STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING -- B. WING	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

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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: 05/09/24 Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010 At this Emergency Preparedness survey, Envive of Sullivan was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 77 certified beds. At the time of the survey, the census was 36. Quality Review completed on 05/10/24	E 0000		
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: 05/09/24 Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010 At this Life Safety Code survey, Envive of Sullivan was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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 V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, and the 300 hall resident rooms, plus battery operated smoke alarms in all resident sleeping rooms on the 100 and 200 halls. The facility has a capacity of 77 and had a census of 36 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached garage used for a maintenance shop and two wood storage sheds. Quality Review completed on 05/10/24			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 3 of 3 battery backup lights that were tested monthly for 30 seconds during 1 of the past 12 months to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in	K 0291	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 due to	05/10/2024

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	accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 05/09/24 between 9:50 a.m. and 12:25 p.m. with the Maintenance Supervisor present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly, however, there was no 30 second monthly testing documentation for February 2024. Based on an interview at the time of record review, the Maintenance Supervisor agreed the PM form for the battery powered emergency lights did not include 30 second monthly testing for each battery powered light for February 2024. During a tour of the facility with the Maintenance Supervisor on 05/09/24, the facility was equipped with three emergency battery powered lights. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **K291-Emergency Lighting NFPA 101** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance was educated by the Executive Director on K291 requirements on testing and maintaining emergency lighting. 2 How other residents having the potential to be affected by the same deficient practice will be identified? The alleged deficient practice could affect all residents, as well as staff and visitors in the facility. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Director Maintenance will perform month reviews for 6	

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			months. These audits are placed in TELS building management system for the future timely task reminders and documentation uploads. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The results of this audit will be presented by the Executive Director during the facility's monthly QAPI meetings. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 10, 2024	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and	K 0300	Submission of this Plan of	05/10/2024

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	observation, the facility failed to ensure documentation for the preventative maintenance of 31 of 31 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Test battery operated smoke detectors reports on 05/09/24 from 9:50 a.m. to 12:25 p.m. with the Maintenance Supervisor present, there was no itemized list of resident room battery operated smoke alarms tested for functionality on a weekly basis during the past twelve months. Based on interview at the time of review, the Maintenance Supervisor stated the battery-operated smoke detector manufacturer recommendations called for weekly testing and have not been itemized for the last twelve months. Based on observations between 12:25 p.m. and 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference.		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 due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **K300-Protection-Other NFPA 101** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance has completed the testing and documented the weekly battery-operated smoke detector testing. 2 How other residents having the potential to be affected by the same deficient practice will be identified? This alleged deficient practice could affect all residents, as well as staff and visitors in the facility. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	3.1-19(b)		The Director of Maintenance will perform weekly review x24 totaling 6 months. These audits are placed in the TELS building management system for future timely task reminders and documentation uploads. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The results of the audits will be presented by the Executive Director at the monthly QAPI meeting for further recommendations. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 10, 2024	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

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	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, interview and observation, 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 staff in the kitchen. Findings include: Based on review of "Sprinkler System Test Report" documentation dated 01/02/24 and 03/15/24 during record review with the	K 0353	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 due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **K353 Sprinkler System-Maintenance and Testing CFR(s): NFPA 101** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	10/01/2024

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	Maintenance Supervisor on 05/09/24 from 9:50 a.m. to 12:25 p.m., 'There are 6 sprinkler heads in the kitchen that need replaced due to corrosion' was noted in the comments section. Based on interview at the time of record review, the Maintenance Supervisor stated the six sprinkler heads in the kitchen had not been replaced and confirmed documentation of the replacement of the aforementioned sprinkler heads on or after 01/02/24 was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility on 05/09/24, the six sprinkler heads in the kitchen showed signs of corrosion. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		The Director of Maintenance has contracted Elwood Fire Protection to order and replace the 6 sprinkler heads in the kitchen. The Director of Maintenance was educated by the Executive Director on K353 requirements to be free of debris and corrosion. 2 How other residents having the potential to be affected by the same deficient practice will be identified? The alleged deficient practice could affect all staff in the kitchen. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance will perform monthly reviews for 6 months. These audits are placed in the TELS building management system for future timely task reminders and documentation uploads. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The results of this audit will be presented by the Executive Director at the monthly QAPI for. Should a concern be found, immediate corrective action will	

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			occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: October 1, 2024	
K 0511 SS=D 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 all ground fault circuit interrupter (GFCI) were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff in the Nutrition Room. Findings include: Based on observation with the Maintenance Supervisor on 05/09/24 at 1:05 p.m., when the GFCI receptacle located within two feet from the sink in the nutrition room by the nurse station was tested with a GFCI tester the electric receptacle	K 0511	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 due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **K511-Utilities-Gas and Electric CFR(s) NFPA 101**	05/12/2024

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	did not trip. Additionally, the receptable tester indicated 'Hot/Neutral reversed'. Based on interview at the time of observation, the Maintenance Supervisor confirmed the GFCI electric receptacle within two feet of the sink in the nutrition room did not trip when tested and indicated Hot/Neutral reversed. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance has replaced all non-functioning GFCI. The Director of Maintenance was educated by the Executive Director on K511 GFCIs are required when within 6 feet if a wet location. These GFCIs must trip and function as intended. 2 How other residents having the potential to be affected by the same deficient practice will be identified? The alleged deficient practice could affect all staff in the nutrition room. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance will perform weekly for 12 weeks, then monthly for 3 months totaling 6 months on the GFCI in the Nutrition Room. 4 How will the corrective action be monitored to ensure the	

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			deficient practice will not recur? The Director of Maintenance will use the GFCI monitoring tool to monitor all GFCI outlets. The results of this auditing tool will be presented by the Executive Director at the monthly QAPI for. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 12, 2024	