STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. BUILDING -- B. WING	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/08/24 Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970 At this Emergency Preparedness survey, Envive of Hartford City was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 78 and had a census of 30 at the time of this survey. Quality Review completed on 01/10/24	E 0000	Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 26, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/08/24 Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970 At this Life Safety Code survey, Envive of Hartford City was found not in compliance with Requirements for Participation in	K 0000	Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 26, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Jackman	HFA	01/21/2024

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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	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 VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the 100 Hall. The facility has a capacity of 78 and had a census of 30 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/10/24			
K 0100 SS=E Bldg. 02	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 maintain latching hardware on 1 of 5 smoke barrier doors. LSC 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 staff and up to 15 residents. Findings include:	K 0100	**K100** General Requirements - Other CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance repaired the latch on the door immediately. **Compliance Date** 1/10/24 The Director of Maintenance has	01/10/2024

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	Based on observation with the Maintenance Director (MD) on 01/08/24 at 01:12 p.m., the set of smoke barrier doors on 100 Hall were provided with latching hardware but failed to close and latch when tested. Based on interview at the time of observation, the MD agreed the smoke doors were equipped with latching devices, but the doors did not properly close and latch when tested. The doors were repaired at the time of observation. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)		been educated by the Executive Director on K100. All smoke and fire doors shall shut and latch on their own power to prevent smoke and fire from spreading. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months. 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. This deficient practice could affect up to 15 residents, staff, and visitors.	
K 0300 SS=E Bldg. 02	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms on 100 Hall was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and	K 0300	**K300** Protection - Other CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance replaced all battery-operated smoke detectors with new devices. The installation date was placed on all newly installed	01/22/2024

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	tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors on 100 Hall. Findings include: Based on records review with the Maintenance Director (MD) and Administrator on 01/08/24 at 12:45 p.m., no documentation for battery replacement of resident room battery operated smoke alarms was available for review. Based on interview at the time of review, the MD stated there was no documentation available to show when the last battery replacement of the battery operated smoke detectors was completed. A battery operated smoke detector was removed from a resident room. The manufacturers instructions stated that the battery was good for 10 years after installation but there was no installation date noted. The manufacturers date was March 2012. Using the manufacturers date for reference, the battery operated smoke detector should have been replaced in March 2022. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		detectors. **Compliance Date** 1/22/24 The Director of Maintenance has been educated by the Executive Director on K300. All battery-operated smoke detectors must be checked weekly for operations and replaced following manufactures recommendations. (10 years from install date) The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months. 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. This deficient practice could affect all residents, staff, and visitors.	
K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of			

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	Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain 1 of 3 corridor doors for cooking facilities that serve 30 or more residents to ensure cooking facilities are protected and not open to the corridor. This deficient practice could affect 10 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/08/24 at 01:25 p.m, the entrance corridor door to the kitchen did not close and self latch into the frame when tested. Based on interview at the time of the observation, the Maintenance Director agreed the corridor door to the kitchen did not close and self latch into the frame when tested. This finding was reviewed with the Administrator and MD at the exit conference.	K 0324	**K324** waiver filed.	07/31/2024

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K 0355 SS=D Bldg. 02	3.1-19(b) NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the maintenance shop. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) and Administrator on 01/08/24 at 01:15 p.m., an ABC portable fire extinguisher in the maintenance shop was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor and stated it is a spare extinguisher. The fire extinguisher was secured at the time of observation. This finding was reviewed with the Administrator and MD at the exit conference.	K 0355	**K355** Portable Fire Extinguishers CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has removed the not-in-use unsecured fire extinguishers. **Compliance Date** 1/16/24 The Director of Maintenance has been educated by the Executive Director on K355 All extinguishers must be installed and secured per NFPA standards. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months. 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. This deficient practice was not in the resident care area but could affect staff in the maintenance shop.	01/16/2024

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	3.1-19(b)			
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 5 residents in the vicinity of the janitor closet. Findings include: Based on observation with the Administrator and Maintenance Director (MD) on 01/08/24 at 01:10 p.m., the corridor door to janitor closet would not close and latch into the frame when tested. Based on interview at the time of observation, the MD agreed the corridor door to the janitor closet would not close and latch into the door frame. The door was repaired at the time of observation. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)	K 0363	**K363** Corridor - Doors CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance fixed the janitor door latch immediately. **Compliance Date** 1/16/24 The Director of Maintenance has been educated by the Executive Director on K363 All doors with closers shall close and latch on their own power. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months. 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. This deficient practice could affect 5 residents in the vicinity of the janitor closet.	01/16/2024
K 0372 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

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	Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 10 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 01/08/24 at 02:20 p.m., the following unsealed penetrations were discovered: a) In the attic above the smoke wall by room 119 there were three 1" by 4" inch unsealed holes with conduit passing through. b) In the attic above the smoke wall there by room	K 0372	**K372** Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has applied fire caulk to all penetrations. **Compliance Date** 1/16/24 The Director of Maintenance has been educated by the Executive Director on K372 All firewall penetrations shall be filled with NFPA approved fire caulk to prevent smoke and fire from spreading. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3 months. 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	01/16/2024

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	119 was a 16" by 4' unsealed cutout in the drywall. Based on interview at the time of observation, the Maintenance Director (MD) agreed the aforementioned smoke wall contained unsealed penetrations. This finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)		further recommendations. This deficient practice could affect staff and at least 10 residents in two smoke compartments.	
K 0511 SS=E Bldg. 02	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 3 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.	K 0511	**K511** Utilities - Gas and Electric CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has replaced all non-functioning GFCI. **Compliance Date** 1/26/24 The Director of Maintenance has been educated by the Executive Director on K511 GFCI's are required when within 6 feet of a wet location. These GFCI's must trip, and function as intended. The Director of Maintenance will perform daily reviews(M-F) for 4 weeks, Weekly reviews for 2 months, monthly reviews for 3	01/26/2024

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	(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used.		months. 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. This deficient practice has the potential to affect staff in the kitchen, pantry, and staff lounge.	

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	NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the kitchen, pantry and staff lounge. Findings include: Based on observation on 01/08/24 between 01:20 p.m. and 01:40 p.m. during a tour of the facility with the Administrator and Maintenance Director (MD), there were two electric receptacles within three feet of the sink in the kitchen that did not trip when tested. One electric receptacle was provided with a ground fault circuit interrupter (GFCI), the other was not. In the pantry there was an electrical receptacle within 4' of the sink that was not GFCI protected (it was a regular electrical receptacle that did not trip when tested). In the staff lounge there was an electrical receptacle within 3' of the sink that was GFCI but did not trip when tested These finding were confirmed by the MD at the time of observation. These findings were reviewed with the Administrator and MD at the exit conference. 3.1-19(b)			