PRINTED: 04/30/2024

				I KINTED.	
DEPARTMENT OF HEALTH AND HUM	FORM APPROVED				
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING	COMPLETED	
	155077	B. WING		03/27/2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR		
ENVIVE OF INDIANAPOLIS			INDIANAPOLIS, IN 46224		

NAME OF PROVIDER OR SUPPLIER			45 BEACHWAY DR			
ENVIVE	OF INDIANAPOLIS					
EINVIVE	OF INDIANAPOLIS	INDIA	INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000						
Bldg						
	A Post Survey Revisit (PSR) to the Emergency	E 0000	Preparation or execution of this			
	Preparedness Survey conducted on 01/30/24 was	Loco	plan of correction does not			
	conducted by the Indiana Department of Health in		constitute admission or agreement			
	accordance with 42 CFR 483.73.		of provider of the truth of the facts			
	accordance with 42 CFR 463.73.		•			
	Survey Date: 03/27/24		alleged or conclusions set forth on the Statement of Deficiencies. The			
	Survey Date: 03/2//24					
	Facility Number: 000032		Plan of Correction is prepared and			
	Provider Number: 155077		executed solely because it is			
			required by the position of Federal			
	AIM Number: 100273330		and State Law. The Plan of			
	Audi pap		Correction is submitted to respond			
	At this PSR survey to the Emergency		to the allegation of noncompliance			
	Preparedness survey, Envive of Indianapolis was		cited during the revisit survey			
	found in compliance with Emergency		conducted March 27, 2024.			
	Preparedness Requirements for Medicare and		Please accept this Plan of			
	Medicaid Participating Providers and Suppliers, 42		Correction as the provider's			
	CFR 483.73.		credible allegation of compliance			
			as of April 12, 2024 provider			
	The facility has 184 certified beds. At the time of		respectfully requests desk			
	the survey, the census was 96.		review with paper compliance			
			to establish that the provider is in			
	Quality Review completed on 04/01/24		substantial compliance.			
			·			
K 0000						
Bldg. 01						
	A Post Survey Revisit (PSR) to the Life Safety	K 0000	Preparation or execution of this			
	Code Recertification and State Licensure Survey		plan of correction does not			
	conducted on 01/30/24 was conducted by the		constitute admission or agreement			
	Indiana Department of Health in accordance with		of provider of the truth of the facts			
	42 CFR 483.90(a).		alleged or conclusions set forth on			
			the Statement of Deficiencies. The			
	Survey Date: 03/27/24		Plan of Correction is prepared and			
			executed solely because it is			
	Facility Number: 000032		required by the position of Federal			
	Provider Number: 155077		and State Law. The Plan of			
	AIM Number: 100273330		Correction is submitted to respond			
	111111.3111001. 1002/0000		Correction to Submitted to respond			

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

TITLE

(X6) DATE

Gregory S Otter **Executive Director** 04/25/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155077	B. W	ING	03/27/202		/2024
NAME OF P	PROVIDER OR SUPPLIER	R	-		ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE (OF INDIANAPOLIS	5		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A. d. DCD	F ' 61 1' 1'			to the allegation of noncompli		
		Envive of Indianapolis was			cited during the revisit survey		
		iance with Requirements for			conducted March 27, 2024.		
	•	dicare/Medicaid, 42 CFR Life Safety from Fire and the			Please accept this Plan of		
		National Fire Protection			Correction as the provider's credible allegation of complian	200	
		(A) 101, Life Safety Code (LSC),			as of April 12, 2024 provider		
	· ·	g Health Care Occupancies and			respectfully requests desk	•	
	410 IAC 16.2.	g freath care occupancies and			review with paper compliance	٠.	
					to establish that the provider i		
	This one story facil	lity was determined to be of			substantial compliance.	O	
		struction and was fully					
		ncility has a fire alarm system					
	_	on in the corridors, in all areas					
	open to the corridor	r and in rooms 11 through 19 in					
	the C Wing. The fa	acility has battery operated					
	smoke detectors in	all other resident sleeping					
	rooms. The facility	has a capacity of 184 and had					
	a census of 96 at th	e time of this survey.					
	A 11 amaga yyih ama mag	idanta harra aratamany access					
		idents have customary access The facility has four detached					
	-	g storage services and one					
		nousing an emergency					
	_	ere each not sprinklered.					
	generator which we	ere each not sprinklered.					
	Quality Review con	mpleted on 04/01/24					
K 0100	NFPA 101						
SS=E	General Requiren	nents - Other					
Bldg. 01	General Requiren						
	List in the REMAR	RKS section any LSC					
		19.1 General Requirements					
		essed by the provided					
	K-tags, but are de	eficient. This information,					
	along with the app	olicable Life Safety Code or					
	NFPA standard ci	itation, should be included					
	on Form CMS-250						
		on and interview, the facility	K 0	100	1: What corrective action(s)	will	10/31/2024
	failed to ensure fire	e resistance rating labels on 1 of			be accomplished for those		

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f ´		r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED
		155077	B. W	NG		03/27/2024
ENVIVE	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	-
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		oor sets were not painted per			residents found to have been	n
		2.3. LSC, Section 4.6.12.3			affected by the deficient	
		e safety features obvious to			practice?	
		uired by the Code, shall be			Waiver filed. Waiver attached	
		r removed. This deficient			2: How other residents havi	_
	-	t over 20 residents, staff and			the potential to be affected by	-
	visitors.				the same deficient practice v	VIII
	Eindings in abids:				be identified and what	
	Findings include:				Corrective action will be take	
	Rosed on observation	ons with the Executive			This deficient practice could a over 20 residents, staff, and	liect
		aintenance Director during a			visitors.	
		From 9:15 a.m. to 10:15 a.m. on			3: What measures will be pu	
		esistance rating label on the			into place or what systemic	•
		oss corridor door set in the A			changes will be made to	
		was painted. The north door in			ensure that the deficient	
		oor set was equipped with a			practice does not recur?	
		ce rating label. Based on			The Director of Maintenance I	nas
		e of the observations, the			been educated by the Executi	
		and the Maintenance Director			Director on K100. All smoke	
		tance rating label on the door			fire doors must have a UL rati	
	in the aforemention	ed cross corridor door set was			plate and must be legible.	
	painted.				4: How the corrective action	
					will be monitored to ensure	the
	These findings were	e reviewed with the Executive			deficient practice will not red	cur
	Director, the Mainto	enance Director and the			i.e., what quality assurance	
	Facilities Managem	ent Support during the exit			program will be put into place	e?
	conference.				The Director of Maintenance	or
					designee will perform Daily au	ıdits
	-	s cited on 01/30/24. The facility			Monday through Friday for 8	
	_	a systemic plan of correction			weeks, then weekly for 4 wee	
	to prevent recurrence	ce.			then monthly for 3 Months total	aling
	21.10(1)				6 months.	
	3.1-19(b)				Results of these reviews will be	oe
					presented by the Executive	,
					Director to the QAPI committee	e tor
					further recommendations.	
K 0211	NFPA 101					
SS=E	Means of Egress	- General				
	I INICALIS OF LAIGSS.	Concidi			•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					ED
		155077	B. W	ING		03/27/20	024
	ROVIDER OR SUPPLIER		•	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Means of Egress -	- General					
	Aisles, passagewa	ays, corridors, exit					
	discharges, exit lo	cations, and accesses are					
		n Chapter 7, and the means					
	_	nuously maintained free of					
	all obstructions to						
		s modified by 18/19.2.2					
	through 18/19.2.1						
	18.2.1, 19.2.1, 7.1		1				
		on and interview, the facility	K 0	211	1: What corrective action(s)	will (04/12/2024
		f 7 means of egress were			be accomplished for those		
		ained free of all obstructions			residents found to have been	n	
	_	full instant use in the case of ency. This deficient practice			affected by the deficient		
		residents, staff and visitors if			practice?		
	needing to exit the f				The Director of Maintenance here removed all furniture/ obstruct		
	needing to exit the i	facility.				lions	
	Findings include:				from the C wing vestibule. 2: How other residents having		
	rindings include.				the potential to be affected b	_	
	Based on observation	ons with the Executive			the same deficient practice v	- 1	
		aintenance Director during a			be identified and what	' '''	
		From 9:15 a.m. to 10:15 a.m. on			corrective action will be take	en.	
	-	was stored in the east exit			This deficient practice could a		
	·	Ving which interfered with exit			over 40 residents, staff and		
		nterview at the time of the			visitors.		
	observations, the Ex	xecutive Director and the			3: What measures will be put	t	
	Maintenance Direct	or agreed the aforementioned			into place or what systemic		
		s not continually maintained			changes will be made to		
	free of all obstruction	ons or impediments to full			ensure that the deficient		
	instant use in the ca	se of fire or other emergency.			practice does not recur?		
					The Director of Maintenance h		
	_	e reviewed with the Executive			been educated by the Executi	ve	
	· ·	enance Director and the			Director on K211 maintaining		
	_	ent Support during the exit			clear path of egress for emerg	jency	
	conference.				evacuation purposes.		
					4: How the corrective action		
	_	s cited on 01/30/24. The facility			will be monitored to ensure t		
	-	a systemic plan of correction			deficient practice will not rec	cur	
	to prevent recurrence	ce.			i.e., what quality assurance		
					program will be put into place	:e?	

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	N (X5) BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	The Director of Maintenance	DATE
	3.1-19(b)			designee will perform Daily Monday through Friday for a weeks, then weekly for 4 we then monthly for 3 Months to 6 months. Results of these reviews wi presented by the Executive Director to the QAPI commit further recommendations.	audits 8 eeks, otaling II be
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Security are being met. In a electrical locks that	king arrangements for the seds of the patient are eking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1,			

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Event ID:

4CYK22 Facility ID: 000032

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED		
		155077	B. W	B. WING		03/27	03/27/2024	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ACHWAY DR			
FNI\/I\/E	OF INDIANAPOLIS				IAPOLIS, IN 46224			
LINVIVE	OI HADIWIAL OFIO			וואטואוו				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ed by a supervised						
		er system and the locked						
		d by a complete smoke						
	1	(or is constantly monitored						
		cation within the locked						
		the sprinkler and detection						
	I -	nged to unlock the doors						
	upon activation.	0050 TIA 40 4						
	18.2.2.2.5.2, 19.2	•						
	DELAYED-EGRE							
	ARRANGEMENT							
		lelayed-egress locking						
	1 *	in accordance with permitted on door						
		•						
		ig low and ordinary hazard						
		ngs protected throughout by						
		ervised automatic fire						
	_	or an approved, supervised						
	automatic sprinkle 18.2.2.2.4, 19.2.2	-						
	ACCESS-CONTR							
	LOCKING ARRAN							
		d Egress Door assemblies						
		lance with 7.2.1.6.2 shall						
	be permitted.	anoc with 7.2.1.0.2 Shall						
	18.2.2.2.4, 19.2.2	2.4						
	· ·	BY EXIT ACCESS						
	LOCKING ARRAN							
		t access door locking in						
	-	7.2.1.6.3 shall be permitted						
		es in buildings protected						
		approved, supervised						
	-	ection system and an						
		ised automatic sprinkler						
	system.	•						
	18.2.2.2.4, 19.2.2	.2.4						
		on and interview, the facility	K 0	222	1: What corrective action(s)	will	04/12/2024	
	failed to ensure the	means of egress through 1 of			be accomplished for those			
	10 doors was readil	y accessible for residents			residents found to have bee	n		
		iagnosis requiring specialized			affected by the deficient			

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i ´		lì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		. BUILDING <u>01</u>		COMPLETED	
		155077	B. W	ING		03/27/2	2024
NAME OF D	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	-	Doors within a required means			practice?		
	_	be equipped with a latch or			The Maintenance Director has	5	
	_	the use of a tool or key from the			placed the code next to each		
	_	therwise permitted by LSC ction 7.2.1.5.3 states locks, if			keypad.		
		require the use of a key, a tool,			2: How other residents havi	-	
	-	ge or effort for operation from			the potential to be affected by	-	
		or-locking arrangements shall			the same deficient practice v	VIII	
	-	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.	fuld affect over 20 residents,			over 20 residents, staff and	iiect	
	starr and visitors.				visitors.		
	Findings include:				3: What measures will be pu	.	
	i manigo merade.				into place or what systemic	`	
	Based on observation	ons with the Executive			changes will be made to		
		aintenance Director during a			ensure that the deficient		
		rom 9:15 a.m. to 10:15 a.m. on			practice does not recur?		
		or door set at the entrance to			The Director of Maintenance h	nas	
		e center lobby was equipped			been educated by the Executi		
	-	ing devices when the door set			Director on K222 maintaining		
	-	sed position. The door set			clear path of egress for emerg		
	could be released to	open by entering a code at			evacuation purposes.	, ,	
	the keypad but the	code was not posted. Based			4: How the corrective action		
	on interview at the	time of the observations, the			will be monitored to ensure t	the	
	Executive Director	stated the D Wing houses			deficient practice will not red	cur	
	residents with the c	linical diagnosis to be in a			i.e., what quality assurance		
	secure wing but agr	reed the code to release the			program will be put into place	:e?	
	door set to open by	the entrance to the D Wing			The Director of Maintenance of	or	
	was not posted at th	e door set.			designee will perform Daily au	ıdits	
					Monday through Friday for 8		
	_	e reviewed with the Executive			weeks, then weekly for 4 weel		
	· ·	enance Director and the			then monthly for 3 Months total	aling	
	_	ent Support during the exit			6 months.		
	conference.				Results of these reviews will be	oe	
					presented by the Executive		
	•	s cited on 01/30/24. The facility			Director to the QAPI committe	e for	
	-	a systemic plan of correction			further recommendations.		
	to prevent recurrence	ce.					
	3.1-19(b)						

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4CYK22 Facility ID: 000032

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155077	B. Wl	NG		03/27/	/2024
NAME OF PROVIDER OR SUPPLIER		•	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas						
		are protected by a fire					
	-	our fire resistance rating					
	`	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
		areas shall be separated					
	from other spaces by smoke resisting						
	partitions and doors in accordance with 8.4.						
	Doors shall be sel	•					
	_	and permitted to have					
		applied protective plates that					
	the door.	inches from the bottom of					
		and zone locations of					
		that are deficient in					
	REMARKS.	that are denoter in					
	19.3.2.1, 19.3.5.9						
	10.0.2.1, 10.0.0.0						
	Area Separation	Automatic Sprinkler N/A					
	•	-Fired Heater Rooms					
		er than 100 square feet)					
	, -	nance, and Paint Shops					
	· ·	ooms (exceeding 64					
	gallons)	,					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal	lons)					
	, ,	orage Rooms/Spaces					
	(over 50 square fe	eet)					
		classified as Severe					
	Hazard - see K32						
		on and interview, the facility	K 0	321	1: What corrective action(s)	will	04/12/2024
		f over 15 hazardous areas such			be accomplished for those		
		age rooms/spaces (over 50			residents found to have bee	n	
	square feet) were se	eparated from other spaces by			affected by the deficient		
	smoke resistant part	titions and doors. Doors shall			practice?		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COMP	LETED	
155077 B. WING 03/27	/2024	
CTREET ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 45 PE ACUMANA DR		
45 BEACHWAY DR		
ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDED'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) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
be self closing or automatic closing in accordance The Director of Maintenance has		
with 7.2.1.8. This deficient practice could affect installed a new self-closing door		
over 20 residents, staff and visitors.		
2: How other residents having		
Findings include: the potential to be affected by		
the same deficient practice will		
Based on observations with the Executive be identified and what		
Director and the Maintenance Director during a corrective action will be taken.		
tour of the facility from 9:15 a.m. to 10:15 a.m. on This deficient practice could affect		
· · · · · · · · · · · · · · · · · · ·		
03/27/24, resident sleeping room D1 had been over 20 residents, staff and visitors.		
'		
door to the room was not equipped with a self into place or what systemic		
closing or automatic closing device. Based on changes will be made to		
interview at the time of the observations, the ensure that the deficient		
Executive Director and the Maintenance Director practice does not recur?		
agreed the aforementioned hazardous area was The Director of Maintenance has		
not separated from other spaces with smoke been educated by the Executive		
resistant partitions and doors. Director on K321. hazardous		
areas such as combustible		
These findings were reviewed with the Executive storage rooms/spaces (over 50		
Director, the Maintenance Director and the square feet) must be separated		
Facilities Management Support during the exit from other spaces by smoke		
conference. resistant partitions and doors.		
Doors shall be self-closing or		
This deficiency was cited on 01/30/24. The facility automatic closing.		
failed to implement a systemic plan of correction 4: How the corrective action		
to prevent recurrence. will be monitored to ensure the		
deficient practice will not recur		
3.1-19(b) i.e., what quality assurance		
program will be put into place?		
The Director of Maintenance or		
designee will perform Daily audits		
Monday through Friday for 8		
weeks, then weekly for 4 weeks,		
then monthly for 3 Months totaling		
6 months.		
Results of these reviews will be		
presented by the Executive		
Director to the QAPI committee for		

155077 B. WING 03/27/2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION COMPONENT PLAN OF CORRECTION EACH COMPONENT EACH CORRECTION EACH CORRECTION EACH COMPONENT EACH EACH COMPONENT EACH COMPONENT EACH EACH EACH EACH EACH EACH EACH EACH	(X5) PLETION ATE
K 0353 SS=E Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.77, 9.7.8, and NFPA 25 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 3.3.54 defines a smooth ceiling as a continuous ceiling free from significant irregularities, Jumps, 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, staff, and visitors. Findings include: In the recommendations. In the recommendation and endity available. In the recommendation and evaluable. In the recommendations. In the recommendation and evaluable. In the recommendation and ev	2/2024

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/27/2024
	PROVIDER OR SUPPLIER OF INDIANAPOLIS	45 BEA	ADDRESS, CITY, STATE, ZIP COD ICHWAY DR IAPOLIS, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:15 a.m. to 10:15 a.m. on 03/27/24, 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 Executive Director and the Maintenance Director agreed the aforementioned opening in the C Wing ceiling did not maintain ceiling construction. These findings were reviewed with the Executive Director, the Maintenance Director and the Facilities Management Support during the exit conference. This deficiency was cited on 01/30/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance h been educated by the Executive Director on K353. All ceiling penetrations need to be propersealed to prevent the transfer of smoke and fire. 4: How the corrective action will be monitored to ensure the deficient practice will not recure, what quality assurance program will be put into placed The Director of Maintenance of designee will perform Daily automoday through Friday for 8 weeks, then weekly for 4 weeks then monthly for 3 Months total 6 months. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	rly of he cur e? or dits ks, aling e
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring 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, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 100 electrical fixtures were protected in accordance with LSC 19.5.1.1. NFPA 70, National Electric Code, 2011 Edition, Article 406.5, states receptacles shall be enclosed	K 0511	1: What corrective action(s) when the accomplished for those residents found to have been affected by the deficient practice?	

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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	A. BUILDING <u>01</u>		COMPLETED		
		155077	B. W	B. WING		03/27/2024		
				CERTE	A DDDDGG GITTY GT ATE TID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
	OF INDIANADOLIO			45 BEACHWAY DR				
ENVIVE	OF INDIANAPOLIS	•		INDIAN	IAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
	so that live wiring terminals are not exposed to contact. NFPA 70, 2011 Edition. Article 406.6,				The Director of Maintenance h	nas		
					replaced the broken GFCI out	let		
	Receptacle Facepla	tes (Cover Plates), requires			and replaced the missing outle	et		
	receptacle faceplate	es shall be installed so as to			covers.			
	completely cover th	ne opening and seat against the			2: How other residents having	ng		
	mounting surface.	This deficient practice could			the potential to be affected b	_		
	affect over 10 resid	ents, staff and visitors.			the same deficient practice v	- 1		
					be identified and what			
	Findings include:				corrective action will be take	n.		
	_				This deficient practice could a	ffect		
	Based on observation	ons with the Executive			all residents, staff and visitors			
	Director and the Ma	aintenance Director during a			3: What measures will be put			
	tour of the facility f	From 9:15 a.m. to 10:15 a.m. on			into place or what systemic			
	03/27/24, one of the	e two wall mounted electrical			changes will be made to			
	outlet boxes in the	C Wing nurse's station pantry			ensure that the deficient			
		posed the internal parts of the			practice does not recur?			
		oox was also not equipped with			The Director of Maintenance h	nas		
	a cover plate. Base	ed on interview at the time of			been educated by the Executi	ve		
	the observations, th	e Executive Director and the			Director on K511 all electrical			
	Maintenance Direct	tor agreed the aforementioned			fixtures must be protected in			
	electrical outlet box	was exposed and not			accordance with LSC 19.5.1.1	. to		
	protected.				prevent accidental access.			
					4: How the corrective action			
	These findings were	e reviewed with the Executive			will be monitored to ensure t	he		
	Director, the Mainte	enance Director and the			deficient practice will not red	ur		
	Facilities Managem	nent Support during the exit			i.e., what quality assurance			
	conference.				program will be put into place	e?		
					The Director of Maintenance of			
	This deficiency was	s cited on 01/30/24. The facility			designee will perform Daily au	dits		
	failed to implement	a systemic plan of correction			Monday through Friday for 8			
	to prevent recurrence	ce.			weeks, then weekly for 4 weel	κs,		
					then monthly for 3 Months total			
	3.1-19(b)				6 months.			
					Results of these reviews will b	e		
					presented by the Executive			
					Director to the QAPI committe	e for		
					further recommendations.			
K 0791	NFPA 101							
SS=F	Construction, Rep	pair, and Improvement						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> B. WING		COMPLETED			
155077		155077	B. W	ING		03/27/	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		(X5)	
PREFIX	(EACH DEFICIENCY 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	
Bldg. 01	Operati Construction, Rep Operations Construction, repa operations shall co means of egress in construction, repa inspected daily to used instantly in c compliance with N 18.7.9, 19.7.9, 4.6 Based on record rev interview; the facilit egress in adjoining of improvement operat LSC Section 19.7.9 and improvement op 4.6.10. LSC Section egress in any area u repair, or improvem for compliance with with NFPA 241, Sta Construction, Altera Operations. LSC So or portions of buildi occupied during cor or additions only wh and required fire pro and continuously m occupied or where a acceptable to the au in place. LSC Section obstructions or imput the case of fire or of	air, and Improvement air, and improvement comply with 4.6.10. Any n any area undergoing ir, or improvements shall be ensure its ability to be ase of emergency and IFPA 241.	K 0		1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance with construction is taking place. 2: How other residents having the potential to be affected by the same deficient practice with be identified and what corrective action will be take. This deficient practice could a all residents, staff and visitors. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance in been educated by the Execution Director on K791. We must ensure the means of egress in adjoining construction, repair a improvement operations composite with state regulations. 4: How the corrective action	n will while ng y will en. ffect t	04/12/2024	

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AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	1 1	JILDING	onstruction 01	(X3) DATE (COMPL 03/27/	ETED
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	Based on observation Director and the Matour of the facility from the facility of the facilities of the facili	ons with the Executive aintenance Director during a from 9:15 a.m. to 10:15 a.m. on leading to the Main Dining a undergoing facility wing, B Wing, C Wing and D were mostly completed. All as an exit with an exit sign. at the time of the executive Director stated facility in the Spring of 2023. Based in the Maintenance Director fanagement Support from 10:15 on 03/27/24, daily egress check not available for review. at the time of record review, gement Support agreed daily mentation was not available for of the survey. The reviewed with the Executive enance Director and the ent Support during the exit as cited on 01/30/24. The facility a systemic plan of correction		TAG	will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. The Director of Maintenance of designee will perform Daily aud Monday through Friday for 8 weeks, then weekly for 4 week then monthly for 3 Months tota 6 months. Results of these reviews will be presented by the Executive Director to the QAPI committee further recommendations.	ur e? r dits ss, ling	DATE
K 0914 SS=E Bldg. 01	Testing Electrical Systems Testing Hospital-grade red locations and whe anesthesia is adm	s - Maintenance and s - Maintenance and ceptacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing.					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 03/27/2024		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
ENVIVE	OF INDIANAPOLIS		INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
IAG			TAG		DATE		
	these locations ar	e tested at intervals not					
	exceeding 12 mor	nths. Line isolation monitors					
	, ,	are tested at intervals of					
	1	to 1 month by actuating					
		h per 6.3.2.6.3.6, which					
		ual and audible alarm. For utomated self-testing, this					
		formed at intervals less					
	· ·	2 months. LIM circuits are					
	•	.2 after any repair or					
	renovation to the	electric distribution system.					
	Records are main	tained of required tests and					
	associated repairs						
	_	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)	view, observation and	K 0914	1. What corrective action(a)	will 04/12/2024		
	interview; the facili		K 0914	1: What corrective action(s) be accomplished for those	WIII 04/12/2024		
		electrical receptacles that failed		residents found to have been	n		
		of over 60 resident rooms were		affected by the deficient			
	_	tal-grade receptacles. NFPA		practice?			
	70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four			The Director of Maintenance h	nas		
				replaced the mentioned			
				receptacles with hospital grad			
		receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any		2: How other residents having			
		three. All receptacles, whether		the potential to be affected by the same deficient practice v	-		
		be listed "hospital grade" and		be identified and what	(VIII		
		not intended that there be a		corrective action will be take	en.		
		placement of existing		This deficient practice could a			
	_	receptacles. It is intended,		six (6) residents, staff and visi			
		nospital grade receptacles be		3: What measures will be put			
		tal grade receptacles upon		into place or what systemic			
		, 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?	200		
I			1	The Director of Maintenance h	ias I		

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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 SU COMPLET 03/27/20	ΓED				
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BE	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
	SUMMARY (EACH DEFICIENT REGULATORY OF Findings include: Based on review of documentation date Director, the Maintent review from 9:10 a electrical receptacle B1, B4 and B8 fails replaced. Based on review, the Maintent electrical receptacle replaced but he cour replaced with hospit on observations with and the Corporate Maintent electrical receptacle replaced but he cour replaced with hospit on observations with and the Corporate Maintent electrical receptacle resident sleeping row hospital-grade. Based on observations, the Director agreed the three resident sleeping row hospital-grade. Based on observations and the Maintent electrical receptace the Maintent electrical recepta	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION "Receptacle Tests - Annual" Id 10/01/23 with the Executive lenance Director and the lance Director during record land to 12:45 p.m. on 01/30/24, les in resident sleeping Room led annual testing and were linterview at the time of record lance Director stated the les which failed 10/01/23 were ld not ensure that they were ltal-grade receptacles. Based let the Maintenance Director Maintenance Director during a lift of 10 p.m. to 3:50 p.m. on leal receptacle locations in loms B1, B4 and B8 were not led on interview at the time of lee Corporate Maintenance line receptacle locations in the ling rooms were not lons with the Executive laintenance Director during a lift of 10:15 a.m. on leal receptacle locations in loms B1, B4 and B8 were not lons with the Executive laintenance Director during a lift of 10:15 a.m. on leal receptacle locations in loms B1, B4 and B8 were not lead on interview at the time of lea Executive Director and the lor agreed the receptacle locations receptacle locations in long later the lift of least later the locations in long later the lift of later the locations in long later the lift of later the locations in long later the l	45 BE	ACHWAY DR	executive changing ent areas, pital grade ction sure the ot recurance oplace? ence will the audit and rade eard. This the Tels minders it will be tive nmittee for	(X5) COMPLETION DATE			
	Director, the Maint	e reviewed with the Executive enance Director and the nent Support during the exit							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING D. NING		(X3) DATE SURVEY COMPLETED		
155077			B. WING		03/27/2024		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	Í	
	1	s cited on 01/30/24. The facility a systemic plan of correction ce.					
K 9999							
Bldg. 01			K 9999	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Feand State Law. The Plan of Correction is submitted to rest to the allegation of noncomplicited during the revisit survey conducted March 27, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliant as of April 12, 2024 provider respectfully requests desk review with paper compliance to establish that the provider is in substantial compliance.	ment facts th on . The d and deral pond ance	1	

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