PRINTED: 12/20/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MED	ICAID SERVICES			OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155473	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2023	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE			STREET 1065 F BERNI			
(X4) ID PREFIX TAG E 0000 Bldg	(EACH DEFICII REGULATORY (Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION reparedness Survey was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) PLAN OF CORRECTION	(X5) COMPLETION DATE	
	conducted by the accordance with a Survey Date: 11/ Facility Number: Provider Number AIM Number: 10 At this Emergence of Berne was four Preparedness Rec Medicaid Particip CFR 483.73. The had a census of 39	Indiana Department of Health in 42 CFR 483.73. 28/23 000546 : 155473		FOR ENVIVE OF BERNE K000 INITIAL COMMENTS Preparation or execution of th plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepared executed solely because it is required by the position of Fe and State Law. The Plan of Correction is submitted to res to the allegation of noncomplicited during the Life Safety St ID324021 completed on Nove 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of complia as of December 15, 2023. Th provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	ment facts th on . The d and deral pond ance urvey ember nce e desk eto	
K 0000						
Bldg. 01	Licensure Survey	de Recertification and State was conducted by the Indiana ealth in accordance with 42 CFR	K 0000	PLAN OF CORRECTION FOR ENVIVE OF BERNE K000 INITIAL COMMENTS Preparation or execution of the plan of correction does not constitute admission or agree		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Maria Diaz **HFA** 12/15/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>		COMPLETED	
		155473	B. WING 11/28/2023			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L			ARKWAY ST		
ENVIVE	OF BERNE			BERNE	, IN 46711		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Eggilitz Namham ()	00546			of provider of the truth of the fa		
	Facility Number: 0 Provider Number: 1				alleged or conclusions set fort the Statement of Deficiencies.		
	AIM Number: 1002				Plan of Correction is prepared		
	Alivi Number, 1002	.07370			executed solely because it is	anu	
	Δt this Life Safety (Code survey, Envive of Berne			required by the position of Fed	loral	
		mpliance with Requirements			and State Law. The Plan of	iciai	
		Medicare/Medicaid, 42 CFR			Correction is submitted to resp	oond	
	_	Life Safety from Fire and the			to the allegation of noncomplia		
		National Fire Protection			cited during the Life Safety Su		
) 101, Life Safety Code (LSC),			ID324021 completed on Nove	-	
	Chapter 19, Existing Health Care Occupancies and				28, 2023.		
	410 IAC 16.2.				Please accept this Plan of		
					Correction as the provider's		
	This one story facili	ity was determined to be of			credible allegation of compliar	ice	
	Type V(III) constru				as of December 15, 2023. The	9	
	_	cility has a fire alarm system			provider respectfully requests	desk	
		on in the corridors, areas open			review with paper compliance		
		battery operated smoke			be considered in establishing	that	
		dent sleeping rooms. The			the provider is in substantial		
		ty of 80 and had a census of			compliance.		
	39 at the time of thi	s survey.					
	All areas where the	residents have customary					
	access were sprinkle	ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 12/04/23					
K 0211	NFPA 101						
SS=E	Means of Egress -	- General					
Bldg. 01	Means of Egress -						
_	Aisles, passagewa						
		cations, and accesses are					
	_	n Chapter 7, and the means					
		uously maintained free of					
	all obstructions to	-					
	emergency, unles	s modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1	.10.1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155473	B. W	B. WING 11/28/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY ST BERNE, IN 46711					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COM	IPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	I	DATE	
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exit doors in the facility were readily accessible		K 0	211	K211 – Mean of Egress-Gene SS=E	eral 12/	07/2023	
		at a clinical diagnosis requiring			1 What corrective action(s)			
		measures. Doors within a			Will be accomplished for the	se		
		gress shall not be equipped			Residents found to have bee			
		that requires the use of a tool			affected by the deficient			
	, ,	ess side unless otherwise			practice?			
	1 -	9.2.2.2.4. Door-locking						
	arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could				No residents were affected By this alleged deficient practi			
	affect 10 residents.				by this alleged delicient practi	ce.		
	affect to residents.							
	Findings include:							
	Based on observation	on with the Administrator and			2. How other residents			
		FD) on 11/28/23 at 12:55 p.m.,			having the potential to be			
		Dining room was marked as a			affected by the same deficie			
	1	agnetically locked, and could be		practice will be identified and		I		
		a four-digit code on the but the code was not posted			what corrective action will be taken?	9		
	_	interview at the time of			taken?			
		e FD, the dining room exit			All residents have the			
		delayed-egress with the		potential to be affected by				
	proper signage but t	the 15 second delay was not		alleged deficient practice.				
		hen removed the 15 second			No residents were affected			
		rith no code posted, the dining			by this alleged deficient			
		not readily accessible to			practice			
	residents without a specialized security	clinical diagnosis requiring			2 What magazines will be said			
	specialized security	measures.			3. What measures will be put in place or what systemic	·		
	The finding was rev	viewed with the Administrator			changes will be made to			
	and FD during the				Ensure that the deficient			
					Practice does not occur?			
	3.1-19(b)							
					The Director of Facilities has			
					removed the egress function			
					and signage from the door. The			
					Code was posted by the door, and the door can be opened y	I		
1	ī				T AND THE DOOR CAN BE DEEDEDED V	/1111 I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			PLETED		
		155473	B. WI	ING		11/28/	2023
NAME OF D	PROVIDER OR SUPPLIE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					ARKWAY ST		
ENVIVE	OF BERNE			BERNE	, IN 46711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	the pasted and The deer con		DATE
					the posted code The door can also be opened when the fire	ı	
					alarm is activated.		
					See Exhibit 1.		
					4. How the corrective		
					action will be monitored to ensure the deficient practice		
					will not recur i.e., what quality		
					assurance program will be p	-	
					Into place?		
					The Executive Director was		
					educated by the Director of		
					Facilities on K221. All exit		
					doors magnetically locked		
					require egress of 15 seconds		
					or the code posted for easy access in the event of an		
					emergency. Door lock test Ta	sk	
					has been added the Tels system		
					and is now required to be		
					completed		
					monthly.		
					The results of these audits wil	l be	
					Reviewed by the Safety/QAPI		
					committee		
					Overseen by the Executive		
					Director		
					and/or Maintenance Director.		
					The results will be reviewed for Patterns, trends and continue		
					Recommendations for process		
					Monitoring and improvement	-	
					Until 100% compliance is		
					achieved.		
					5. Date of Completion:		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155473		(X2) MULTIPLE (A. BUILDING B. WING	01	COM	TE SURVEY TPLETED 28/2023	
NAME OF I	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP PARKWAY ST	COD	
ENVIVE	OF BERNE			IE, IN 46711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORT OF	CESC IDENTIFY TING INFORMATION	IAG			DATE
				12/7/2023		
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking are CLINICAL NEEDS LOCKING Where special locking dinical security neutrons are detection system at an attended locks or keys carried the Clinical security neutrons are being met. In selectrical locks that release upon loss building is protected detection system at an attended locks pace); and both the clinical or security and control of the control locks or keys carried the control locks or keys carried the such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT: Where special locks after the Clinical or Security needs of the control locks that release upon loss building is protected automatic sprinkles space is protected detection system at an attended lockspace); and both the control locks that the control locks that release upon loss building is protected detection system at an attended lockspace); and both the control locks that the control locks that release upon loss building is protected detection system at an attended lockspace); and both the control locks that the control	king arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ded by staff at all times; or e means available to the				
	upon activation.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/28/2023	
	PROVIDER OR SUPPLIE	R	1065 P	ADDRESS, CITY, STATE, ZIP COD PARKWAY ST E, IN 46711	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	DELAYED-EGRE ARRANGEMENT Approved, listed systems installed 7.2.1.6.1 shall be assemblies servic contents in buildi an approved, supdetection system automatic sprinkl 18.2.2.2.4, 19.2.2 ACCESS-CONTILOCKING ARRA Access-Controlle installed in accorde permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOB LOCKING ARRA Elevator lobby exaccordance with on door assemblithroughout by an automatic fire detapproved, supervisem. 18.2.2.2.4, 19.2.2 Based on observatifailed to ensure 1 carrangements were LSC 7.2.1.6.1(3) we process shall release egress within 15 scapproved by the automapplication or required in 7.2.1.5 conditions:	delayed-egress locking in accordance with permitted on door ng low and ordinary hazard ngs protected throughout by pervised automatic fire or an approved, supervised er system. 2.2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall 2.2.4 BY EXIT ACCESS NGEMENTS it access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised section system and an rised automatic sprinkler	K 0222	K222 – Egress Doors SS=E 1 What corrective action(s) Will be accomplished for the Residents found to have bee affected by the deficient practice? No residents were affected By this alleged deficient pract	en

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	R MEDICARE & MEDIC					MB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155473	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2023	
			1065 F BERNI	ADDRESS, CITY, STATE, ZIP COD PARKWAY ST E, IN 46711 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	N BE	(X5) COMPLETION
	(EACH DEFICIENT REGULATORY OF The finding was reversible.) (b) The force shall continuously applies (c) The initiation of activate an audible door opening. (d) Once the lock happlication of force relocking shall be be deficient practice of Dining room. Findings include: Based on observation with the Facilities I on 11/28/23 at 12:5 door was set up for second delay signatested the irreversible was not initiated. Bobservation, the FE delay egress and stand working and resign.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Into be required to be ad for more than 3 seconds. If the release process shall signal in the vicinity of the as been released by the to the releasing device, by manual means only. This bould affect 35 residents in the on during a tour of the facility Director (FD) and Administrator In process with 15 In process to release the lock ased on interview at the time of In tried 3 times to activate the lated the delayed egress was moved the 15 second delay wiewed with the FD and the lang the exit conference.	ID PREFIX TAG	2. How other residents having the potential to be affected by the same defic practice will be identified a what corrective action will taken? All residents have the potential to be affected by the affected by the alleged deficient practice. No residents were affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. 3. What measures will be printed in place or what systemic changes will be made to Ensure that the deficient Practice does not occur? The Director of Facilities have removed the egress function and signage from the door. Code was posted by the does not occur also be opened when the fir alarm is activated. See Exhibit 1.	ient and be nis The or, d with an	(X5) COMPLETION DATE
				action will be monitored to ensure the deficient practi will not recur i.e., what qua assurance program will be	ce ality	

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The Executive Director was educated by the Director of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2023	
NAME OF PROVIDER OR SU	PPLIER	1065 P	ADDRESS, CITY, STATE, ZIP COD ARKWAY ST E, IN 46711		
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
	RY OR LSC IDENTIFYING INFORMATION	TAG	Facilities on K222. All exit doors magnetically locked require egress of 15 seconds or the code posted for easy access in the event of an emergency. Door lock test Tas has been added the Tels syste and is now required to be completed monthly. The results of these audits will Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. 5. Date of Completion:	m be	
Section 18.3 requirements provided K-t information, Safety Code should be in Based on reco		K 0300	K300 – Protection - Other SS=F	12/13/2023	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155473	B. W	ING		11/28/2023	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	C .			ARKWAY ST		
ENVIVE	OF BERNE			BERNE	E, IN 46711		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		the preventative maintenance			l		
		operated smoke alarms in			1 What corrective action(s)		
		complete. NFPA 101 in			Will be accomplished for the		
		ting life safety features obvious			Residents found to have bee	en	
	_	required by the Code, shall be			affected by the deficient		
		72, 29.10 Maintenance and			practice?		
	_	equipment shall be maintained					
		lance with the manufacturer's			No residents were affected		
	_	ons and per the requirements			By this alleged deficient pract	ice.	
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection,						
	testing, and maintenance programs shall satisfy				2. How other residents		
the requirements of this Code and conform to the				having the potential to be			
	equipment manufacturer's published instructions.				affected by the same deficie		
	Section14.4.8.1 states unless otherwise				practice will be identified an		
		ne manufacturer's published			what corrective action will b	e	
	_	and multiple-station smoke			taken?		
	_	aced when they fail to respond					
		but shall not remain in service			All residents have the		
		s from the date of manufacture.			potential to be affected by this	;	
	_	ice could affect all residents,		alleged deficient practice			
	staff, and visitors.						
					by this alleged deficient		
	Findings include:				practice		
	Based on records re	eview with the Facilities			3. What measures will be pu	t	
	Director (FD) and A	Administrator on 11/28/23 at			in place or what systemic		
		mentation for battery			changes will be made to		
	replacement of resid	dent room battery operated			Ensure that the deficient		
	smoke alarms was a	available for review. Based on			Practice does not occur?		
	interview at the tim	e of review, the Facilities					
		e was no documentation			The Director of Facilities will		
	available to show w	when the last battery			Replace ALL battery-operated	1	
	replacement of the	battery operated smoke			Smoke dectectors.		
	detectors was completed. It was observed during				See Exhibit 2A.		
	the facility tour that the battery operated smoke						
	alarms in the reside	ent room looked to be similar. A			4. How the corrective		
	battery operated sm	oke detector was removed			action will be monitored to		
	. –	309. The manufacturers			ensure the deficient practice		
	instructions stated t	hat the battery was good for			will not recur i.e., what quali		
10 years after installation but there was no				assurance program will be n	-		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/28/2023	
	PROVIDER OR SUPPLIER		1065	r address, city, state, zip cod PARKWAY ST IE, IN 46711	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	installation date not was March 2012. U reference, the batter should have been re	ed. The manufacturers date sing the manufacturers date for y operated smoke detector placed in March 2022.	TAG	Into place? The Executive Director was educated by the Director of Facilities on K300. ALL Battery-operated devices mube tested per manufactures recommendations, document and replaced as needed. Battoperated devices will be tested weekly. This task will be placed into the Tels Building Manages system for future scheduling reminders. The results of these audits we Reviewed by the Safety/QAF committee Overseen by the Executive Director and/or Maintenance Director and/or Maintenance Director The results will be reviewed to Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved.	ted, ttery ed eed ement and for ed ss
				5. Date of Completion: 12/13/2023; devices were installed. See Exhibit 2B	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the			

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NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE ENVIVE OF BERNE IN 46711 D SUMMARY STATEMENT OF DEFICIENCIE ERREIL TAG Inspection, Testling, 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 D) 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 NIFPA 25 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25, ESU 9.75 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Isting, and Maintenance or Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section so 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 cold affect all residents, staff, and vistors in the facility. Findings include: ANDIENTED TODRESTOR STREET ADDRESS, CITY, STATE, ZIP COD 1065 PARKWAY STATE D IN 40711 BERNE, IN 46711 IN 40711 BERNE, IN 46711 IN 40711 IN 40711 IN 40711 IN 40711 IN 40711 IN 40711 IN 40		r of health and hu R medicare & medic		FORM APPROVED OMB NO. 0938-039			
In the second content of the species			RECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u>			COMPLETED	
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 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 and interview, the facility failed to maintain automatic sprinkler systems shall be inspected, tested, and maintained 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 personned or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. PREFIX TAG PROPORTATE CORPORTATE COMPLET CORPORTATE CORPOR	ENVIVE OF BERNE		1065 F BERNI	PARKWAY ST E, IN 46711		(X5)	
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 systems. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff; and visitors in the facility. K 0353 K353 – Sprinkler System – Maintenance and Testing SS=F 1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice. Provide in REMARKS information on coverage for any non-requist. K 0353 K353 – Sprinkler System – Maintenance and Testing SS=F 1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	PREFIX	`			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
potential to be affected by this		Inspection, Testin Water-based Fire Records of syster inspection and tessecure location and a) Date sprinkled b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkled 9.7.5, 9.7.7, 9.7.8 Based on record refailed to maintain a accordance with N sprinkler systems somaintained in accordance with N sprinkler systems somaintained in accordance for the Inspection, Water-Based Fire I 2011 Edition, Section owner or designate or repair deficienci found during the in required by this stat shall be performed personnel or a qual 4.3.1 requires recordinspections, tests, a components and shauthority having judeficient practice of the system of the syst	ng, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. It system last checked It system test It supply source RKS information on non-required or partial er system. It and NFPA 25 view and interview, the facility automatic sprinkler systems in FPA 25. LSC 9.7.5 requires all shall be inspected, tested, and rdance with NFPA 25, Standard Testing, and Maintenance of Protection Systems. NFPA 25, ion 4.1.4.1 states the property of representative shall correct es or impairments that are aspection, test and maintenance indard. Corrections and repairs by qualified maintenance iffied contractor. NFPA 25, rds shall be made for all and maintenance of the system hall be made available to the risdiction upon request. This ould affect all residents, staff,		Maintenance and Testing SS=F 1 What corrective action(s) Will be accomplished for the Residents found to have bee affected by the deficient practice? No residents were affected By this alleged deficient practic 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the	en ice. nt d e	

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Based on review of "Sprinkler System Inspection"

documentation dated 01/23/23, 04/06/23, 07/07/23

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alleged deficient practice.

No residents were affected

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2023	
	PROVIDER OR SUPPLIER		1065 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY ST E, IN 46711	
	SUMMARY: (EACH DEFICIEN REGULATORY OR and 10/23/23 during Administrator and F a.m. on 11/28/23, th control valve sign is interview at the tim stated the repair has provided documents confirmed on 11/28 company to remedy	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION grecord review with the Facilities Director (FD) at 11:30 he comment section stated the s not in sight. Based on he of record review, the FD hot been completed but hation of a work request //23 by their contracted the problem.			ut DATE DATE
				Into place? The Executive Director was educated by the Director of Facilities on K353. ANY decencies noted on inspections must b fixed and documented in a timely manner. This task will be placed into Tels Building Management s for future scheduling and reminders. The results of these audits we Reviewed by the Safety/QAF committee	the ystem vill be

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DEPARTMENT OF HEALTH AND HUMAN SERVICI	ΞS
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE A. BUILDING B. WING	e construction 6 <u>01</u>	(X3) DATE SURVEY COMPLETED 11/28/2023
	PROVIDER OR SUPPLIER OF BERNE		1065	ET ADDRESS, CITY, STATE, ZIP COD 5 PARKWAY ST NE, IN 46711	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				Overseen by the Executive Director and/or Maintenance Director The results will be reviewed Patterns, trends and continu Recommendations for proce Monitoring and improvemen Until 100% compliance is achieved. 5. Date of Completion: 12/31/2023	for led less
K 0511 SS=D Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2			
	failed to ensure electors. NFPA 70, 2011 Editors. Terminals, Receptative wiring terminal	on and interview, the facility strical wirings were protected. tion. Article 406.5 (F) Exposed cles shall be enclosed so that is are not exposed to contact. It is could affect staff in the in.	K 0511	K511 – Utilities-Gas and Ele SS=D 1 What corrective action(s) Will be accomplished for the Residents found to have be affected by the deficient practice?	nose
	Based on observation with the Facilities I 01:00 p.m. in the king ceiling light fixture exposed wires hang	on during a tour of the facility Director (FD) on 11/28/23 at the supply room there was a with the cover missing leaving ing from the light fixture. at the time of observation, the		No residents were affected By this alleged deficient prace 2. How other residents having the potential to be affected by the same defici practice will be identified a	ient

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2023	
	PROVIDER OR SUPPLIER		1065 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY ST E, IN 46711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	_	he aforementioned condition exposed wiring was visible.		what corrective action will b taken?	oe e	
	This finding was reand FD at the exit conditions of the exit conditi	viewed with the Administrator onference.		All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice	s	
				3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?	ut .	
				The Director of Facilities will replace the light fixture and insured all wire connections are covered and meet standa in the kitchen supply room. See Exhibit 3.	ards	
				4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quali assurance program will be plate?	ity	
				The Executive Director was educated by the Director of Facilities on K511. All wire/connections must be sea covered by approved standar		
				The results of these audits wi Reviewed by the Safety/QAP committee Overseen by the Executive		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF BERNE			PARKWAY ST E, IN 46711	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terredo not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard used with general cords are not used wiring of a structure	ent - Power Cords and ent - Power Strips and electrical equipment electronal and meet electronical and meet electronics, ent care resident rooms that ent - Power Strips in ent ent - Power Strips ent - Power Strips for PCREE ent - UL 60601-1. Power Strips ent - Power Strips e	TAG		DATE . for ed ss
		purpose for which it was the conditions of 10.2.4.			
	10.2.3.6 (NFPA 99	9), 10.2.4 (NFPA 99), 400-8			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155473		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/28/2023		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE			1065 PA	ADDRESS, CITY, STATE, ZIP COD ARKWAY ST , IN 46711			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE
	REGULATORY OR (NFPA 70), 590.30 Based on observation failed to ensure 2 of used multi-plug adarwiring. LSC 9.1.2 requipment shall be National Electrical Article 400.8 requirement permitted, flexible of used as a substitute This deficient pract. Based on observation (FD) and Administrator agreed use in room 400 and were removed at the		K 09	TAG		seen ice.	
					4. How the corrective action will be monitored to		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		(X3) DATE COMPL	ETED	
	155473		B. WING		11/28/	2023	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BERNE			1065 P	ADDRESS, CITY, STATE, ZIP COD ARKWAY ST E, IN 46711			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.15	DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	ensure the deficient practice will not recur i.e., what qualit assurance program will be p Into place? The Executive Director was educated by the Director of Facilities on K920 Multi plug adaptors are not permitted. Or approved URL rated surge protectors can be used. Extension cords/adapters will be done twice a week for 4 weeks, once a week for 4 weeks, once a week for 4 monthly for 4 months for a tota 6 months. The results of these audits will Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved.	ty ut nly	DATE
					5. Date of Completion:		
					12/12/2023		

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