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	12/06/2024

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 0000 Bldg. 01	An investigation of Complaint Number IN00447597 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number IN00447597 - A Federal/State deficiency related to the allegation was cited at K100. Survey Date: 12/06/24 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Complaint 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 105 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	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 to the allegation of noncompliance cited during the Complaint Survey conducted December 6, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 20, 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
Gregory S Otter	Executive Director	12/20/2024

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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	detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 12/09/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on record review, observation and interview; the facility failed to ensure fire resistance rating labels on 1 of 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 at 9:55 a.m. on 12/06/24, the fire resistance rating label on the south door in the cross corridor door set in the A Wing by Room 10 was painted and not legible. 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 stated replacement doors have been on order and are scheduled to be replaced with doors equipped with fire resistance rating labels on 12/20/24. The Executive Director provided e-mail documentation from the door replacement coordinator dated 12/05/24 stating "we should see the doors near the end of next week, so we are tentatively keeping the installation date of December 20th". Review of "Life Safety Code Waiver Request" documentation dated 04/10/24 with the Executive Director for the south door fire resistance rating label being painted indicated the waiver request	K 0100	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** New doors with the proper fire resistance rating label in the cross corridor door set in the A Wing by Room 10 have been installed. **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.	12/20/2024

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	was from 03/27/24 through 10/31/24. Based on interview at the time of review of the waiver request on 12/06/24, the Executive Director stated Corporate staff was to work with IDOH to extend the waiver past 10/31/24 but agreed the waiver extension was never followed through and agreed the fire resistance rating label on the door in the aforementioned cross corridor door set was still not legible at the time of the 12/06/24 revisit. These findings were reviewed with the Executive Director during the exit conference. This deficiency was cited on 01/30/24 and on 03/27/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) This federal tag relates to complaint number IN00447597.		**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 monthly review X6. Results of these reviews will be presented by the Director of Maintenance to the QAPI committee for further recommendations.	