STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155859	A. BUILDING -- B. WING	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BEECH GROVE	501 N 17TH AVE BEECH GROVE, IN 46107

(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: 01/26/23 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 At this Emergency Preparedness survey, Envive of Beech Grove was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 52 certified beds. At the time of the survey, the census was 32. Quality Review completed on 01/30/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. Based on record review with the Administrator and the Maintenance Supervisor during from 9:10 a.m. to 12:00 p.m. on 01/26/23, documentation of an annual fuel quality test for the facility's two diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators and agreed documentation of an annual fuel quality test for each of the two diesel fuel fired emergency generators was not available for review at the time of the survey. b. Based on review of "Emergency Generator - Monthly Test Log" documentation for the most recent twelve month period with the Administrator during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, the facility has two diesel fuel fired emergency generators. One emergency generator has a name plate rating of 350 kW and monthly load testing documentation indicated monthly load testing achieves 40 kW to 45 kW during load testing which does not meet or exceed 30% of the name plate rating. The second emergency	E 0041	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; A.The appropriate vendor was scheduled to complete the appropriate fuel analysis on each generator to be in compliance with this standard. B.The appropriate vendor was called and scheduled to complete the required annual load test to each generator to be in compliance with this standard. c. The appropriate vendor was called and scheduled to complete the required supplemental load testing for four hours that is to occur within the most recent three years. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken; All residents residing at this facility have the potential to be affected by the alleged deficient	02/26/2023

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	generator has a name plate rating of 60 kW and monthly load testing documentation indicated monthly load testing achieves 220 kW during load testing. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators, the 220 kW load value documented for the 60 kW emergency generator value was in error and agreed documentation of an annual load bank test for each of the two diesel fuel fired emergency generators within the most recent twelve month period was not available for review at the time of the survey. c. Based on record review with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's two diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review at the time of the survey. These findings were reviewed with the Administrator during the exit conference.		practice. A.The appropriate vendor was called out to complete the appropriate fuel analysis on each generator to be in compliance with this standard. B.The appropriate vendor was called and scheduled to complete the required annual load test to each generator to be in compliance with this standard. C. The appropriate vendor was called and scheduled to complete the required supplemental load testing for four hours that is to occur within the most recent three years. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The Maintenance staff were inserviced on required generator fuel testing, proper load documentation, required time frames of completion of load times. Scheduled logs/calendars were added for documentation and scheduling to ensure the alleged deficient practice does not reoccur.	

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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: 01/26/23 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 At this Life Safety Code survey, Envive of Beech Grove was found not in compliance with Requirements for Participation in 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 facility was surveyed as three separate buildings due to the different construction types of different portions of the building. Building 0102, the one story health care center constructed	K 0000	How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; This system will be monitored monthly by the maintenance Director and/or designee and report findings to be provided to the QA committee that will also monitor compliance.	

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	in 1997, was determined to be of Type II (000) construction and fully sprinklered. Building 0102 had hard wired smoke detectors located near smoke barriers and in all resident sleeping rooms. Building 0202, consisting of the first floor of the fully sprinklered three story building with a basement adjacent to the health care center, and separated by a two hour wall was determined to be of Type I (332) construction. The first floor and the basement of the adjacent building which was constructed in 1959 was surveyed due to customary access to the chapel and Salon in the building. Building 0202 had a complete corridor smoke detection system. Building 0302 is a split level facility consisting of the Therapy Wing addition with each of the two floors exiting at ground level was determined to be of Type V (111) construction and fully sprinklered. The Therapy Wing addition was constructed in 2015 and has a fire alarm system with hard wired smoke detection located near smoke barriers. The facility has a capacity of 52 and had a census of 32 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered. Quality Review completed on 01/30/23			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the			

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	shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out-of-service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Disaster Preparedness: Emergency Procedure - Fire Watch" documentation dated 01/06/23 with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, the fire watch plan for fire alarm system impairment was incomplete. The plan did not expressly state when a fire watch for fire alarm system would be initiated. The plan did not state when the required fire alarm system is out-of-service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. The plan also failed to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Administrator agreed the fire watch documentation for fire alarm system impairment was incomplete.	K 0346	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; This Provider developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper authorities to be notified consistent with the requirements of LSC, Section 9.6.1.6. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken; All residents residing at this facility have the potential to be affected by the same alleged practice. This Provider reviewed current systems and developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper authorities to be notified consistent with the requirements	02/26/2023

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	This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		of LSC, Section 9.6.1.6. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The Maintenance staff were inserviced on the Fire Watch policy, notifications and time frames consisted with the requirements of LSC, Section 9.6.1.6. This Provider developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper authorities to be notified consistent with the requirements of LSC, Section 9.6.1.6. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; The new and updated policy will be added to the facility Emergency Plan which is reviewed and updated annually. This plan will be reviewed by the monthly QA committee to ensure it is consistent with the LSC standards and updated as needed.	

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K 0353 SS=F 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 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, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon	K 0353	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; This Provider developed logs to ensure monthly sprinkler system gauge and valve inspection is documented and checked each month to ensure systems are properly working. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken; All residents residing in the facility	03/26/2023

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	request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Administrator and the Maintenance Supervisor from 9:10 a.m. to 12:00 p.m. on 01/26/23, monthly sprinkler system gauge and valve inspection documentation for nine months of the most recent twelve month period was not available for review. Review of "Sprinkler Inspection Report" documentation dated 03/15/22, 08/19/22 and 11/23/22 indicated the sprinkler system inspection contractor performed sprinkler system gauge and valve inspections for three months of the most recent twelve month period but additional sprinkler system gauge and valve inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:00 p.m. on 01/26/23, the facility has supervised wet sprinkler systems. Based on interview at 1:10 p.m. on 01/26/23, the Maintenance Supervisor stated "no sir, I do not" in response to being asked if the facility performs monthly sprinkler gauge and valve inspections in addition to the contractor inspections. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		have the potential to be affected by the alleged deficient practice. This Provider developed logs to ensure monthly sprinkler system gauge and valve inspection is documented and checked each month to ensure systems are properly working. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The maintenance staff were inserviced on the documentation logs and requirements of monthly gauge and valve inspections. This Provider developed logs to ensure monthly sprinkler system gauge and valve inspection is documented and checked each month to ensure systems are properly working. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; The sprinkler system gauge and valve inspection logs will be reviewed monthly for the completion by the Maintenance Director and or designee. The logs will be provided to the QA committee to monitor and check	

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			monthly for proper documentation and completion.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Disaster	K 0354	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; This Provider developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper authorities to be notified consistent with the requirements of LSC, Section 9.6.1.6. How other residents having the potential to be affected by the same alleged deficient practice	02/26/2023

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	Preparedness: Emergency Procedure - Fire Watch" documentation dated 01/06/23 with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, the fire watch plan for sprinkler system impairment was incomplete. The plan did not expressly state when a fire watch would be initiated. The plan did not state when the required automatic sprinkler system is out-of-service for 10 hours or more in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. The plan also failed to contact IDOH, which is an authority having jurisdiction, and failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The fire watch policy for automatic sprinkler system impairment also failed to contact the alarm monitoring company, the building owner and the insurance company if the required automatic sprinkler system is out-of-service for 10 hours or more in a 24-hour period. Based on interview at the time of record review, the Administrator agreed the fire watch plan for sprinkler system impairment was incomplete. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		will be identified and what corrective action will be taken; All residents residing at this facility have the potential to be affected by the same alleged practice. This Provider reviewed current systems and developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper authorities to be notified consistent with the requirements of LSC, Section 9.6.1.6. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The Maintenance staff were inserviced on the Fire Watch policy, notifications and time frames consisted with the requirements of LSC, Section 9.6.1.6. This Provider developed a complete written policy indicating procedures to be followed in the event of the fire alarm system when out of service for more than 4 hours in a 24 hour period; procedure for fire watch and proper	

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			authorities to be notified consistent with the requirements of LSC, Section 9.6.1.6. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; The new and updated policy will be added to the facility Emergency Plan which is reviewed and updated annually. This plan will be reviewed by the monthly QA committee to ensure it is consistent with the LSC standards and updated as needed.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each	K 0521	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; The appropriate vendor was called and scheduled to inspect and provide any necessary maintenance as required by this standard. How other residents having the potential to be affected by the same alleged deficient practice	02/26/2023

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	damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and the Maintenance Supervisor from 9:10 a.m. to 12:00 p.m. on 01/26/23, documentation of fire damper inspections conducted within the most recent four year period was not available for review. Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:00 p.m. on 01/26/23, a fire damper was noted in HVAC ductwork which penetrated the two hour fire resistance rated smoke barrier wall above the suspended ceiling above the corridor door set by Room 130 in the A Wing and above the suspended ceiling above the corridor door set by Room 144 in the B Wing. Documentation affixed to the fire dampers did not provide the date of the most recent inspection and necessary maintenance. A sheet of paper was affixed to the corridor wall above the suspended ceiling at each of the two fire damper locations indicating the most recent fire damper inspection and necessary		will be identified and what corrective action will be taken; All residents residing in the healthcare center has the potential to be affected by the alleged deficient practice. The appropriate vendor was called and scheduled to inspect and provide any necessary maintenance as required by this standard. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The Maintenance staff were inserviced on the requirements of this standard to ensure ongoing inspection and maintenance occurs within the required time frame for all fire dampers. The appropriate vendor was called and scheduled to inspect and provide any necessary maintenance as required by this standard. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; Scheduled maintenance is set up with the vendor and calendar	

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	maintenance was performed in 2016. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated additional fire damper inspection and maintenance documentation was not available for review and agreed documentation of fire damper inspections conducted within the most recent four year period was not available for review. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		developed by provider to monitor compliance of fire dampers. This monitoring will occur by the Maintenance Director and/or designee. The QA committee will review and monitor monthly and annually to ensure completion and ongoing compliance.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the second and third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire/Disaster Drill", "Fire Drill Report" and "Record of Drills: Fire"	K 0712	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; An annual fire drill schedule was developed by Envive Healthcare upon taking over operations on Oct 1, 2022. This schedule is being followed to ensure a fire drill is conducted on each shift for	02/26/2023

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	documentation with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, documentation of a second shift and a third shift fire drill or staff training documentation on fire drill procedures in the second quarter (April, May, June) 2022 and third quarter (July, August, September) 2022 was not available for review. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the second and third shifts in the aforementioned calendar quarters was not available for review. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		each quarter. Since Envive Healthcare has taken over operations, fire drills have appropriately been conducted on each shift in each quarter. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice; An annual fire drill was developed by Envive Healthcare upon taking over operations on Oct 1, 2022. This schedule is being followed to ensure a fire drill is conducted on each shift for each quarter. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; Envive Healthcare took over operations on October 1, 2022 and instituted a new policy and procedure to ensure fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. Maintenance staff were inserviced on the required fire drill schedule and requriement of conducting fire drills quarterly on each shift.	

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			How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; This system will be monitored monthly by the maintenance Director and/or designee and report and findings provided to the QA committee that will also monitor compliance.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder			

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	circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's two diesel fuel fired emergency generators. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and the Maintenance Supervisor during from 9:10 a.m. to 12:00 p.m. on 01/26/23, documentation of an annual fuel quality test for the facility's two diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency	K 0918	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; A.The appropriate vendor was scheduled to complete the appropriate fuel analysis on each generator to be in compliance with this standard. B.The appropriate vendor was called and scheduled to complete the required annual load test to each generator to be in compliance with this standard. c. The appropriate vendor was called and scheduled to complete the required supplemental load testing for four hours that is to occur within the most recent three years. How other residents having the potential to be affected by the same alleged deficient practice	02/26/2023

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	generators and agreed documentation of an annual fuel quality test for each of the two diesel fuel fired emergency generators was not available for review at the time of the survey. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise 2 of 2 emergency generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include:		will be identified and what corrective action will be taken; All residents residing at this facility have the potential to be affected by the alleged deficient practice. A.The appropriate vendor was called out to complete the appropriate fuel analysis on each generator to be in compliance with this standard. B.The appropriate vendor was called and scheduled to complete the required annual load test to each generator to be in compliance with this standard. c. The appropriate vendor was called and scheduled to complete the required supplemental load testing for four hours that is to occur within the most recent three years. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The Maintenance staff were inserviced on required generator fuel testing, proper load documentation, required time frames of completion of load times.	

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	Based on review of "Emergency Generator - Monthly Test Log" documentation for the most recent twelve month period with the Administrator during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, the facility has two diesel fuel fired emergency generators. One emergency generator has a name plate rating of 350 kW and monthly load testing documentation indicated monthly load testing achieves 40 kW to 45 kW during load testing which does not meet or exceed 30% of the name plate rating. The second emergency generator has a name plate rating of 60 kW and monthly load testing documentation indicated monthly load testing achieves 220 kW during load testing. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators, the 220 kW load value documented for the 60 kW emergency generator value was in error and agreed documentation of an annual load bank test for each of the two diesel fuel fired emergency generators within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to document 36 month period emergency generator testing for 2 of 2 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers		Scheduled logs/calendars were added for documentation and scheduling to ensure the alleged deficient practice does not reoccur. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; This system will be monitored monthly by the maintenance Director and/or designee and report findings to be provided to the QA committee that will also monitor compliance.	

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	Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's two diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review at the time of the survey. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/26/23 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 At this Life Safety Code survey, Envive of Beech Grove was found not in compliance with Requirements for Participation in 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 facility was surveyed as three separate buildings due to the different construction types of different portions of the building. Building 0102, the one story health care center constructed in 1997, was determined to be of Type II (000) construction and fully sprinklered. Building 0102 had hard wired smoke detectors located near smoke barriers and in all resident sleeping rooms. Building 0202, consisting of the first floor of the fully sprinklered three story building with a basement adjacent to the health care center, and separated by a two hour wall was determined to be of Type I (332) construction. The first floor and the basement of the adjacent building which was constructed in 1959 was surveyed due to customary access to the chapel and Salon in the building. Building 0202 had a complete corridor smoke detection system. Building 0302 is a split level facility consisting of the Therapy Wing addition with each of the two floors exiting at ground level was determined to be of Type V (111)			

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	construction and fully sprinklered. The Therapy Wing addition was constructed in 2015 and has a fire alarm system with hard wired smoke detection located near smoke barriers. The facility has a capacity of 52 and had a census of 32 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered. Quality Review completed on 01/30/23			
K 0711 SS=E Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire.	K 0711	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; This Provider updated the fire safety plan to discuss the extinguishment of fire in the kitchen and explicitly states the	03/26/2023

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	6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice could affect over 2 staff and visitors in the kitchen. Findings include: Based on review of "Emergency Disaster Preparedness: Emergency Procedure - Fire" documentation dated 01/06/23 with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, the written fire safety plan did not discuss the extinguishment of fire in the kitchen and did not explicitly state the use of K Class portable fire extinguishers in the kitchen due to fire. Based on interview at the time of record review, the Administrator agreed the written fire safety plan did not discuss the extinguishment of fire in the kitchen and did not explicitly state the use of K Class portable fire extinguishers in the kitchen due to fire. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		use of K Class portable fire extinguishers in the kitchen due to fire. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken; All residents residing in the facility have the potential to be affected by the alleged deficient practice. This Provider updated the fire safety plan to discuss the extinguishment of fire in the kitchen and explicitly states the use of K Class portable fire extinguishers in the kitchen due to fire. What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur; The maintenance Staff were inserviced on the updated fire safety plan including the extinguishment of fire in the kitchen and explicitly states the use of K Class portable fire extinguishers in the kitchen due to fire The system change and correction was this Provider updated the fire safety plan to discuss the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155859	A. BUILDING 02 B. WING	01/26/2023

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			extinguishment of fire in the kitchen and explicitly states the use of K Class portable fire extinguishers in the kitchen due to fire. How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur; The Fire safety plan will be reviewed monthly by the maintenance staff to ensure it is updated and consistent with this standard. The maintenance will report monthly findings and ongoing compliance to the QA team each month.	
K 0000 Bldg. 03	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: 01/26/23 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 At this Life Safety Code survey, Envive of Beech Grove was found not in compliance with Requirements for Participation 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),	K 0000		

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	Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was surveyed as three separate buildings due to the different construction types of different portions of the building. Building 0102, the one story health care center constructed in 1997, was determined to be of Type II (000) construction and fully sprinklered. Building 0102 had hard wired smoke detectors located near smoke barriers and in all resident sleeping rooms. Building 0202, consisting of the first floor of the fully sprinklered three story building with a basement adjacent to the health care center, and separated by a two hour wall was determined to be of Type I (332) construction. The first floor and the basement of the adjacent building which was constructed in 1959 was surveyed due to customary access to the chapel and Salon in the building. Building 0202 had a complete corridor smoke detection system. Building 0302 is a split level facility consisting of the Therapy Wing addition with each of the two floors exiting at ground level was determined to be of Type V (111) construction and fully sprinklered. The Therapy Wing addition was constructed in 2015 and has a fire alarm system with hard wired smoke detection located near smoke barriers. The facility has a capacity of 52 and had a census of 32 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered. Quality Review completed on 01/30/23			