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	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/16/23 Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010 At this Emergency Preparedness survey, Envive of Sullivan was found in substantial 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 03/20/23	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Wente	Executive Director	03/29/2023

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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	preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated	E 0004	**E004** EP Plan annual review and update CFR(s): 483.73(a)	03/22/2023

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	at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Disaster Manual on 03/16/23 at 12:44 p.m. with the Maintenance Supervisor present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review provided was 10/28/21. Based on interview at the time of review, the Maintenance Supervisor said the Disaster Manual has not been reviewed and updated within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference.		**Immediate Intervention** EP Plan has been reviewed and updated by the Maintenance director and Executive Director. **Compliance Date** 3-22-23 The Director of Maintenance has been educated by the Executive Director on E004 EP Plan must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in the facility. Exhibit A updated EP Plan/policy sheet signed and dated.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency			

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	155468	A. BUILDING -- B. WING	03/16/2023

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	preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Disaster Manual on 03/16/23 at 12:44 p.m. with the Maintenance Supervisor present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review provided was 10/28/21. Based on interview at the time of review, the Maintenance Supervisor said the Disaster Manual's policies and procedures has not been reviewed and updated within the past twelve months. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference.	E 0013	**E013** Development of EP Policy and procedures CFR(s): 483.73(b) **Immediate Intervention** EP Plan Policy and procedures has been reviewed and updated by the Maintenance director and Executive Director. **Compliance Date** 3-22-23 The Director of Maintenance has been educated by the Executive Director on E013 EP Plan policies and procedures must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in the facility. Exhibit A updated EP Plan/policy Sheet signed and dated.	03/22/2023

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E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Manual on 03/16/23 at 12:44 p.m. with the Maintenance Supervisor present, documentation for an updated communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review was 10/28/21. Based on interview at the time of record review, the Maintenance Supervisor stated that the communication plan had not been reviewed and updated within the last 12 months.	E 0029	**E029** Development of Communications Plan CFR(s): 483.73(c) **Immediate Intervention** EP Plan Communication has been reviewed and updated by the Maintenance director and Executive Director. **Compliance Date** 3-22-23 The Director of Maintenance has been educated by the Executive Director on E029 EP Plan Communication must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in	03/22/2023

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	This finding was reviewed with the Executive Director and the Maintenance Supervisor at the exit conference.		the facility. Exhibit A updated EP Plan/policy Sheet signed and dated.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness			

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	training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency	E 0036	**E036** EP Training and testing CFR(s):	03/22/2023

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	preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Disaster Manual on 03/16/23 at 12:44 p.m. with the Maintenance Supervisor present, documentation for an updated training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review being 10/28/21. Based on interview at the time of record review, the Maintenance Supervisor stated that the training and testing program had not been reviewed and updated in the last 12 months. This finding was reviewed with the Executive Director and Maintenance Supervisor at the exit conference.		483.73(c) **Immediate Intervention** EP Plan Communication has been reviewed and updated by the Maintenance director and Executive Director. **Compliance Date** 3-22-23 The Director of Maintenance has been educated by the Executive Director on E029 EP Plan Communication must be reviewed and updated annually. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in the facility. Exhibit A updated EP Plan/policy Sheet signed and dated.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/16/23 Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010 At this Life Safety Code survey, Envive of	K 0000		

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	Sullivan was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type 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 03/20/23			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility	K 0345	**K345**	03/22/2023

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	failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on observation of the fire alarm control panel on 03/16/23 at 1:47 p.m. during a tour of the facility with the Maintenance Supervisor, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 03/08/2018 at 5:09 a.m. Based on interview at the time of observation, the Maintenance Supervisor stated he was unaware of the discrepancy and would have the date and time updated on the fire alarm panel. This finding was reviewed with the Executive Director and Maintenance Supervisor at the exit conference. 3.1-19(b)		Fire alarm System testing and Maintenance CFR(s): NFPA 101 **Immediate Intervention** The Director of Maintenance has called Ellwood Fire Protection to program the correct time and date on fire panel. Exhibit B Fire plan audit **Compliance Date** 3-22-23 The Director of Maintenance has been educated by the Executive Director on K345 Fire Alarm panel must display accurate time and date information. The Director of Maintenance will perform monthly review X6. To ensure correct information on fire panel display. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in the facility.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation and interview, the facility failure to ensure 1 of 1	K 0781	**K781** Portable Space heaters NFPA 101	03/16/2023

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	portable space heater was not used in the facility. This deficient practice could affect 20 residents, staff and visitors in the dining room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility at 1:37 p.m. on 03/16/23, a portable space heater was noted in the dining room next to the Dietary desk. Manufacturer's documentation affixed to the back of the portable space heater did not state the maximum temperature achieved by the unit. Based on interview at the time of the observation, the Maintenance Supervisor confirmed a portable space heater was used at the aforementioned location. Based on record review with the Maintenance Supervisor on 03/16/23, the facility's "Portable Electrical Space Heaters' policy states 'It is the policy of this facility to adhere to the interpretive guidance of F323 which prohibits the use of portable electrical space heaters in resident areas, and Life Safety Code, which states portable space heating devices shall be prohibited in all health care occupancies'. This finding was reviewed with the Executive Director and the Maintenance Supervisor at the exit conference. 3.1-19(b)		**Immediate Intervention** The Director of Maintenance removed the portable space heater. **Compliance Date** 3-16-23 The Director of Maintenance has been educated by the Executive Director on K781 Portable space heaters are not allowed in patient care areas. The Director of Maintenance will perform monthly review X6. Rounding all patient care areas to ensure no space heaters are in use. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect 20 residents, staff and visitors in the facility. Exhibit C Space heater audit	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 01 B. WING	03/16/2023

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

(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
	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 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)			
	Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 1 of 1 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	K 0918	**K918** Electrical Systems - Essential Electric System NFPA 101 **Immediate Intervention** The Director of Maintenance has performed a four-hour 3 year run test. **Compliance Date** 3-22-23 The Director of Maintenance has	03/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 01 B. WING	03/16/2023

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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 Maintenance Supervisor from 9:30 a.m. to 1:00 p.m. on 03/16/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the LP gas fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has one LP gas fired emergency generator 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 Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		been educated by the Executive Director on K918. Generators are required to be ran and documented weekly, ran under load monthly, and 4 hour run every three years. Results of testing and documentation will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff, and visitors in the facility. Exhibit D Three-year four-hour continuous run/load testing documentation	