Shanika Parker

PRINTED: 04/09/2025 FORM APPROVED OMB NO. 0938-039

04/07/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING		(X3) DATE SURVEY  COMPLETED  03/05/2025	
	PROVIDER OR SUPPLIER		45 E	EET ADDRESS, CITY, STATE, ZIP COD BEACHWAY DR NANAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
E 0000	conducted by the In accordance with 42 Survey Date: 03/05. Facility Number: 0 Provider Number: 100. At this Emergency of Indianapolis was Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 184 the survey, the censure Quality Review cordinates the survey of Indianapolis was Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 184 the survey, the censure Indianapolis was Indianapolis was Emergency Prepare Medicare and Medianapolis was Emergency Prepare Medicare and Medianapolis was Emergency Prepare Medicare and Medianapolis was Indianapolis was Emergency Prepare Medicare and Medianapolis was Indianapolis was Emergency Prepare Medicare and Medianapolis was Indianapolis was	00032 155077 273330  Preparedness survey, Envive found not in compliance with dness Requirements for caid Participating Providers FR 483.73.  Certified beds. At the time of the was 111.  Impleted on 03/10/25 42 CFR Subpart 483.73 is NOT	E 0000		
E 0039 SS=F Bldg	Based on record reversal failed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community	6.54(d)(2), 418.113(d)( rements  view and interview, the facility dercises to test the emergency der year, including drills using the emergency C facility must do the  annual full-scale exercise that	E 0039  E039 EP Testing Requirements 1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?  The Maintenance director, along with the Executive Director, will		vill n
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	TITLE	(X6) DATE	

Any defiency statement 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 disclodays 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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RN, DNS

ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPI	LETED
		155077	B. W	ING		03/05	/2025
				CED FEE	ADDRESS COMMA STATE SID COD		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
		_			ACHWAY DR		
ENVIVE	OF INDIANAPOLIS	5		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWING BY AN OF CORRECTION	ECTION (X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	A T.C.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	facility-based func	tional exercise.			host a facility tabletop drill tha	nt	
	1	ty experiences an actual natural			includes all department direct		
		gency that requires activation					
		plan, the LTC facility is exempt			The maintenance director will	ll also	
		next required full-scale			perform a full-scale building of		
		or individual, facility-based			on the missing resident was		
	full-scale functional exercise for 1 year following the onset of the actual event.  (ii) Conduct an additional exercise that may include, but is not limited to the following:  a. A second full-scale exercise that is community-based or an individual, facility-based				require our staff to activate th	е	
					emergency plan		
	functional exercise	).			2. How other residents have	the	
	b. A mock disaster	drill; or			potential to be affected by the	ne	
	c. A tabletop exerc	ise or workshop that is led by a			same deficient		
	facilitator that incl	udes a group discussion, using			practice will be identified an	d	
	a narrated, clinical	ly-relevant emergency scenario,			what corrective action will b		
	and a set of problem	m statements, directed			taken?		
	messages, or prepa	ared questions designed to					
	challenge an emerg	gency plan.			This deficient practice could a	affect	
	(iii) Analyze the L'	TC facility's response to and			all residents, staff and visitors		
	maintain document	tation of all drills, tabletop			A facility tabletop drill that		
	exercises, and eme	rgency events, and revise the			included all directors was		
	LTC facility's eme	rgency plan, as needed in			completed.		
	accordance with 42	2 CFR 483.73(d)(2). This					
	deficient practice of	could affect all occupants.			A full-scale building drill on t	he	
					missing resident will require of	our	
	Findings include:				staff to activate the emergence	:y	
					plan		
	Based on review or	f "Emergency Operations Plan"					
	documentation date	ed 12/17/24 with the					
	Maintenance Direc	etor and the Field Maintenance					
	Supervisor during	record review from 8:55 a.m. to					1
	12:00 p.m. on 03/0	5/25, documentation for a					
	full-scale exercise	that is community-based or an					
	individual, facility-	-based functional exercise					
	within the most rec	cent two year period was not			3. What measures will be		
	available for review	w. The facility also did not			putting place or what syster	nic	
document any actual natural or man-made				changes will be made to			

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emergency that required activation of the

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ensure that the deficient

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	OF CORRECTION TO THE STORY OF CORRECTION TO THE		JILDING	CONSTRUCTION (X3) DATE SURVEY  COMPLETED 03/05/2025		ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  practice does not occur?  The Director of Maintenance of educated by the Executive Director on E039 EP Testing Requirements. Two disaster disave been added to the Tels building system to be performed on an annual requirement.	vas rills	(X5) COMPLETION DATE
					4. How the corrective action will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place.  This Tels task will be reviewed the Safety/QAPI committee. Lead by the Executive Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved.  5. Date of Completion:  4-10-25	e? I by r r I	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			JILDING	nstruction 01	COM	E SURVEY PLETED 5/2025	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS			45 BEA	DDRESS, CITY, STATE, ZIP COE CHWAY DR APOLIS, IN 46224	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
Bldg. 01	Licensure Survey we Department of Hea 483.90(a).  Survey Date: 03/05  Facility Number: Of Provider Number: AIM Number: 100  At this Life Safety Indianapolis was for Requirements for Periodical Medicare/Medicaid Life Safety From Finational Fire Protes Life Safety Code (In Health Care Occup)  This one story facility are III (211) consistent open to the corridor the C Wing. The fact with smoke detection open to the corridor the C Wing. The fact smoke detectors in rooms. The facility a census of 111 at the All areas where resemble were sprinklered. The fact with smoke detectors in rooms. The facility and census of 111 at the All areas where resemble were sprinklered. The fact were sprinklered and the fact which we were sprinklered to the corridor of the corridor that the fact where the fact which we were sprinklered. The fact which we were sprinklered to the f	200032 155077 273330 Code survey, Envive of und not in compliance with	K 0	000			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/05/2025	
	PROVIDER OR SUPPLIER		45	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 1. Based on observa	ation and interview, the facility	K 0222	K222 Egress Doors		04/10/2025
	failed to ensure the 10 doors was readily without a clinical di security measures. of egress shall not b lock that requires the egress side unless of 19.2.2.2.4. LSC Seprovided, shall not not special knowledge the egress side. Doo be permitted in accordeficient practice constaff and visitors.  Findings include:  Based on observation Director and the Fie	means of egress through 2 of y accessible for residents agnosis requiring specialized Doors within a required means e equipped with a latch or e use of a tool or key from the therwise permitted by LSC ection 7.2.1.5.3 states locks, if require the use of a key, a tool, go or effort for operation from or-locking arrangements shall ordance with 19.2.2.2.5.2. This ould affect over 20 residents,	K 0222	1 What corrective actio be accomplished for the Residents found to have affected by the deficient practice?  1 The Maintenance It has posted the code at the entrance door and to the door entrance.  2 Lock was removed room B22  2. How other residents potential to be affected same deficient practice will be identified.	ose ye been ht  Director the main e D wing  d from  have the by the	04/10/2025
	p.m. on 03/05/25, the entrance lobby was an exit sign. The domagnetic locking downen the door set was the doors but the code with the code with the corridor door set the D Wing from the marked as a facility corridor door set was locking devices to k fully closed position released to open by	facility from 12:00 p.m. to 1:50 ne corridor door set at the main marked as a facility exit with por set was equipped with exices to keep the doors closed ras in the fully closed position. The released to open by the keypad by the entrance was not posted at the keypad. The serving as the entrance to be center lobby was also exit with an exit sign. The this also equipped with magnetic the ep the door set was in the function. The door set could be entering a code at the keypad to posted. Based on interview		what corrective action taken?  1 This deficient practaffect over 20 residents, visitors in the Facility The coposted by door immedia 2 This deficient practaffect 2 residents in the sleeping room. The lock removed.  3. What measures will putting place or what schanges will be made to	tice could staff and ode was tely tice could resident was be ystemic	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155077	B. W	ING		03/05/2025	
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DI AN OE CODDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	at the time of the ob	oservations, the Maintenance			ensure that the deficient		
	Director and the Fie	eld Maintenance Supervisor			practice does not occur?		
	stated only the D Wing houses residents with the						
	_	be in a secure wing but					
	agreed the code to release the door set to open by						
		D Wing and at the door set for			The Director of Maintenance v	vas	
		obby was not posted at the			educated by the Executive		
	keypad.				Director on K222 Egress door		
					Doors in Egress Path must me	eet	
	These findings were reviewed with the Executive				CMS codes for safety evacuat	rion	
	Director, the Maintenance Director and the Field				if needed. Testing of egress		
	Maintenance Supervisor during the exit				doors have been added to the		
	conference.				Tels building system.		
	3.1-19(b)						
	3.1 15(0)				4. How the corrective action		
	2. Based on observa	ation and interview, the facility			will be monitored to ensure t	he	
		f over 50 corridor doors to			deficient practice will not red		
		oms doors were arranged such			i.e., what quality assurance		
		e clients in an emergency if the			program will be put into place	e?	
		ed. This deficient practice					
		idents in resident sleeping			This Tels task will be reviewed	d by	
	Room B22.				the Safety/QAPI committee		
					Lead by the Executive Directo	r	
	Findings include:				and/or Maintenance Director.		
					The results will be reviewed fo	or	
	Based on observation	ons with the Maintenance			patterns, trends and continued	1	
	Director and the Fie	eld Maintenance Supervisor			recommendations for process		
	during a tour of the	facility from 12:00 p.m. to 1:50			monitoring and improvement l	<i>Jntil</i>	
	p.m. on 03/05/25, th	ne corridor door to resident			100% compliance is achieved		
	sleeping Room B22	was provided with a lock on					
	the door handle whi	ich required a key to unlock			5. Date of Completion:		
	the door from the co	orridor side of the door. The					
	lock on the door has	ndle was equipped with a			4-10-25		
	thumb twist device	on the room side of the door.					
	The door was not lo	ocked at the time of the					
	observations but the	e locking device was operable.					
	Based on interview	at the time of the					
	observations, the M	aintenance Director and the					
	Field Maintenance	Supervisor asked staff in the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2025		
ENVIVE	ROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=E Bldg. 01	should it become lo acknowledged a key unlock the door. Bathe observations, the the Field Maintenar was used as a storagrenovations and had replace the door har at the time of the su.  These findings were Director, the Maintenance Superconference.  3.1-19(b)  NFPA 101  Fire Alarm System Maintenance 1. Based on record interview; the facilitalarm systems was a 9.6.1.3. LSC 9.6.1. be installed, tested, with NFPA 70, National Fire Aledition, Section 14. performed in according Frequencies. Table alarm system smoke tested annually. Sea all inspections, testi provided that including requested in Figure	was readily available to used on interview at the time of the Maintenance Director and use Supervisor stated the room the room during recent facility. If the Maintenance Assistant addle with a non-locking device revey.  The reviewed with the Executive enance Director and the Field visor during the exit.  The Testing and the Field visor during the exit of 1 fire maintained in accordance with 3 requires a fire alarm system to and maintained in accordance ional Electrical Code and NFPA tharm Code. NFPA 72, 2010 the A.5 requires testing shall be alance with Table 14.4.5 Testing 14.4.5 at 15.(h) states fire the detectors shall be functional cition 14.6.2.4 states a record of the gand maintenance shall be also all applicable information 14.6.2.4. This deficient it over 20 residents, staff and	K 0345	K345 Fire Alarm System _ Te and Maintenance  1 What corrective action(s) to be accomplished for those Residents found to have be affected by the deficient practice?  Elwood Fire Protection has now completed the sensitive testing on smoke detectors in rooms C11 througe C19  2. How other residents have potential to be affected by the same deficient	Will en ion tivity gh

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WI		<u>-</u>	03/05/	
		100017			_	00/00/	2020
NAME OF E	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TO HAVE OF T	RO VIDER OR SOLVEIEL	•		45 BEA	CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					practice will be identified and	b	
	Based on review of	the fire alarm system			what corrective action will be	9	
	inspection contractor's "Fire Alarm Report"				taken?		
	documentation dated 05/15/24 and 11/04/24 with						
	the Maintenance Director and the Field				This deficient practic	e	
	Maintenance Super	visor during record review			could affect over 20 residents,		
	from 8:55 a.m. to 1:	2:00 p.m. on 03/05/25, smoke			staff and visitors in the C		
	detector testing doc	umentation within the most			Wing. Elwood Frie		
		h period for smoke detectors			Protection has completed the		
	installed in resident	sleeping rooms C11 through			sensitivity testing.		
		ole for review. The 05/15/24			, ,		
	and 11/04/24 testing	g documentation did include					
	six areas in the C Wing but it did not include the				3. What measures will be		
		oms. Based on interview at			putting place or what system	nic	
		eview, the Field Maintenance			changes will be made to		
		ire alarm system smoke			ensure that the deficient		
		umentation for resident			practice does not occur?		
		through C19 within the most			produce does not occur.		
		h period was not available for					
		bservations with the					
		for and the Field Maintenance			The Director of Maintenance v	v2c	
		tour of the facility from 12:00			educated by the Executive	vas	
		n 03/05/25, fire alarm system			-		
		installed in resident sleeping	Director on K345 Sprinkler				
	rooms C11 through				System - Mtn and Testing.	tina	
	100ms C11 tilrough	C1).			Smoke detector sensitivity tesi	•	
	Those findings	a ravious d with the Evenutive			is required every 2 years. This has been added to the Tels	ıdSK	
		e reviewed with the Executive					
		enance Director and the Field			building system for required tir	riely	
	-	visor during the exit			testing.		
	conference.						
	3.1-19(b)						
	2. Based on record	review, observation and					
		ty failed to ensure 1 of 1 fire			4. How the corrective action		
		maintained in accordance with			will be monitored to ensure t	he	
	-	3 requires a fire alarm system to			deficient practice will not rec		
		and maintained in accordance			i.e., what quality assurance		
		ional Electrical Code and NFPA			program will be put into plac	e?	
		larm Code. NFPA 72, 2010			g so par piao		

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		JILDING	onstruction 01	(X3) DATE COMPL 03/05/	ETED	
	OF PROVIDER OR SUPPLIED E OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD  45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Edition, Section 14 performed in accor Frequencies. Secti- shall be checked w Section 14.4.5.3.2 s checked every alter otherwise permitted 14.4.5.3.5 states sm found to have a sen marked sensitivity recalibrated or be r a record of all inspe- maintenance shall be applicable informat 14.6.2.4. This defin 20 residents, staff a  Findings include:  Based on review of inspection contract documentation date Maintenance Direct Supervisor during in 12:00 p.m. on 03/0 testing documentat installed in resident C19 was not availate sensitivity testing of areas in the C Wing resident sleeping ro the time of record in Supervisor agreed se documentation for detectors installed in through C19 within period was not avail observations with t the Field Maintenant	A.5 requires testing shall be dance with Table 14.4.5 Testing on 14.4.5.3.1 states sensitivity ithin 1 year after installation. states sensitivity shall be mate year thereafter unless 1 by compliance with 14.4.5.3.3. noke detectors or smoke alarms stitivity outside the listed and range shall be cleaned and eplaced. Section 14.6.2.4 states ections, testing and be provided that includes all the provided that include the provided that include the provided that the provided that include the provided that includes the p			This Tels task will be reviewe the Safety/QAPI committee Lead by the Executive Director. The results will be reviewed for patterns, trends and continue recommendations for process monitoring and improvement 100% compliance is achieved.  5. Date of Completion: 4-10-25	d by or or d s Until		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155077	B. Wl	NG		03/05/	2025
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		•	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, 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 APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	resident sleeping roo	noke detectors are installed in oms C11 through C19.					
Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.							
	3.1-19(b)						
K 0353	NFPA 101						'
SS=F Bldg. 01	Sprinkler System -	- Maintenance and Testing					
	facility failed to may systems in accordant requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Waystems. NFPA 25 states the property or representative shall or impairments that inspection, test and standard. Correction performed by qualified contractor records shall be made and maintenance of shall be made availaging jurisdiction upon records.	Based on record review and interview, the cility failed to maintain automatic sprinkler stems in accordance with NFPA 25. LSC 9.7.5 quires all sprinkler systems shall be inspected, sted, and maintained in accordance with NFPA 5, Standard for the Inspection, Testing, and faintenance of Water-Based Fire Protection systems. NFPA 25, 2011 Edition, Section 4.1.4.1 attes the property owner or designated presentative shall correct or repair deficiencies impairments that are found during the spection, test and maintenance required by this andard. Corrections and repairs shall be erformed by qualified maintenance personnel or qualified contractor. NFPA 25, 4.3.1 requires cords shall be made for all inspections, tests, and maintenance of the system components and teall be made available to the authority having risdiction upon request. This deficient practice buld affect all residents, staff and visitors in the		n ator et the e	04/10/2025		
	Findings include:  Based on review of inspection contractor	the sprinkler system or's "Sprinkler System Test			what corrective action will be taken?  This deficient practice could at all residents, staff and visitors the	ffect in	
	Report documental	tion dated 11/04/24 and	1		facility. Elwood Fire Protection	rıas	'

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155077 B. WING 03/05/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 02/12/25 with the Maintenance Director and the repaired the issues. Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, deficiencies were noted for the facility's two dry 3. What measures will be sprinkler systems during the inspection for the putting place or what systemic facility. The "Comments" section of the 11/04/24 changes will be made to and 02/12/25 sprinkler system inspection reports ensure that the deficient stated "The accelerator is not turned on". Based practice does not occur? on interview at the time of record review, the Field Maintenance Supervisor stated he contacted the sprinkler system inspection contractor at the time of the survey who stated they thought the The Director of Maintenance was educated by the Executive accelerators were functioning but agreed it could not be assured each of the two accelerators were Director on K353 Sprinkler functioning properly. System - Mtn and Testing. Sprinkler systems are required to These findings were reviewed with the Executive be tested timely and any Director, the Maintenance Director and the Field deficiencies fixed promptly. This Maintenance Supervisor during the exit task has been added to the Tels conference. building system for required timely testing. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was inspected and tested annually. NFPA 25, 2011 Edition, the Standard for 4. How the corrective action the Inspection, Testing, and Maintenance of will be monitored to ensure the Water-Based Fire Protection Systems, Table deficient practice will not recur 7.1.1.2 requires wet and dry barrel hydrants to be i.e., what quality assurance inspected annually and after each operation. program will be put into place? Table 7.1.1.2 also states hydrants shall be tested annually to ensure proper functioning. This This Tels task will be reviewed by deficient practice could affect all residents, staff the Safety/QAPI committee and visitors. Lead by the Executive Director and/or Maintenance Director. Findings include: The results will be reviewed for patterns, trends and continued

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Based on review of the sprinkler system

inspection contractor's "Fire Hydrant Report"

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recommendations for process

monitoring and improvement Until

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED	
		155077	B. W	ING		03/05/	/2025
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS			45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ed 10/17/23 with the			100% compliance is achieved		
		tor and the Field Maintenance					
	-	record review from 8:55 a.m. to			5. Date of Completion:		
	-	5/25, fire hydrant inspection and ion within the most recent			4/40/05		
	_	d was not available for review.			4/10/25		
	_	at the time of record review,					
		nce Supervisor agreed fire					
		and testing documentation					
		ent twelve month period was					
	not available for re-	view and provided a letter from					
	the contractor dated 03/05/25 stating the fire						
hydrant inspection will be performed prior to							
		n observations with the					
		tor and the Field Maintenance					
	-	a tour of the facility from 12:00					
		n 03/05/25, the facility has one					
	of the facility.	located on the northwest side					
	of the facility.						
	These findings wer	e reviewed with the Executive					
		enance Director and the Field					
		visor during the exit					
	conference.						
	3.1-19(b)					ļ	
K 0355	NFPA 101						
SS=F	Portable Fire Exti	nguishers					
Bldg. 01	T ORABIC THE EXT	nguishers					
	1. Based on observ	ation and interview, the facility	K 0	355	K355 Portable Fire		04/10/2025
		f 23 portable fire extinguishers	110	555	Extinguishers		0 1/ 10/ 2020
	were inspected at le	east monthly and the			1 What corrective action(s) V	Vill	
	_	ocumented including the date			be accomplished for those		
	_	erson performing the			Residents found to have bee	n	
	_	dance with NFPA 10. LSC			affected by the deficient		
	_	ble fire extinguishers shall be			practice?		
		inspected and maintained in			<u>_</u>		
		FPA 10. NFPA 10, the			Elwood Fire Protecti	-	
1	Standard for Portab	ble Fire Extinguishers, 2010			has inspected and marked the	ا ڊ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155077 B. WING 03/05/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR **ENVIVE OF INDIANAPOLIS** INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Edition, Section 7.2.1.2 states fire extinguishers missing extinguisher. shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the 2. How other residents have the manual inspection was performed and the initials potential to be affected by the of the person performing the inspection shall be same deficient recorded. Where manual inspections are practice will be identified and conducted, records for manual inspections shall what corrective action will be be kept on a tag or label attached to the fire taken? extinguisher, on an inspection checklist maintained on file, or by an electronic method. This deficient practice Records shall be kept to demonstrate that at least could affect all residents, staff the last 12 monthly inspections have been and visitors in the facility. performed. This deficient practice could affect all Elwood Fire Protection residents, staff and visitors. has inspected and marked the missing extinguisher. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 03/05/25, the wall mounted ABC type 3. What measures will be portable fire extinguisher installed in the Main putting place or what systemic Shut Off room had missing monthly inspection changes will be made to documentation on the contractor affixed ensure that the deficient maintenance tag for the nine month period of June practice does not occur? 2024 through February 2025. The portable fire extinguisher inspection contractor had affixed a hanging tag to the fire extinguisher stating the most recent annual maintenance was performed in The Director of July 2023. Based on interview at the time of the Maintenance was educated by the observations, the Maintenance Director and Field Executive Director on K355 Portable Fire Extinguishers. This Maintenance Supervisor stated additional monthly fire extinguisher inspection task has been added to the Tels documentation was not available for review and building system for required agreed the aforementioned portable fire timely testing extinguisher location had missing monthly inspection documentation for nine months of the most recent twelve month period.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155077		A. BUILDING B. WING	01	COMPLETED 03/05/2025	
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director, the Mainte Maintenance Superv conference.	e reviewed with the Executive enance Director and the Field visor during the exit		4. How the corrective action will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place.  This Tels task will be	er?
	failed to ensure 1 of was given maintena one year apart. NFF Portable Fire Exting requires that fire ext to maintenance at in year, at the time of I specifically indicate electronic notification extinguisher maintenexamination of the fintended to give many extinguisher will open and to determine if I will prevent its open replacement is necessary to the proper testing or internal many Section 7.3.3 states have a tag or label s	tion and interview, the facility 123 portable fire extinguishers nee at periods not more than 12A 10, the Standard for guishers, at Section 7.3.1.1.1 cinguishers shall be subjected attervals of not more than 1 mydrostatic test, or when d by an inspection or on. Section 3.3.15 defines mance as a thorough a fire extinguisher that is a ximum assurance that a fire erate effectively and safely physical damage or condition ation, if any repair or assary, and if hydrostatic maintenance is required. The each fire extinguisher shall ecurely attached that and year the maintenance was		This Tels task will be reviewed by the Safety/QAPI committee  Lead by the Executive Director and/or Maintenance Director.  The results will be reviewed for patterns, trends a continued recommendations process monitoring and improvement Until 100% compliance is achieved.  5. Date of Completion:  4/10/25	/e
	performed, identifies work, and identifies performing the work affect all residents, s Findings include:  Based on observation Director and the Fieduring a tour of the	s the person performing the the name of the agency c. This deficient practice could			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	construction  01	(X3) DATE SURVEY  COMPLETED  03/05/2025	
	PROVIDER OR SUPPLIER		45 BE	T ADDRESS, CITY, STATE, ZIP COD EACHWAY DR ANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0363 SS=E Bldg. 01	wall mounted ABC installed in the Main most recent annual July 2023. Based o observations, the M Field Maintenance of recent annual maint Shut Off room portal was more than one of the Maintenance Superconference.  3.1-19(b)  NFPA 101  Corridor - Doors  Based on observation failed to ensure 3 of resident sleeping roclosing and latching would resist the past practice could affect visitors.  Findings include:  Based on observation Director and the Fiedduring a tour of the p.m. on 03/05/25, the sleeping Room A23 an impediment to lawhen tested to close mechanism on each	ed a maintenance tag to the type portable fire extinguisher in Shut Off room indicating the maintenance was performed in in interview at the time of the aintenance Director and the Supervisor agreed the most enance performed for the Main able fire extinguisher location year old.  The reviewed with the Executive enance Director and the Field visor during the exit  Tower 50 corridor doors to come had no impediment to generate the door frame and sage of smoke. This deficient it over 20 residents, staff and  The reviewed with the Maintenance and Maintenance Supervisor facility from 12:00 p.m. to 1:50 the corridor door to resident, Room B4 and B23 each had teching into the door frame enultiple times. The latching corridor door failed to ching plate on the door frame	K 0363	K363 Corridor – Doors  What corrective action(s) W be accomplished for those Residents found to have be affected by the deficient practice?  Central Indiana hardware has been contracted replace the doors on A23 and B23 B4 was fixed in-house.  2. How other residents have potential to be affected by the same deficient practice will be identified an what corrective action will be	en ed to ed the he	

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	NT 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 03/05/2025
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
ENVIVE  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN REGULATORY OF when tested to clos interview at the tim Maintenance Direc Supervisor agreed to corridor doors each into the door frame passage of smoke.  These findings wer Director, the Maint	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e multiple times. Based on the of the observations, the tor and the Field Maintenance the aforementioned three had an impediment to latching and would not resist the e reviewed with the Executive the enance Director and the Field to visor during the exit			ice iff  mic  by the ridor ch.
				Tels building system for required timely testing.  4. How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into pla  This Tels task will be reviewed by the Safety/QAPI committee  Lead by the Execut Director and/or Maintenance Director.  The results will be reviewed for patterns, trends continued recommendations process monitoring and improvement Until 100% compliance is achieved.	the ecur ace? be

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF P	ROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	
ENVIVE (	OF INDIANAPOLIS			NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) E COMPLETION DATE
				5. Date of Completion:	
				10-31-25 Waiver filed	
				LIFE SAFETY CODE WAIVEREQUEST State Form 54147 (R / 8-19) Indiana State Department of Health-Division of Long-Telectore  INSTRUCTIONS: Use this for Annual or Temporary Warequests of a K-tag cited on Life Safety Code survey. Sustine completed.  form, alowith all supporting document with the Plan of Correction. Please use one form for each K-tag, or portion of a K-tag, for which a waiver is being requested.	of  orm  s form  aiver  n the  bmit  ng  tation,  ch
				<u>WAIVER:</u> Specific life safety requirements may be waive noncompliance cannot be corrected without an unreas financial hardship on the fact and it does not pose a threat residents' health and safety.	d if the  onable  illity  t to
				TEMPORARY WAIVER: A Temporary Waiver for a defitime period may be conside noncompliance with a specisafety code requirement for corrective action will take m	ined red for fic life which

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/05/2025
	ROVIDER OR SUPPLIE DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				than ninety (90) days to comp. The documentation submitted the facility for approval of a temporary waiver must includ timetable to correct the deficie and steps the facility has take increase fire safety awarenes while noncompliance is being corrected.  ***********************************	d by de a ency en to s  *******  ********   The second of
				Temporary End Date (month, day, year)	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	01	COMPLETED 03/05/2025
		193077			03/03/2023
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
ENIVIVE	OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224	
LINVIVE	T			1	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
mo	REGUENTORT	RESCRIPTION IN ORGANIZATION	Ind	10-31-2025	BATE
				ANNUAL (CONTINUING)	
				WAIVER JUSTIFICATION	
				1. Evidence the deficiency d	006
				not pose a threat to resident	II.
				health or safety:	
				(Attach additional sheets of	or
				documentation as applicable.	•
				Temporary waiver requested	(see
				below)	
				2. Evidence of how correction	on
				poses an unreasonable	
				financial hardship to the	
				facility:	
				(Attach additional sheets, estimates, cost reports, or oth	ner
				documentation as applicable	
				support claim of hardship.)	
				Temporary waiver requested	(see
				below)	
				TEMPORARY WAIVER	
				JUSTIFICATION	
				1. Evidence that the deficien	ісу
				does not pose a threat to	
				residents' health or safety:  (Attach additional sheets of	nr.
				documentation as applicable.	II.
				These doors still shut to preven	•
				smoke and fire spread but car	II.
				latch	

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2. Evidence of why corrections cannot be completed in ninety

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE (	OF INDIANAPOLIS			IAPOLIS, IN 46224	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
				(90) days from date of surve (Attach additional sheets, estimates, contracts, or other documentation.) Central Indiana hardware is providing quotes for replacem but stated they need time to manufacture these doors.	
				3. Describe timetable for	
				completion of correction.	
				Include milestones and	_
				evidence to be provided to to ISDH	ne
				Life Safety Code Supervis	sor
				to show progress toward	
				completion:	
				(Attach additional sheets o	or
				documentation as applicable.,	
				The campus will update ISDH	with
				install dates once CIH has it	
				scheduled	
				4. Describe evidence of	
				correction/completion that w	
				be submitted to the ISDH Lif	e
				Safety Code Supervisor	
				within fifteen (15) days of	
				end date:	Luciale
				The campus will provide ISDF	
				pictures and or invoices once completed.	
				ADDITIONAL	
				SAFETY MEASURES TO	
				COMPENSATE FOR	
				DEFICIENCY:	
				(Check those implemented	,
				and attach details )	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155077	B. WI	NG		03/05/	2025
				STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	R			ACHWAY DR		
ENVIVE	of Indianapolis	}		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					1. Additional Fire Extinguishe	rs	
					10. Additional fire drills		
					2. Additional Smoke Detection		
					11. Fire Watch (rounds every		
					fifteen (15) minutes)	_	
					3. Additional sprinklers / wate curtain	r	
					12. Safety rounds—specify		
					frequency		
					4. Infrared inspection of moto	rs	
					and electrical panels		
					13. HVAC shut down tied to f	ire	
					alarm		
					5. Additional inspections		
					14. Practical and/or competer	псу	
					skills testing		
					6. Local fire department: mor	nthly	
					inspections		
					15. Hands-on fire extinguishe	r	
					training		
					7. Local fire department: quar	terly	
					inspections	ii	
					<ul><li>16. Emergency procedure tra</li><li>8. Local fire department: revie</li></ul>	•	
					emergency plans	W OI	
					17. Install additional / horizon	tal	
					exit	.aı	
					Additional maintenance		
					18. Hire structural/electrical/fi	re	
					protection engineering firm		
					develop plan of action.		
					Other:		
					Other:		
					Administrator (Signature)		
					="" p="">		
					Title		
					Executive Director		
					Date (month, day, year) 3-27-	2025	
					Corporate Office (Signature)		

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/05/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
				="" p=""> Title Corporate Maintenance Director Date (month, day, year) 3-27-2025  Contact: Amy Kelley, Life Safety Code Supervisor Telephone: 317-234-8502 Indiana State Department of Health Fax: 317-233-7322 2 North Meridian Street E-mail: amkelley@isdh.in.gov Indianapolis, IN 46204		
K 0712 SS=C Bldg. 01	failed to conduct que times under varying second and third should be the transfer of the trans	·	K 0712	K712 Fire Drills  What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?  A fire schedule meetin CMS requirement has been posted in the maintenance directors office and placed on the Tels building systems for future	ng he	

following was noted:

a. three of four first shift fire drills conducted

within the most recent twelve month period on

reminders and

requirements.

documentation upload

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPI					
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER 155077		B. WING		COMPLETED 03/05/2025	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER	<b>!</b>			CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		and on 01/31/25 were		IAG			DATE
	· ·	ctively, 7:30 a.m., 7:30 a.m. and					
	7:40 a.m.						
		nd shift fire drills conducted					
		ent twelve month period on					
		11/30/24 and on 02/21/25 were			2. How other residents have		
	4:30 p.m. and 4:30	ctively, 4:00 p.m., 4:35 p.m.,			potential to be affected by th same deficient	е	
		p.m. I shift fire drills conducted			practice will be identified and	4	
		ent twelve month period on			what corrective action will be		
		and on 12/30/24 were			taken?	-	
		ctively, 12:45 a.m., 12:40 a.m.					
	and 12:00 a.m.				This deficient practic	e	
		at the time of record review,			could affect all residents, staff		
		nce Supervisor stated the			and visitors in the campus.		
		ee shifts per day, additional			Schedule has been	_	
		ition within the most recent			posted for the rest of the caler	ndar	
	_	d was not available for review ementioned first, second and			year and posted in Tels.		
	-	were not conducted at			3. What measures will be		
		nder varying conditions.	putting place or what systemic		nic		
					changes will be made to		
	These findings were	e reviewed with the Executive			ensure that the deficient		
	· ·	enance Director and the Field			practice does not occur?		
	•	visor during the exit					
	conference.						
	3.1-19(b)				The Director of		
	3.1-51(c)				Maintenance was educated by	/ the	
					Executive Director on K712 Fi		
					Drills. Fire Drills must b	ре	
					held and different times on		
					different shifts. This task has		
					been added to the Tels		
					building system for timely		
					scheduled requirements.		
					4. How the corrective action		
					will be monitored to ensure t	he	
					deficient practice will not rec	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	3
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE ( A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 03/05/2025
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipmed Maintenanc Based on record reversal for all Patient Care of the formal patient Care of the formal care of	ent - Testing and iew and interview, the facility required maintenance and documentation of inspections Related Electrical Equipment 9 2012 edition, sections 10.3 and ical integrity, resistance, touch current tests for fixed E is performed as required in als are established with als. All PCREE used in patient in accordance with 10.3.5.4 or put into service and after any on. Any system consisting of pliances demonstrates FPA 99 as a complete system. structions, and procedures infacturer include information	K 0921	i.e., what quality assurance program will be put into place.  This Tels task will be reviewed by the Safety/QAPI committee  Lead by the Executive Director and/or Maintenance Director.  The results will be reviewed for patterns, trends a continued recommendations of process monitoring and improvement Until 100% compliance is achieved.  5. Date of Completion:  4-10-25  K921 Electrical Equipment - Testing and Maintenance  What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?  Testing and documentation will be perform on all Patient Care Related Electrical Equipment (PCREE).  2. How other residents have potential to be affected by the deficient by the control of the potential to be affected by the deficient practicely.	e? //e and or  10/31/2025  II n //e the e
RM CMS-2567(02	2-99) Previous Versions Ob	solete Event ID: J	N1821 Facilit	y ID: 000032 If continuation s	heet Page 24 of 33

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  03/05/2025
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	as required by 10.5 development of a p maintenance. Electronic and maintenance mand safety labels and instructions on the conference of electrical equipments and demonstrate complifications is mademonstrate complifications, maintenance appliances received.	3.1.1 and are considered in the rogram for electrical equipment rical equipment instructions anuals are readily available, and condensed operating appliance are legible. A record ment tests, repairs, and annuals of a period of time to tance in accordance with the resonnel responsible for the e and use of electrical continuous training. This ffects all residents in the	TAG	same deficient practice will be identified and what corrective action will be taken?  This deficient practice could affect all residents, staff and visitors. Testing and documentation will be performed 3. What measures will be putting place or what systemic changes will be ma to ensure that the deficient practice does not occur?	e
	Director and the Fig from 8:55 a.m. to 1 testing documentation	view with the Maintenance eld Maintenance Supervisor 2:00 p.m. on 03/05/25, PCREE son was not available for interview at the time of record		The Director of Maintenance was educated by Executive Director on K921  PCREE testing requirements	the .
	the task for physica is in Direct Supply but maintenance sta	faintenance Supervisor stated I and visual checks of PCREE TELS Logbook Documentation off haven't been doing all facility did not have leakage		4. How the corrective action will be monitored to ensure t deficient practice will not reci.e., what quality assurance program will be put into place.  This Tels task will be	e?
	Director, the Maint	e reviewed with the Executive enance Director and the Field visor during the exit		reviewed by the Safety/QAPI committee Lead by the Executiv Director and/or Maintenance Director. The results will be	
				reviewed for patterns, trends a continued recommendations	and for

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process monitoring and improvement Until 100% compliance is achieved.

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I f		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
155077		155077	B. WING 03/05/2025			2025	
NAME OF PROVIDER OR SUPPLIER  ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(EACH DEFICIEN				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  5. Date of Completion:  10-31-25 Waiver filed LIFE SAFETY CODE WAIVER REQUEST State Form 54147 (R / 8-19) Indiana State Department of Health-Division of Long-Term Care  INSTRUCTIONS: Use this is for Annual or Temporary Waiv Requests of a K-tag cited on to Life Safety Code survey. Substite completed. form, along with all supporting documenta with the Plan of Correction. Please use one form for each K-tag, or portion of a  K-tag, for which a waiver is being reques  ANNUAL (CONTINUING) WAIVER: Specific life safety of requirements may be waived if noncompliance cannot be	n form ver he mit tion,	
					corrected without an unreasor financial hardship on the facili and it does not pose a threat t residents' health and safety.	ty	
					TEMPORARY WAIVER: A Temporary Waiver for a define time period may be considered noncompliance with a specific safety code requirement for with corrective action will take more	d for life hich	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/05/2025	
	ROVIDER OR SUPPLIE DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224	
	OF INDIANAPOLIS SUMMARY (EACH DEFICIEN		45 BEA	ACHWAY DR	lete. I by e a ency n to s  *******  *******  IN
				polis.com LSC Survey Date (month, dayear): 3-05-2025 K-tag: K 921 Check One: Annual x Temporary	
				End Date (month, day, year):	.

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	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/05/2025
	ROVIDER OR SUPPLIE DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				ANNUAL (CONTINUING) WAIVER JUSTIFICATION  1. Evidence the deficiency does not pose a threat to resident health or safety: (Attach additional sheets of documentation as applicable.) Temporary waiver requested (below)  2. Evidence of how correction poses an unreasonable financial hardship to the facility: (Attach additional sheets, estimates, cost reports, or othe documentation as applicable to support claim of hardship.) Temporary waiver requested (below)  TEMPORARY WAIVER JUSTIFICATION  1. Evidence that the deficient does not pose a threat to residents' health or safety: (Attach additional sheets of documentation as applicable.) The PCREE is all the same equipment that has been in loterm use at the facility with no reports of adverse effects to the residents	cy r

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	OF CORRECTION	IDENTIFICATION NUMBER  155077	A. BUILDING B. WING	01	COMPLETED 03/05/2025
	ROVIDER OR SUPPLIEF DF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				2. Evidence of why correction cannot be completed in nine (90) days from date of surve (Attach additional sheets, estimates, contracts, or other documentation.)  We need time to order testing equipment, establish a testing policy with documentation, and train staff on how to test and record results properly	ety y:
				3. Describe timetable for completion of correction. Include milestones and evidence to be provided to to ISDH  Life Safety Code Supervisto show progress toward completion:  (Attach additional sheets of documentation as applicables. The campus will update ISDH policy and training procedures once completed.	sor or ) I with
				4. Describe evidence of correction/completion that we be submitted to the ISDH Lift Safety Code Supervisor within fifteen (15) days of end date:  A copy of completed testing a documentation will be provided ADDITIONAL SAFETY MEASURES TO COMPENSATE FOR DEFICIENCY:	rie : :

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	TOF HEALTH AND HUI R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/05/2025	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	
ENVIVE	OF INDIANAPOLIS	•	INDIAN	NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OF			(Check those implemented and attach details.)  1. Additional Fire Extinguished 10. Additional Fire drills  2. Additional Smoke Detection 11. Fire Watch (rounds every fifteen (15) minutes)  3. Additional sprinklers / water curtain  12. Safety rounds—specify frequency  4. Infrared inspection of motor and electrical panels  13. HVAC shut down tied to falarm  5. Additional inspections  14. Practical and/or competer skills testing  6. Local fire department: moninspections  15. Hands-on fire extinguished training  7. Local fire department: qualinspections  16. Emergency procedure transpections  16. Emergency procedure transpections  17. Install additional / horizonexit  9. Additional maintenance  18. Hire structural/electrical/fiprotection engineering firm develop plan of action.  Other: X Training on PCREE testing will be provided to the maintenance team.	ers ers er ors fire ors rterly aining ew of otal

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="" p="">

Other:

Administrator (Signature)

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155077	A. BUILDING B. WING	<u>01</u>	03/05/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX			ID PREFIX	(X5) COMPLETION			
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE			
				Title Executive Director Date (month, day, year) 3-27- Corporate Office (Signature) ="" p=""> Title Corporate Maintenance Direct Date (month, day, year) 3-27-2025  Contact: Amy Kelley, Lit Safety Code Supervisor Telephone: 317-234-8502 Indiana State Department of Health Fax: 317-233-7322 2 North Meridian Street E-mail: amkelley@isdh.in.gov Indianapolis, If 46204	fe		
K 9999							
Bldg. 01	STANDARDS  3.1-19(a) The facili constructed, equipp the health and safety the public.	MENT AND PHYSICAL  by must be designed, ed and maintained to protect by of residents, personnel, and	K 9999	K9999 3.1-19 ENVIRONME AND PHYSICAL STANDARD  What corrective action(s) Wi be accomplished for those Residents found to have bee affected by the deficient practice?  A full room-to-room	s II		
		not been met as evidenced by: on and interview, the facility		audit was conducted by the maintenance team .All missing	a		

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failed to provide smoke detectors in 4 of over 50

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detectors were replaced.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		<u>01</u>	COMPLETED		
155077		B. WING 03/05/2025			03/05/2025			
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 DROWINED'S BLANCE COR		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
		oms. This deficient practice			2. How other residents have	the		
	could affect over 20	residents, staff and visitors.			potential to be affected by th	e		
	Findings include:				same deficient practice will be identified and	d		
					what corrective action will be			
	Based on observation	ons with the Maintenance			taken?			
		eld Maintenance Supervisor						
	_	facility from 12:00 p.m. to 1:50			This deficient practic			
	_	ll resident sleeping rooms in the			could affect over 20 residents,			
		ped with a smoke detector			staff and visitors in the campu	S.		
	_	ping rooms C20, C22, D20 and erview at the time of the			All missing detectors were			
		faintenance Director and the			replaced.			
		Supervisor stated the resident						
		recently undergone						
		detectors were probably						
		novation and not reinstalled			3. What measures will be			
		ementioned four resident			putting place or what system	nic		
		re not currently provided with a			changes will be made to			
	smoke detector.				ensure that the deficient			
					practice does not occur?			
		e reviewed with the Executive						
	, , , , , , , , , , , , , , , , , , ,	enance Director and the Field			The Director of			
	_	visor during the exit			Maintenance was educated by	y the		
	conference.				Executive Director on K9999			
	2 1 10(b)				ENVIRONMENT AND PHYSIC	CAL		
	3.1-19(b)				STANDARDS. All resident sleeping rooms need to have			
					working smoke detectors for			
					safety purposes. This task ha	ns l		
					been added to the Tels buildir			
					system for timely scheduled	ĭ		
					requirements. Weekly checks	on		
					these smoke detectors will be			
					paper documented moving			
					forward.			
					4. How the corrective action			
					will be monitored to ensure t	the		
				deficient practice will not rec	eur			

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l '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/05/2025		
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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE	
				i.e., what quality assurance program will be put into place			
				This Tels task will be reviewed by the Safety/QAPI committee			
				Lead by the Executiv Director and/or Maintenance Director.	/e		
				The results will be reviewed for patterns, trends a continued recommendations f process monitoring and improvement Until 100% compliance is achieved.			
				5. Date of Completion:			

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