STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/05/25 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Emergency Preparedness survey, Envive of Indianapolis was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 111. Quality Review completed on 03/10/25 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual,	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*	04/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shanika Parker	RN, DNS	04/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based 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 functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 12/17/24 with the Maintenance Director and the Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, documentation for a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period was not available for review. The facility also did not document any actual natural or man-made emergency that required activation of the		*host a facility tabletop drill that includes all department directors.* *The maintenance director will also perform a full-scale building drill on the missing resident was require our staff to activate the emergency plan* . **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors.* *A facility tabletop drill that included all directors was completed.* *A full-scale building drill on the missing resident will require our staff to activate the emergency plan* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient**	

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	155077	A. BUILDING -- B. WING	03/05/2025

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	emergency plan within the most recent two year period. Based on interview at the time of record review, the Field Maintenance Supervisor stated the facility had documented an actual power outage occurrence within the most recent one year period but he could not locate the documentation during the survey and agreed emergency preparedness testing documentation was not available for review at the time of the survey. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.		**practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* E039 EP Testing Requirements**.** Two disaster drills have been added to the Tels building system to be performed on an annual requirement. **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?** *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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *4-10-25*	

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K 0000 Bldg. 01	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: 03/05/25 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Life Safety Code 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 111 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 03/10/25	K 0000		

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 10 doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the 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 corridor door set at the main entrance lobby was marked as a facility exit with an exit sign. The door set was equipped with magnetic locking devices to keep the doors closed when the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad by the entrance doors but the code was not posted at the keypad. The corridor door set serving as the entrance to the D Wing from the center lobby was also marked as a facility exit with an exit sign. The corridor door set was also equipped with magnetic locking devices to keep the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad but the code was not posted. Based on interview	K 0222	K222 Egress Doors **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *1 The Maintenance Director has posted the code at the main entrance door and to the D wing door entrance.* *2 Lock was removed from room B22* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *1 This deficient practice could affect over 20 residents, staff and visitors in the Facility The code was posted by door immediately* *2 This deficient practice could affect 2 residents in the resident sleeping room. The lock was removed.* **3. What measures will be putting place or what systemic changes will be made to**	04/10/2025

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	at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor stated only the D Wing houses residents with the clinical diagnosis to be in a secure wing but agreed the code to release the door set to open by the entrance to the D Wing and at the door set for the main entrance lobby was not posted at the keypad. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors to resident sleeping rooms doors were arranged such that staff can rescue clients in an emergency if the door becomes locked. This deficient practice could affect two residents in resident sleeping Room B22. 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 corridor door to resident sleeping Room B22 was provided with a lock on the door handle which required a key to unlock the door from the corridor side of the door. The lock on the door handle was equipped with a thumb twist device on the room side of the door. The door was not locked at the time of the observations but the locking device was operable. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor asked staff in the		**ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K222 Egress doors. *Doors in Egress Path must meet CMS codes for safety evacuation if needed. Testing of egress doors have been added to the Tels building system.* **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?** *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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** 4-10-25	

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	area if a key was available to unlock the door should it become locked but no staff acknowledged a key was readily available to unlock the door. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor stated the room was used as a storage room during recent facility renovations and had the Maintenance Assistant replace the door handle with a non-locking device at the time of the survey. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5 at 15.(h) states fire alarm system smoke detectors shall be functional tested annually. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect over 20 residents, staff and visitors in the C Wing. Findings include:	K 0345	K345 Fire Alarm System _ Testing and Maintenance **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *Elwood Fire Protection has now completed the sensitivity testing on smoke detectors in rooms* C11 through C19 . **2. How other residents have the potential to be affected by the same deficient**	04/10/2025

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	Based on review of the fire alarm system inspection contractor's "Fire Alarm Report" documentation dated 05/15/24 and 11/04/24 with the Maintenance Director and the Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, smoke detector testing documentation within the most recent twelve month period for smoke detectors installed in resident sleeping rooms C11 through C19 was not available for review. The 05/15/24 and 11/04/24 testing documentation did include six areas in the C Wing but it did not include the resident sleeping rooms. Based on interview at the time of record review, the Field Maintenance Supervisor agreed fire alarm system smoke detector testing documentation for resident sleeping rooms C11 through C19 within the most recent twelve month period was not available for review. 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, fire alarm system smoke detectors are installed in resident sleeping rooms C11 through C19. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010		**practice will be identified and what corrective action will be taken?** *This deficient practice could affect over 20 residents, staff and visitors in the C Wing. Elwood Frie Protection has completed the sensitivity testing.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K345 Sprinkler System - Mtn and Testing**.** Smoke detector sensitivity testing is required every 2 years. This*task has been added to the Tels building system for required timely testing.* **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?**	

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	Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect over 20 residents, staff and visitors in the C Wing. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Report" documentation dated 10/17/23 with the Maintenance Director and the Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, smoke detector sensitivity testing documentation for smoke detectors installed in resident sleeping rooms C11 through C19 was not available for review. The 10/17/23 sensitivity testing documentation did include six areas in the C Wing but it did not include the resident sleeping rooms. Based on interview at the time of record review, the Field Maintenance Supervisor agreed sensitivity testing documentation for fire alarm system smoke detectors installed in resident sleeping rooms C11 through C19 within the most recent two year period was not available for review. 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,		*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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *4-10-25*	

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	fire alarm system smoke detectors are installed in resident sleeping rooms C11 through C19. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler System Test Report" documentation dated 11/04/24 and	K 0353	**K353 Sprinkler System - Maintenance and Testing** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *Elwood has fixed the accelerator and tested the Hydrant all meet requirements* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors in the facility. Elwood Fire Protection has*	04/10/2025

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	02/12/25 with the Maintenance Director and the 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 sprinkler systems during the inspection for the facility. The "Comments" section of the 11/04/24 and 02/12/25 sprinkler system inspection reports stated "The accelerator is not turned on". Based 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 accelerators were functioning but agreed it could not be assured each of the two accelerators were functioning properly. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 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 the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. Table 7.1.1.2 also states hydrants shall be tested annually to ensure proper functioning. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Fire Hydrant Report"		*repaired the issues.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K353 Sprinkler System - Mtn and Testing**.** Sprinkler systems are required to be tested timely and any deficiencies fixed promptly. *This task has been added to the Tels building system for required timely testing.* **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?** *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 and continued recommendations for process monitoring and improvement Until*	

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	documentation dated 10/17/23 with the Maintenance Director and the Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, fire hydrant inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor agreed fire hydrant inspection and testing documentation within the most recent twelve month period was not available for review and provided a letter from the contractor dated 03/05/25 stating the fire hydrant inspection will be performed prior to 03/14/25. 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 facility has one private fire hydrant located on the northwest side of the facility. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		*100% compliance is achieved.* **5. Date of Completion:** *4/10/25*	
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers 1. Based on observation and interview, the facility failed to ensure 1 of 23 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010	K 0355	**K355 Portable Fire Extinguishers** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *Elwood Fire Protection has inspected and marked the*	04/10/2025

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	155077	A. BUILDING 01 B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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	Edition, Section 7.2.1.2 states fire extinguishers 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 manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors. 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 portable fire extinguisher installed in the Main Shut Off room had missing monthly inspection documentation on the contractor affixed maintenance tag for the nine month period of June 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 July 2023. Based on interview at the time of the observations, the Maintenance Director and Field Maintenance Supervisor stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for nine months of the most recent twelve month period.		*missing extinguisher.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors in the facility.* *Elwood Fire Protection has inspected and marked the missing extinguisher.* : **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on K355 Portable Fire Extinguishers. This task has been added to the Tels building system for required timely testing*	

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	155077	A. BUILDING 01 B. WING	03/05/2025

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	These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 23 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, staff and visitors. 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 fire extinguisher inspection		**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?** 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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *4/10/25*	

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	155077	A. BUILDING 01 B. WING	03/05/2025

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	contractor had affixed a maintenance tag to the wall mounted ABC type portable fire extinguisher installed in the Main Shut Off room indicating the most recent annual maintenance was performed in July 2023. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the most recent annual maintenance performed for the Main Shut Off room portable fire extinguisher location was more than one year old. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. 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 corridor door to resident sleeping Room A23, Room B4 and B23 each had an impediment to latching into the door frame when tested to close multiple times. The latching mechanism on each corridor door failed to protrude into the latching plate on the door frame	K 0363	K363 **Corridor – Doors** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *Central Indiana hardware has been contracted to replace the doors on A23 and B23 B4 was fixed in-house.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be**	10/31/2025

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	when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the aforementioned three corridor doors each had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**taken?** *This deficient practice could affect 20 residents, staff and visitors* *A contractor will be obtained replace the doors* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director* K363 Corridor Doors*Must shut and latch. This task has been added to the Tels building system for required timely testing.* **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?** *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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.*	

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			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 form for Annual or Temporary Waiver Requests of a K-tag cited on the Life Safety Code survey. Submit the completed. form, along with all supporting documentation, 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.* *ANNUAL (CONTINUING) WAIVER: Specific life safety code requirements may be waived if the noncompliance cannot be corrected without an unreasonable financial hardship on the facility and it does not pose a threat to residents' health and safety.* *TEMPORARY WAIVER: A Temporary Waiver for a defined time period may be considered for noncompliance with a specific life safety code requirement for which corrective action will take more*	

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	155077	A. BUILDING 01 B. WING	03/05/2025

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			than ninety (90) days to complete. The documentation submitted by the facility for approval of a temporary waiver must include a timetable to correct the deficiency and steps the facility has taken to increase fire safety awareness while noncompliance is being corrected. ********** ********** ********** ********** **Facility Name:** Envive of Indianapolis **Provider Number:** 000032 **Address *(number and street, city, state, and ZIP code)*:** 45 Beachway Dr Indianapolis, IN 46224 **Contact Name:** Doug Daudelin **Title:** Executive Director **Telephone Number:** (317) 474-1995 **E-mail:** ExecutiveDirector@enviveofindianapolis.com **LSC Survey Date *(month, day, year)*:** 3-05-2025 **K-tag:** K 363 ***Check One*: Annual x** Temporary **End Date *(month, day, year)*:**	

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	155077	A. BUILDING 01 B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			10-31-2025 **ANNUAL (CONTINUING) WAIVER JUSTIFICATION** **1. Evidence the deficiency does not pose a threat to residents' health or safety:** *(Attach additional sheets or documentation as applicable.)* Temporary waiver requested (see below) **2. Evidence of how correction poses an unreasonable financial hardship to the facility:** *(Attach additional sheets, estimates, cost reports, or other documentation as applicable to support claim of hardship.)* Temporary waiver requested (see below) **TEMPORARY WAIVER JUSTIFICATION** **1. Evidence that the deficiency does not pose a threat to residents' health or safety:** *(Attach additional sheets or documentation as applicable.)* These doors still shut to prevent smoke and fire spread but cannot latch **2. Evidence of why corrections cannot be completed in ninety**	

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	155077	A. BUILDING 01 B. WING	03/05/2025

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			(90) days from date of survey: *(Attach additional sheets, estimates, contracts, or other documentation.)* Central Indiana hardware is providing quotes for replacement but stated they need time to manufacture these doors. **3. Describe timetable for completion of correction. Include milestones and evidence to be provided to the ISDH** **Life Safety Code Supervisor to show progress toward completion:** *(Attach additional sheets or documentation as applicable.)* The campus will update ISDH with install dates once CIH has it scheduled **4. Describe evidence of correction/completion that will be submitted to the ISDH Life Safety Code Supervisor within fifteen (15) days of end date:** The campus will provide ISDH with pictures and or invoices once completed. **ADDITIONAL SAFETY MEASURES TO COMPENSATE FOR DEFICIENCY:** *(Check those implemented and attach details.)*	

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	155077	A. BUILDING 01 B. WING	03/05/2025

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			1. Additional Fire Extinguishers 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 motors and electrical panels 13. HVAC shut down tied to fire alarm 5. Additional inspections 14. Practical and/or competency skills testing 6. Local fire department: monthly inspections 15. Hands-on fire extinguisher training 7. Local fire department: quarterly inspections 16. Emergency procedure training 8. Local fire department: review of emergency plans 17. Install additional / horizontal exit 9. Additional maintenance 18. Hire structural/electrical/fire protection engineering firm to develop plan of action. Other: Other: Administrator (*Signature*) ="" p="">Title Executive Director Date *(month, day, year) 3-27-2025* Corporate Office (*Signature*)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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			=”” 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	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first, second and third shifts for at least 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director and the Field Maintenance Supervisor during record review from 8:55 a.m. to 12:00 p.m. on 03/05/25, the following was noted: a. three of four first shift fire drills conducted within the most recent twelve month period on	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 meeting CMS requirement has been posted in the maintenance directors office and placed on the Tels building systems for future reminders and documentation upload requirements.*	04/10/2025

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	155077	A. BUILDING 01 B. WING	03/05/2025

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	04/13/24, 10/24/24 and on 01/31/25 were conducted at, respectively, 7:30 a.m., 7:30 a.m. and 7:40 a.m. b. four of four second shift fire drills conducted within the most recent twelve month period on 05/15/24, 08/31/24, 11/30/24 and on 02/21/25 were conducted at, respectively, 4:00 p.m., 4:35 p.m., 4:30 p.m. and 4:30 p.m. c. three of four third shift fire drills conducted within the most recent twelve month period on 06/12/24, 09/23/24 and on 12/30/24 were conducted at, respectively, 12:45 a.m., 12:40 a.m. and 12:00 a.m. Based on interview at the time of record review, the Field Maintenance Supervisor stated the facility operates three shifts per day, additional fire drill documentation within the most recent twelve month period was not available for review and agreed the aforementioned first, second and third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)		**2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors in the campus. Schedule has been posted for the rest of the calendar year and posted in Tels.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K712 Fire Drills. Fire Drills must be 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 the deficient practice will not recur**	

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			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 and continued recommendations f or process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *4-10-25*	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information	K 0921	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 performed on all Patient Care Related Electrical Equipment (PCREE).* **2. How other residents have the potential to be affected by the**	10/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/05/2025

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	as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Director and the Field Maintenance Supervisor from 8:55 a.m. to 12:00 p.m. on 03/05/25, PCREE testing documentation was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated the task for physical and visual checks of PCREE is in Direct Supply TELS Logbook Documentation but maintenance staff haven't been doing all checks because the facility did not have leakage testing equipment. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**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 made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive* Director on K921 PCREE testing requirements **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?** *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 and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.*	

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	155077	A. BUILDING 01 B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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 form for Annual or Temporary Waiver Requests of a K-tag cited on the Life Safety Code survey. Submit the completed. form, along with all supporting documentation, 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.* *ANNUAL (CONTINUING) WAIVER: Specific life safety code requirements may be waived if the noncompliance cannot be corrected without an unreasonable financial hardship on the facility and it does not pose a threat to residents' health and safety.* *TEMPORARY WAIVER: A Temporary Waiver for a defined time period may be considered for noncompliance with a specific life safety code requirement for which corrective action will take more*	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			than ninety (90) days to complete. The documentation submitted by the facility for approval of a temporary waiver must include a timetable to correct the deficiency and steps the facility has taken to increase fire safety awareness while noncompliance is being corrected. ********** ********** ********** ********** **Facility Name:** Envive of Indianapolis **Provider Number:** 000032 **Address *(number and street, city, state, and ZIP code)*:** 45 Beachway Dr Indianapolis, IN 46224 **Contact Name:** Doug Daudelin **Title:** Executive Director **Telephone Number:** (317) 474-1995 **E-mail:** ExecutiveDirector@enviveofindianapolis.com **LSC Survey Date *(month, day, year)*:** 3-05-2025 **K-tag:** K 921 ***Check One*: Annual x** Temporary **End Date *(month, day, year)*:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	03/05/2025

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			10-31-2025 **ANNUAL (CONTINUING) WAIVER JUSTIFICATION** **1. Evidence the deficiency does not pose a threat to resident health or safety:** *(Attach additional sheets or documentation as applicable.)* Temporary waiver requested (see below) **2. Evidence of how correction poses an unreasonable financial hardship to the facility:** *(Attach additional sheets, estimates, cost reports, or other documentation as applicable to support claim of hardship.)* Temporary waiver requested (see below) **TEMPORARY WAIVER JUSTIFICATION** **1. Evidence that the deficiency does not pose a threat to residents' health or safety:** *(Attach additional sheets or documentation as applicable.)* The PCREE is all the same equipment that has been in long term use at the facility with no reports of adverse effects to the residents	

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			2. Evidence of why corrections cannot be completed in ninety (90) days from date of survey: *(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 **3. Describe timetable for completion of correction. Include milestones and evidence to be provided to the ISDH** **Life Safety Code Supervisor to show progress toward completion:** *(Attach additional sheets or documentation as applicable.)* The campus will update ISDH with policy and training procedures once completed. **4. Describe evidence of correction/completion that will be submitted to the ISDH Life Safety Code Supervisor within fifteen (15) days of end date:** A copy of completed testing and documentation will be provided. **ADDITIONAL SAFETY MEASURES TO COMPENSATE FOR DEFICIENCY:**	

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			(Check those implemented and attach details.) 1. Additional Fire Extinguishers 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 motors and electrical panels 13. HVAC shut down tied to fire alarm 5. Additional inspections 14. Practical and/or competency skills testing 6. Local fire department: monthly inspections 15. Hands-on fire extinguisher training 7. Local fire department: quarterly inspections 16. Emergency procedure training 8. Local fire department: review of emergency plans 17. Install additional / horizontal exit 9. Additional maintenance 18. Hire structural/electrical/fire protection engineering firm to develop plan of action. Other: X Training on PCREE testing will be provided to the maintenance team. Other: Administrator (*Signature*) ="" p="">	

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			Title Executive Director Date *(month, day, year) 3-27-2025* Corporate Office (*Signature*) ="" 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 9999 Bldg. 01	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide smoke detectors in 4 of over 50	K 9999	**K9999 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *A full room-to-room audit was conducted by the maintenance team .All missing detectors were replaced.*	04/10/2025

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	resident sleeping rooms. This deficient practice could affect over 20 residents, staff and visitors. 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, all resident sleeping rooms in the facility were equipped with a smoke detector except resident sleeping rooms C20, C22, D20 and D22. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor stated the resident sleeping rooms had recently undergone renovation, smoke detectors were probably removed for the renovation and not reinstalled and agreed the aforementioned four resident sleeping rooms were not currently provided with a smoke detector. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**2. How other residents have 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 in the campus. All missing detectors were replaced.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K9999 ENVIRONMENT AND PHYSICAL STANDARDS. All resident sleeping rooms need to have working smoke detectors for safety purposes. *This task has been added to the Tels building system for timely scheduled requirements. Weekly checks on these smoke detectors will be paper documented moving forward.* **4. How the corrective action will be monitored to ensure the deficient practice will not recur**	

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			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 and continued recommendations f or process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *4-10-25*	