STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/30/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/27/24 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this PSR survey to the Emergency Preparedness survey, Envive of Indianapolis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 96. Quality Review completed on 04/01/24	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the revisit survey conducted March 27, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 12, 2024 **provider respectfully requests desk review with paper compliance** to establish that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/30/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/27/24 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At this PSR survey, Envive of Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Wing. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 04/01/24		to the allegation of noncompliance cited during the revisit survey conducted March 27, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 12, 2024 **provider respectfully requests desk review with paper compliance** to establish that the provider is in substantial compliance.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure fire resistance rating labels on 1 of	K 0100	**1: What corrective action(s) will be accomplished for those**	10/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12 cross corridor door sets were not painted per LSC, Section 4.6.12.3. LSC, Section 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors. Findings include: 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, the fire resistance rating label on the south door in the cross corridor door set in the A Wing by Room 10 was painted. The north door in the cross corridor door set was equipped with a 3-hour fire resistance rating label. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the fire resistance rating label on the door in the aforementioned cross corridor door set was painted. 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)		**residents found to have been affected by the deficient practice?** Waiver filed. Waiver attached. **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 20 residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K100. All smoke and fire doors must have a UL rating plate and must be legible. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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 further recommendations.	
K 0211 SS=E	NFPA 101 Means of Egress - General			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: 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, furniture was stored in the east exit vestibule of the C Wing which interfered with exit access. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 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.	K 0211	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has removed all furniture/ obstructions from the C wing vestibule. **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 changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K211 maintaining a clear path of egress for emergency evacuation purposes. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		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 further recommendations.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 doors was readily accessible for residents without a clinical diagnosis requiring specialized	K 0222	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors. Findings include: 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, the corridor door set at the entrance to the D Wing from the center lobby was equipped with magnetic locking devices when the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad but the code was not posted. Based on interview at the time of the observations, the Executive Director stated the D Wing houses residents with the clinical diagnosis to be in a secure wing but agreed the code to release the door set to open by the entrance to the D Wing was not posted at the door set. 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)		**practice?** The Maintenance Director has placed the code next to each keypad. **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 20 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K222 maintaining a clear path of egress for emergency evacuation purposes. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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 further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 15 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall	K 0321	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: 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, resident sleeping room D1 had been converted to a combustible supply storage room as part of the facility renovation. The corridor door to the room was not equipped with a self closing or automatic closing device. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces with smoke resistant partitions and doors. 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)		The Director of Maintenance has installed a new self-closing door closer to the door. **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 20 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K321. hazardous areas such as combustible storage rooms/spaces (over 50 square feet) must be separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			further recommendations.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 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, staff, and visitors. Findings include:	K 0353	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has installed the missing smoke detector. **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 all residents, staff and visitors. **3: What measures will be put into place or what systemic**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE 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 has been educated by the Executive Director on K353. All ceiling penetrations need to be properly sealed to prevent the transfer of smoke and fire. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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 further recommendations.	
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, 9.1.1, 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) will be accomplished for those residents found to have been affected by the deficient practice?**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	so that live wiring terminals are not exposed to contact. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over 10 residents, staff and visitors. Findings include: 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, one of the two wall mounted electrical outlet boxes in the C Wing nurse's station pantry was loose which exposed the internal parts of the outlet. The outlet box was also not equipped with a cover plate. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned electrical outlet box was exposed and not protected. 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)		The Director of Maintenance has replaced the broken GFCI outlet and replaced the missing outlet covers. **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 all residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K511 all electrical fixtures must be protected in accordance with LSC 19.5.1.1. to prevent accidental access. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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 further recommendations.	
K 0791 SS=F	NFPA 101 Construction, Repair, and Improvement			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Operati Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 Based on record review, observation and interview; the facility failed to ensure the means of egress in adjoining construction, repair and improvement operations comply with LSC 19.7.9.1. LSC Section 19.7.9.1 states construction, repair, and improvement operations shall comply with 4.6.10. LSC Section 19.7.9.2 states the means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with 7.1.10.1 and shall also comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations. LSC Section 4.6.10.1 states buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place. LSC Section 7.1.10.1 states the means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0791	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance will check and document for clear egress in construction areas while construction is taking place. **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 all residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K791 We must ensure the means of egress in adjoining construction, repair and improvement operations comply with state regulations. **4: How the corrective action**	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE 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, the wing leading to the Main Dining Room was currently undergoing facility renovation. The A wing, B Wing, C Wing and D Wing renovations were mostly completed. All wings were marked as an exit with an exit sign. Based on interview at the time of the observations, the Executive Director stated facility renovations began in the Spring of 2023. Based on record review with the Maintenance Director and the Facilities Management Support from 10:15 a.m. to 11:45 a.m. on 03/27/24, daily egress check documentation was not available for review. Based on interview at the time of record review, the Facilities Management Support agreed daily egress check documentation was not available for review at the time of the survey. 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)		**will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance 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 further recommendations.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 3 of over 60 resident rooms were replaced with hospital-grade receptacles. NFPA 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 receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 6 residents and staff.	K 0914	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has replaced the mentioned receptacles with hospital grade. **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 six (6) residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has	04/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on review of "Receptacle Tests - Annual" documentation dated 10/01/23 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, electrical receptacles in resident sleeping Room B1, B4 and B8 failed annual testing and were replaced. Based on interview at the time of record review, the Maintenance Director stated the electrical receptacles which failed 10/01/23 were replaced but he could not ensure that they were replaced with hospital-grade receptacles. 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, all electrical receptacle locations in resident sleeping rooms B1, B4 and B8 were not hospital-grade. Based on interview at the time of the observations, the Corporate Maintenance Director agreed the receptacle locations in the three resident sleeping rooms were not hospital-grade. 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, all electrical receptacle locations in resident sleeping rooms B1, B4 and B8 were not hospital-grade. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the receptacle locations in the three resident sleeping rooms were not hospital-grade. These findings were reviewed with the Executive Director, the Maintenance Director and the Facilities Management Support during the exit conference.		been educated by the Executive Director on K914 When changing out receptacles in resident areas, it is required to use hospital grade receptacle. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform an annual outlet audit and replaced with Hospital grade receptacles moving forward. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 9999 Bldg. 01	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)	K 9999	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the revisit survey conducted March 27, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 12, 2024 **provider respectfully requests desk review with paper compliance** to establish that the provider is in substantial compliance.	04/12/2024