STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155699	A. BUILDING -- B. WING	02/21/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/21/23 Facility Number: 000290 Provider Number: 155699 AIM Number: 100379970 At this Emergency Preparedness survey, Envive of Hartford City was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 78 and had a census of 33 at the time of this survey. Quality Review completed on 02/23/23	E 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal laws. Please accept this plan of correction as our credible allegation of compliance.	
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: 02/21/2023 Facility Number: 000290 Provider Number: 155699 AIM Number: At this Life Safety Code survey, Envive of Hartford City was found not in compliance with Requirements for Participation in	K 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal laws. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Bledsoe	Executive Director	03/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 78 and had a census of 33 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/23/23			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility	K 0223	**K 223**	03/10/2023

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	failed to ensure the corridor doors to 1 of 1 hazardous area enclosure were self-closing and kept in the closed position. This deficient practice could affect staff and residents in the corridor by the kitchen dishwashing room. Findings include: Based on observation with the Maintenance Director on 02/21/23 at 1:10 p.m., the corridor door to the kitchen dishwashing room was equipped with a self-closing device, but the self-closing device would not fully close and latch to keep the door in the closed position. Based on interview at the time of observation, the Maintenance Director agreed the self-closing device on the door was not functioning properly as it did allow the door to latch. The finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents in the corridor by the kitchen dishwashing room have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A self-closing device has been placed on door in the corridor to the kitchen dish room. Maintenance Director has been educated on K223 citation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** b <="" bmonitoring="" be="" reviewed="" during="" monthly="" quality="" assurance="" meetings="" and="" ongoing="" continued="" compliance.<=""	

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			p="">	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 resident room corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 1 resident in room 201. Findings include: Based on observation with the Maintenance Director on 02/21/23 at 1:40 p.m., the corridor door to resident room 201 would not close into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not close into the door frame because the bed was obstructing the opening. The finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K 363** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Bed was removed and replaced with a regular size bed allowing the door to close. Maintenance Director has been educated on K363 citation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	03/10/2023

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			into place; and b <="" bmonitoring="" be="" reviewed="" during="" monthly="" quality="" assurance="" meetings="" and="" ongoing="" continued="" compliance.<="" p="">	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all occupants in the building. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/21/23 at 12:45 p.m., the four boilers had inspection certificates with an expiration date of 03/13/21. Based on interview at the time of the observation, the Maintenance Director stated the inspection for the boilers had been completed but they have had problems getting the permits.	K 0500	**K 500** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to**	03/10/2023

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	The finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur;** All boiler permits have been obtained and posted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** b <="" bmonitoring="" will="" be="" reviewed="" during="" monthly="" quality="" assurance="" meetings="" and="" ongoing="" for="" continued="" compliance.<="" p="">	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure exposed wiring located in the kitchen was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect all kitchen staff. Findings include: Based on observations during a tour of the facility	K 0511	**K 511** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the**	03/10/2023

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	with the Maintenance Director (MD) on 02/21/23 at 1:15 p.m., there was electrical wiring that was exposed on the large refrigerator/freezer plug at the end of the power cord. Based on interview at the time of observation, the MD agreed there were exposed wiring on the refrigerator/freezer in the kitchen where the plug attaches to the power cord. The finding was reviewed with the Executive Director and MD during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director has been educated on K511 citation. Maintenance will check after all outside work is done to ensure they have left the area safe and will pass inspection. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** b <="" bmonitoring="" will="" be="" reviewed="" during="" monthly="" quality="" assurance="" meetings="" and="" ongoing="" for="" continued="" compliance.<="" p="">	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1	K 0761	**K 761** **What corrective action(s) will be accomplished for those**	03/10/2023

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	communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the		**residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director has been educated on K761 citation and trained on inspecting and testing fire doors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** b=""> monitoring will be reviewed during monthly quality assurance meetings for 6 months and will be ongoing for continued compliance	

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	door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 02/21/23 current documentation of an annual inspection for the fire door assemblies was not available for review. The last record of fire door inspection was completed in 2021. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at			

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	these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 39 of 39 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include:	K 0914	**K 914** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director has been	03/10/2023

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	Based on observations during a tour of the facility with the Maintenance Director on 02/21/23 between 12:30 p.m. and 1:50 p.m., the facility's 39 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknown the last time the annual testing was completed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		educated on K 914 citation. All receptacles have been tested and logged. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** b=""> monitoring will be reviewed during monthly quality assurance meetings for 6 months and will be ongoing for continued compliance	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In			

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	non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to all staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/21/23 at 1:15 p.m., the freezer in the kitchen was plugged into and supplied power by an extension cord. Based on interview at the time of observation, the Maintenance Director acknowledged an extension cord was in use in the kitchen. The finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips for non-PCREE (patient-care-related electrical equipment) in resident rooms (outside of resident care vicinity) meet UL 1363. This deficient practice affects two residents.	K 0920	**K 920** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The power strip and extension cord were removed. No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director has been educated on K920 citation Staff was in serviced on not using power strips or extension cords. **How the corrective action(s) will be monitored to ensure the**	03/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 01 B. WING	02/21/2023

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

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	Findings include: Based on observation with the Maintenance Director on 02/21/23 at 11:50 a.m., in the Activity room there was a power strip in use that did not meet UL-1363. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in the Activity room that did not meet UL-1363. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and** ="" b="">monitoring will be reviewed during monthly quality assurance meetings for 6 months and will be ongoing for continued compliance.	