each patient bed location			replaced the mentioned	145	
		vith a minimum of four			receptacles with hospital grad	e.	
	_	hall be permitted to be of the			2: How other residents havi		
		uadruplex type, or any			the potential to be affected b	-	
	combination of the	three. All receptacles, whether			the same deficient practice v	-	
	four or more, shall	be listed "hospital grade" and			be identified and what		
	so identified. It is a	not intended that there be a			corrective action will be take	n.	
		placement of existing			This deficient practice could a		
		receptacles. It is intended,			over 6 residents, staff and vis	itors	
		hospital grade receptacles be			3: What measures will be pu	t	
		ital grade receptacles upon			into place or what systemic		
		e, renovation, or as existing			changes will be made to		
		placement. This deficient			ensure that the deficient		
	practice could affect	et over 6 residents and staff.			practice does not recur?		
	F. 1				The Director of Maintenance I		
	Findings include:				been educated by the Executi		
	D4 ' '	CHD4 1- T4 A 10			Director on K914 When chang		
		"Receptacle Tests - Annual"			out receptacles in resident are		
		ed 10/01/23 with the Executive enance Director and the			it is required to use hospital g	rade	
					receptacle. 4: How the corrective action		
	-	ance Director during record					
		.m. to 12:45 p.m. on 01/30/24, es in resident sleeping Room			will be monitored to ensure		
	electrical receptació	es in resident steepling Koom	1		deficient practice will not red	ur	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE (A. BUILDING B. WING	O1	COMI	E SURVEY PLETED 0/2024
	PROVIDER OR SUPPLIER		45 BE	ADDRESS, CITY, STATE, ZIP ACHWAY DR	COD	
EINVIVE	OF INDIANAPOLIS		INDIA	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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0918	replaced. Based on review, the Mainten electrical receptacle replaced but he coureplaced with hospi on observations wit and the Corporate Maintenance of the facility for 1/30/24, all electrices dent sleeping rose hospital-grade. Base the observations, the Director agreed the three resident sleepin hospital-grade. These findings were Executive Director,	d annual testing and were interview at the time of record ance Director stated the s which failed 10/01/23 were d not ensure that they were tal-grade receptacles. Based in the Maintenance Director Maintenance Director during a rom 1:10 p.m. to 3:50 p.m. on the cal receptacle locations in the locations were not locations in the locations were not locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations were not locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations were not locations in the locations in the locations in the locations in the locations were not locations in the locations were not locations in the locations in locations in the locations in the locations in the locations in l		i.e., what quality ass program will be put in the Director of Mainte perform an annual our replace with hospital is receptacles moving for audit will be placed in system for scheduled and documentation. Results of these review presented by the Exercite Director to the QAPI of further recommendation.	enance will telt audit and grade brward. This to the Tels reminders ews will be cutive committee for	
SS=F Bldg. 01	Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the ncess shall be provided to nis capability for the life branches. Maintenance generator and transfer rmed in accordance with e inspected weekly, and 30 minutes 12 times a				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WING 01/30/2024		2024		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
END 40 4E	05 11151441450110				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE.	DATE
	vear in 20-40 day	intervals, and exercised					
		onths for 4 continuous hours.					
		ider load conditions include					
	a complete simula						
		ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	l -	rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
	· ·	tablished according to					
		uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
		arked, readily identifiable,					
	-	n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for i						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		review and interview, the	K 0	918	1: What corrective action(s) v	will	02/29/2024
		sure a written record of weekly			be accomplished for those		
		generator was maintained for			residents found to have beer	1	
		st recent 52 week period.			affected by the deficient		
		requires onsite generators shall			practice?		
	be maintained in ac	cordance with NFPA 110,			1.The Director of Maintenance	:	
	Standard for Emerg	ency and Standby Power			documented all weekly		
	Systems. NFPA 11	0, 8.4.1 requires an Emergency			inspections since that date and	d is	
	Power Supply Syste	em (EPSS) including all			not in the Tels system weekly.		
	appurtenant compo	nents, shall be inspected			2.The Director of Maintenance	!	
	weekly and exercise	ed monthly. NFPA 99, Section			called Evapar and had them		
	6.4.4.2 requires a w	ritten record of inspection,			preform the Load bank.		
	performance, exerc	ising period, and repairs for the			3. Evapar has preformed a fue	el	
	generator to be regu	larly maintained and available			sample		
	for inspection by th	e authority having			4. Evapar has changed the		
	jurisdiction. This d	eficient practice could affect all			batteries.		
	residents, staff and	visitors.			2: How other residents havir	ng	
					the potential to be affected by	-	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155077 B. WING 01/30/2024

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	l í	JILDING	nstruction 01	(X3) DATE COMPL 01/30/	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION
PREFIX TAG	REGULATORY OF Section 8.4.2.3 stati installations that do 8.4.2 shall be exerce EPSS (Emergency shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not inameplate kW ratin total test duration of hours. This deficier residents, staff and Findings include: Based on review of Weekly Load Test" Executive Director, the Corporate Main review from 9:10 a load testing document and March 2023 was addition, load testing tests conducted weekly through 01/17/24 dipercentage achieves generator during the time of record residesel fired emerge documented on a woversized and the fatesting cannot achieved percentage for each plate rating so they percentage for each	es diesel-powered EPS not meet the requirements of ised monthly with the available Power Supply System) load and nnually with supplemental Test) at not less than 50 percent atte kW rating for 30 continuous less than 75 percent of the EPS ag for 1 continuous hour for a f not less than 1.5 continuous at practice could affect all		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION DATE
	bank testing docum twelve month perio	at agreed supplemental load entation for the most recent d was not available for review.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/30/2024	
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIAL DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	during a tour of the p.m. on 01/30/24, the emergency generated on the northeast side manufacturer's namindicated it was rated. These findings were	e reviewed with the Executive					
		enance Director and the ance Director during the exit					
	3.1-19(b)						
	interview; the facili fuel quality test was diesel fuel fired em Health Care Faciliti 6.5.4.1.1.2 states Tysystem) generators tested in accordance Section 6.4.4.1.1.3 performed in accord for Emergency and Edition, Chapter 8. a fuel quality test sl annually using tests standards. This def residents, staff and	review, observation and ity failed to ensure an annual is performed for the facility's ergency generator. NFPA 99, ites Code, 2012 Edition, Section type 2 EES (Essential Electrical sets shall be inspected and ite with Section 6.4.4.1.1.3. Items is maintenance shall be dance with NFPA 110, Standard Standby Power Systems, 2010 NFPA 110, Section 8.3.8 states mail be performed at least is approved by ASTM incient practice could affect all visitors.					
	Findings include:						
	documentation date Director, the Maint Corporate Maintena review from 9:10 a.	T'Fuel Analysis Report" and 12/19/22 with the Executive enance Director and the enance Director during record during r					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			ILDING	01	COMPL 01/30/	ETED	
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR				
ENVIV	E OF INDIANAPOLIS			INDIAN	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
	the facility's diesel within the most reconstruction of available for review Director stated the emergency generate of an annual fuel quesel fuel fired emergency generated of an annual fuel quesel fuel fired emergency generated on observation Director and the Conduring a tour of the p.m. on 01/30/24, the emergency generated on the northeast side manufacturer's namindicated it was rated. These findings were Director, the Maint Corporate Maintena conference. 3.1-19(b) 4. Based record review Maintena conference. 3.1-19(b)	fuel fired emergency generator ent twelve month period was view. Based on interview at the ew, the Corporate Maintenance facility has one diesel fired or and agreed documentation hality test for the facility's ergency generator within the month period was not vat the time of the survey. Ons with the Maintenance or prorate Maintenance Director facility from 1:10 p.m. to 3:50 the facility has one diesel fired or located outside the building e of the property. The					

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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 01/30/2024	
	ROVIDER OR SUPPLIER OF INDIANAPOLIS	45 BE	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 9999	Based on review of the emergency generator inspection contractor's "Generator Maintenance Report" documentation dated 11/21/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, emergency generator batteries need to be replaced. The "Comments/Remarks" section of the 11/21/23 report stated "batteries failed load test and need replaced (dated 2018)". Based on interview at time of the observations, the Maintenance Director and the Corporate Maintenance Director stated the emergency generator is tested weekly and will operate, the batteries are scheduled to be replaced on 02/05/23 but agreed emergency generator battery replacement documentation on or after 11/21/23 was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. Documentation affixed to each of the two starting batteries indicated they were manufactured in October 2018. These findings were reviewed with the Executive Director, the Maintenance Director during the exit conference. 3.1-19(b)	d , the			
Bldg. 01	State Findings	K 9999	1: What corrective action(s)	will 02/29/2024	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2024 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE be accomplished for those 3.1-19 ENVIRONMENT AND PHYSICAL residents found to have been STANDARDS affected by the deficient practice? 3.1-19(a) The facility must be designed, The Maintenance Director has constructed, equipped and maintained to protect installed/reinstalled any/all smoke the health and safety of residents, personnel, and detectors in all resident rooms. the public. 2: How other residents having the potential to be affected by the same deficient practice will This State Rule has not been met as evidenced by: Based on observation and interview, the facility be identified and what failed to provide smoke detectors in 2 of over 60 corrective action will be taken. resident sleeping rooms. This deficient practice This deficient practice could affect could affect over 20 residents, staff and visitors. over 20 residents, staff and visitors 3: What measures will be put Findings include: into place or what systemic changes will be made to Based on observations with the Maintenance ensure that the deficient Director and the Corporate Maintenance Director practice does not recur? during a tour of the facility from 1:10 p.m. to 3:50 The Director of Maintenance has p.m. on 01/30/24, all resident sleeping rooms were been educated by the Executive equipped with a smoke detector except resident Director on the requirement to sleeping Room B22 and D9. The facility was maintain any/all in-room safety currently being renovated but resident rooms B22 designed equipment designed to and D9 were occupied by residents. Based on protect the health and safety of interview at the time of the observations, the residents. Personnel and the Maintenance Director and the Corporate Maintenance Director agreed resident sleeping 4: How the corrective action Room B22 and D9 were not provided with a smoke will be monitored to ensure the detector. deficient practice will not recur i.e., what quality assurance These findings were reviewed with the Executive program will be put into place? Director, the Maintenance Director and the The Director of Maintenance will Corporate Maintenance Director during the exit perform monthly X6 audits or conference. resident rooms. This audit will be placed into the Tels system for 3.1-19(b) scheduled reminders and documentation.

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Results of these reviews will be presented by the Executive

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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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>		<u>01</u>	COMPLETED	
		155077	B. WING			01/30/2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS				STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
		Director to the QAPI committee		e for			
					further recommendations.		

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