EPARTMENT OF HEALTH AND HUMAN SERVICES	
ENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		î ´				SURVEY ETED	
		155690	B. Wl	NG		08/13/	/2024
	PROVIDER OR SUPPLIER			1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	conducted by the In accordance with 42 Survey Date: 08/13 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this Emergency of Anderson was fo Emergency Prepare Medicare and Mediand Suppliers, 42 C capacity of 97 and 1 of this survey.	5/24 00027 55690	E 00	000	Plan of Correction FOR Envior of anderson Preparation or execution of the 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 Feand State Law. The Plan of Correction is submitted to resto the allegations of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey conducted August 13, 2024.	ment facts th on . The d and deral pond ne on s	
K 0000							
Bldg. 01							
	Licensure Survey w Department of Heal 483.90(a). Survey Date: 08/13 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety 0	00027 55690	K 0	000	Plan of Correction FOR Envior of anderson Preparation or execution of the 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 Ferand State Law. The Plan of Correction is submitted to res	ment facts th on . The d and	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURI	3	TITLE		(X6) DATE

Ryan Kinzie **Executive Director** 08/30/2024

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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	r í	JILDING	onstruction 01	(X3) DATE : COMPL 08/13/	ETED
	PROVIDER OR SUPPLIER			1821 LII	ADDRESS, CITY, STATE, ZIP COD NDBERG RD ISON, IN 46012		
(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 APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation of Protect Life Safety Code). This one story facility of V111 constructs sprinklered with except kitchen alcove. The with smoke detection to the corridors and detection in the 500 rooms. The facility census of 49 at the total cares where the access were sprinkless.	the and the 2012 edition of the ention Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2. The was determined to be of ention and was fully eption of the back half of the facility has a fire alarm system on in the corridors, areas open battery powered smoke and 600 hall resident sleeping has a capacity of 97 and had a time of this survey. The survey of the survey of the survey ered. All areas providing the sprinklered with exception of kitchen alcove.			to the allegations of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey conducted August 13, 2024.	on s	
K 0161 SS=E Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5 Construct I (442), I of stories sprinklered	tion Type (332), II (222) Any number non-sprinklered and					
	2 II (111)	One story					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ´	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED		
		155690	B. WING		08/13/2024
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				INDBERG RD RSON, IN 46012	
	OF ANDERSON		ANDER	NOON, IN 40012	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	non-sprinklered	R LSC IDENTIFYING INFORMATION	TAG	BENEED,	DATE
	non-sprinklered	Maximum 3 stories			
	sprinklered	Waximum o stories			
	3 II (000)	Not allowed			
	non-sprinklered				
	4 III (211)	Maximum 2 stories			
	sprinklered				
	5 IV (2HH))			
	6 V (111)				
	7 III (200)	Not allowed			
	non-sprinklered	Not allowed			
	8 V (000)	Maximum 1 story			
	sprinklered	,			
	•	s must be sprinklered			
	throughout by an	approved, supervised			
		in accordance with section			
	9.7. (See 19.3.5)				
		ription, in REMARKS, of the			
		number of stories, including			
		on which patients are of smoke or fire barriers and			
	· · · · · · · · · · · · · · · · · · ·	. Complete sketch or attach			
		f the building as appropriate.			
		on and interview, the facility	K 0161	K161 - It is the practice of En	vive 09/13/2024
	failed to maintain t	he building type of V (111) by		of Anderson to maintain the	
	_	e-hour ceiling smoke barrier		building type of V (111) by	
		nd living areas were maintained		ensuring smoke barriers are	
		esistance of the one-hour		maintained to ensure the fire	
		ent practice affects all staff,		resistance of the one-hour ba	
		idents in one smoke		1: What corrective action(s)	WIII
	compartment.			be accomplished for those residents found to have been	n
	Findings include:			affected by the deficient	"
	<i>g</i>			practice?	
	Based on observati	ons with the Maintenance		The 30 residents who could h	ave
	Director, Administ	rator, and the Regional VP on		been affected by the alleged	
	_	o.m., in room 114 and the 114		deficient practice had no nega	ative
	storeroom, the one-	-hour fire-rated ceiling		outcome On 8/29/24 contract	ors

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED		
		155690	B. W	ING		08/13/	/2024	
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					NDBERG RD			
ENVIVE	OF ANDERSON			ANDER	SON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY 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 O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	assembly collapsed	in early 2024 due to a broken			repaired Room 114 and the 1	14		
	pipe. Based on inte	rview at the time of			storeroom's collapsed ceiling	in		
	observation, the Ma	aintenance Director agreed the			order to provide fire resistance			
	one-hour fire-rated	ceiling assembly collapsed due			the one-hour barrier by replac			
	to a broken pipe, ar	nd stated the ceiling collapsed			the drywall to this area.	Ū		
	in early 2024 and h	as not yet been repaired.			-			
		-			2: How other residents havi	ng		
	The finding was re-	viewed with the Regional VP,			the potential to be affected b	-		
	Administrator, and	Maintenance Director during			the same deficient practice v	-		
	the exit conference	•			be identified and what			
					corrective action will be take	n.		
	3.1-19(b)				Rounds were made on 8/14/2	024		
					and no other residents have the	пе		
					potential to be affected by the			
					alleged deficient practice as a	II		
					other areas meet the requiren	nents		
					of the building type of V.			
					3: What measures will be pu	t		
					into place or what systemic			
					changes will be made to			
					ensure that the deficient			
					practice does not recur?			
					The Maintenance Director was	s		
					given education by the			
					administrator regarding the			
					requirement for ensuring smol	ke		
					barriers are maintained to ens	ure		
					the fire resistance of the one-l	nour		
					barrier.			
					Staff were reeducated on			
					8/30/2024 regarding the policy	/		
					related to ensuring smoke bar	riers		
					are maintained to ensure the t	fire		
					resistance of the one-hour bar	rier.		
					The Maintenance Director will			
					audit the building for effective	fire		
					resistance. This will be added	to to		
					the preventative maintenance	list.		
					4: How the corrective action			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690			A. BUILDING B. WING	<u>01</u>	COMPLETED 08/13/2024
	ROVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(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 APPROPRIA DEFICIENCY)	DATE
				will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. The Maintenance Director will fire resistance to his preventa maintenance checklist which to be completed weekly for 4 we and then every two weeks for months and then monthly for a months as part of the prevent maintenance program moving forward. The results of these audits will reviewed by the QA committe overseen by the Executive Director. If a threshold of 1000 not achieved, an action plan to be developed. The facility that the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for no than 6 months. 5. Date of completion: 9/13/2024	cur ce? add tive will eks two 3 ative I be e % is vill rough the
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to	General ays, corridors, exit cations, and accesses are a Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/13/2024 155690 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1821 LINDBERG RD **ENVIVE OF ANDERSON** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0211 **K211 –** It is the practice of Envive 09/13/2024 failed to maintain 1 of 12 exit discharges doors of Anderson to ensure exit were free of impediments to full instant use in the discharge doors are free of case of fire or other emergency in accordance with impediments to full instant use in LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door case of fire. assembly is required to be equipped with panic or 1: What corrective action(s) will fire exit hardware, (3) It shall be constructed so be accomplished for those that a horizontal force not to exceed 15 lbf (66 N) residents found to have been actuates the cross bar or push pad and latches. affected by the deficient This deficient practice could affect 15 residents in practice? the 200-hall. The 15 residents who could have been affected by the alleged Findings include: deficient practice had no negative outcome. The Maintenance Based on observation with the Maintenance Director repaired the panic Director, Administrator, and the Regional VP on hardware to the 300-hall exit door 08/13/24 at 1:10 p.m., the 300-hall exit door was allowing the door to provide full equipped with panic hardware, but the door would instant use in case of fire. The not open on the first try. The Maintenance door now opens correctly. Director tried three times to open the door and with great force the door opened on the third try. 2: How other residents having Based on an interview at the time of observation. the potential to be affected by the Maintenance Director agreed it took excessive the same deficient practice will force to open the exit door. be identified and what corrective action will be taken. The finding was reviewed with the Regional VP, Rounds were made on 8/14/2024 Administrator, and Maintenance Director during and no other residents have the the exit conference. potential to be affected by the alleged deficient practice as all 3.1-19(b) other resident doors opened with no issues. 3: What measures will be put into place or what systemic changes will be made to

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ensure that the deficient practice does not recur? The Maintenance Director was

given education by the administrator regarding the requirement for ensuring exit

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/13/2024
	ROVIDER OR SUPPLIE DF ANDERSON	R	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
ENVIVE C (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			DATE Paris Par
i l			1	1	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	l í	ILDING	onstruction 01	(X3) DATE COMPL 08/13/	LETED
	PROVIDER OR SUPPLIEF			1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE
K 0223 SS=E Bldg. 01		osing Devices assageway, stairway			5. Date of completion: 9/13/24		
	or hazardous area and kept in the cloopen by a release 7.2.1.8.2 that autodoors throughout entire facility upon * Required manua * Local smoke det smoke passing the required smoke do * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2	al fire alarm system; and ectors designed to detect rough the opening or a etection system; and aler system, if installed; and					
	failed to ensure the hazardous area encl kept in the closed p	on and interview, the facility corridor doors to 7 of 12 osures were self-closing and osition. This deficient practice dents in the 500-hall and	K 02	223	 K223 – It is the practice of Envor Anderson to ensure corridor doors leading to hazardous are enclosures are self-closing an kept in the closed position. 1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient 	r ea d will	09/13/2024
	Director, Administr 08/13/24 between 1 404, 407, 403, 406, storeroom, and the than 50 square feet of supplies and othe each room a hazard rooms were not equ	on with the Maintenance ator, and the Regional VP on 2:00 p.m. and 2:00 p.m., rooms the 300 storeroom, the 600 clean PPE storeroom were larger and contained over 15 boxes or combustible storage making ous area. All doors to the ipped with a self-closing to fully close and keep each			practice? The 30 residents who could have been affected by the alleged deficient practice had no negate outcome. Rooms 404, 405 and 407 were all cleaned out. Self-closing devices were place on doors for Room 406, the 30 storeroom, the 600 clean storeroom and the PPE	tive d	

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VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/13/2024
PROVIDER OR SUPPLIEF		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
SUMMARY (EACH DEFICIEN REGULATORY OF door in the closed p the time of observar agreed all seven roc areas, the self-closin not functioning pro with a self-closing of	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION osition. Based on interview at tion, the Maintenance Director oms were hazardous storage ng device on the doors were perly, or were not equipped device. viewed with the Regional VP, Maintenance Director during	1821 L	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) storeroom. 2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be tak Rounds were made on 8/14/2 and no other residents have a potential to be affected by the alleged deficient practice as a other corridor doors leading the hazardous areas are self-closed: 3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director was given education by the	ing by will en. 2024 the e all o sing. ut
			administrator regarding the requirement for corridor door leading to hazardous area enclosures are self-closing at kept in the closed position. Staff were reeducated on 8/30/2024 regarding the polic related to corridor doors lead hazardous area enclosures a self-closing and kept in the closition. The Maintenance Director wi audit corridor doors that lead hazardous areas ensuring that they have self-closing device are maintained in the closed position. This will be added to preventative maintenance list.	ing to are losed If to at s and loo the t.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155690	B. W	NG		08/13/	/2024
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			NDBERG RD		
FNVIVE	OF ANDERSON				SON, IN 46012		
LINVIVE.	- ANDLINGON			ANDEN			
(X4) ID	SUMMARY	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	LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
					will be monitored to ensure t	_	
					deficient practice will not rec	ur	
					i.e., what quality assurance	•	
					program will be put into plac		
					The Maintenance Director will		
					audit corridor doors that lead t		
					hazardous areas ensuring tha		
					they have self-closing devices are maintained in the closed	anu	
					position to the preventative		
					maintenance checklist which v	will	
					be completed weekly for 4 we		
					and then every two weeks for		
					months and then monthly for 3		
					months as part of the preventa		
					maintenance program moving		
					forward.		
					The results of these audits will	l be	
					reviewed by the QA committee		
					overseen by the Executive		
					Director. If a threshold of 100%	∕₀ is	
					not achieved, an action plan w	/ill	
					be developed. The facility thr	ough	
					the QAPI program, will review	,	
					update, and make changes to		
					POC as needed for sustaining		
					substantial compliance for no	less	
					than 6 months.		
					5. Date of completion:		
					9/13/2024		
K 0271	NEDA 404						
SS=E	NFPA 101	vita					
	Discharge from Ex						
Bldg. 01	Discharge from Ex						
		arranged in accordance with					
		vel walking surface meeting 7.1.7 with respect to					
		ion and shall be maintained					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155690	B. W	ING	_	08/13/	2024
	PROVIDER OR SUPPLIER		1821 L		ADDRESS, CITY, STATE, ZIP COD NDBERG RD RSON, IN 46012		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	BROWDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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)	16	DATE
	ree of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure 1 of provided with an ursurface in accordance dition) section 7.7. affect 20 residents to Findings include: Based on observation Director, Administration of the section of the secti	s. Additionally, the exit a hard packed all-weather on and interview, the facility of 12 exit discharges were hobstructed level walking on with NFPA 101 (2012). This deficient practice could hat would use the 100-hall exit. On with the Maintenance ator, and the Regional VP on a mean, the 100-hall exit discharge walkway leading to the walkway was uneven, had owing through the cracks. At the time of observation, the for agreed the walkway was in did not provide an walking surface.	KO	TAG	K271 – It is the practice of Envor Anderson to ensure exit discharges are provided with a unobstructed level walking surface. 1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? The 20 residents will could have been affected by the alleged deficient practice had negative outcome. The facility the process of obtaining quote perform this job. 2: How other residents having the potential to be affected by the alleged deficient practice where identified and what corrective action will be take Rounds were made on 8/14/2 and no other residents have the potential to be affected by the alleged deficient practice as an other means of egress are lit. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director was given education by the administrator regarding the requirement for ensuring exit discharges are provided with a discharge and provided with a discharges are provided with a discharge and provided with a discharge are provided	vive an will no he no is in es to vill en. 024 he	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/13/2024
	ROVIDER OR SUPPLIE	R	1821 L	ADDRESS, CITY, STATE, ZIP CO INDBERG RD RSON, IN 46012	DD
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE COMPLETION DATE
				unobstructed level walk surface. Staff were reeducated of 8/30/2024 regarding the related to ensuring exit are provided with an unlevel walking surface. The Maintenance Direct audit exit discharges. The Maintenance list. 4: How the corrective a will be monitored to endeficient practice will rive., what quality assurprogram will be put into the Maintenance Direct auditing exit discharges preventative maintenance checklist which will be weekly for 4 weeks and two weeks for two mont then monthly for 3 mont of the preventative main program moving forward. The results of these auditing reviewed by the QA condoverseen by the Execut Director. If a threshold of not achieved, an action be developed. The fact the QAPI program, will rupdate, and make chan POC as needed for sussubstantial compliance than 6 months. 5. Date of completion:	e policy discharges obstructed tor will this will be the tor ecur ance o place? tor will add to his toe completed then every the and the as part intenance d. dits will be mmittee ive of 100% is plan will ility through review, ges to the taining

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		ľ	ILDING	onstruction 01	(X3) DATE COMPL 08/13 /	ETED	
	PROVIDER OR SUPPLIER	2		1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD SON, IN 46012		
(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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0281 SS=E	NFPA 101				11/30/24 **Waiver requested		
Bldg. 01	discharge, is arrar and shall be eithe or capable of auto manual intervention 18.2.8, 19.2.8	ans of Egress ans of egress, including exit nged in accordance with 7.8 r continuously in operation matic operation without	H 00	201	K294 It is the prestice of En	ilvo	00/12/2024
	failed to ensure con of 12 exits. For the exit access shall includes, corridors, rampassageways leading of this requirement, only designated statescalators, walkway leading to a public could affect up to 3 and 500 exit paths. Finding includes:	tinuity of egress lighting for 2 purposes of this requirement, elude only designated stairs, aps, escalators, and g to an exit. For the purposes exit discharge shall include irs, aisles, corridors, ramps, and exit passageways way. This deficient practice 5 residents when using the 600	K 02	281	of Anderson to ensure continuity of egress lighting for all exits. 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 35 residents who could have been affected by the alleged deficient practice had no negative outcome. Lights were installed and placed at the 2 exit discharge sidewalks from the 600 to 500 halls exits.		09/13/2024
	Director, Administr 08/13/24 at 2:00 p.r from the 600 and 50 egress lighting for p the 600-hall to the p at the time of obser Director confirmed devices illuminating was undetermined i	on with the Maintenance rator, and the Regional VP on m., the exit discharge sidewalks 00 halls exits did not have portions of the sidewalks from public way. Based on interview vations, the Maintenance there were no other lighting g the sidewalks, and stated it f all of the aforementioned exit d with complete egress			2: How other residents having the potential to be affected by the same deficient practice who be identified and what corrective action will be take Rounds were made on 8/14/20 and no other residents have the potential to be affected by the alleged deficient practice as all other means of egress are lit.	y vill n. 024	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 08/13/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012			
(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	
140	lighting. The finding was rev	riewed with the Regional VP, Maintenance Director during		3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director was given education by the administrator regarding the requirement for ensuring conto of egress lighting for all exits. Staff were reeducated on 8/30/2024 regarding the policic related to ensuring continuity egress lighting for all exits. The Maintenance Director will audit egress lighting. This will added to the preventative maintenance list. 4: How the corrective action will be monitored to ensure deficient practice will not reive, what quality assurance program will be put into place. The Maintenance Director will egress lighting to his preventamintenance checklist which be completed weekly for 4 we and then every two weeks for months and then monthly for months as part of the prevent maintenance program moving forward. The results of these audits wireviewed by the QA committed overseen by the Executive Director. If a threshold of 100 not achieved, an action plant be developed. The facility the	s inuity y of I be the cur ce? I add ative will beks two 3 ative 9 Il be e % is vill	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING B. WING	01	COMPLETED 08/13/2024			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD				
ENVIVE	OF ANDERSON			RSON, IN 46012			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for no than 6 months.	the		
				5. Date of completion: 9/13/2024			
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II comprotection measures ubstituted for spring areas where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and the closet footprint Standard for Install Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure 1 of provided with adequal 13, 2010 edition, see shall be located so a	Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA are Installation of Sprinkler are permitted to be ankler protection in specific or local regulations prohibit alers are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers as required by NFPA 13,	K 0351	K351 – It is the practice of Envor Anderson to ensure all area are completely covered by sprinkler protection. 1: What corrective action(s) to be accomplished for those	as		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/13/2024			
	PROVIDER OR SUPPLIER OF ANDERSON		STREET 1821 L ANDE		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		s shall be provided to ensure	TAG	residents found to have bee	DATE
	adequate coverage	of the hazard. This deficient t 20 residents in one smoke		affected by the deficient practice? The 20 residents who could h	
	Findings include:			been affected by the alleged deficient practice had no negative outcome. On 8/14/24 and one	
	Based on observation with the Maintenance Director, Administrator, and the Regional VP on			this facility has requested a q from Elwood Fire system to	
	08/13/24 at 12:50 p.m., in the kitchen there was an alcove that was not completely covered by			replace the sprinkler head in alcove in the laundry room.	
	sprinkler protection. The front half of the alcove was protected by the sprinkler head near the		have been told that the item we		
	alcove but the coverage for the back half was blocked by a wall. Based on interview at the time			require is on back order for a minimum of 6 weeks.	
		Maintenance Director agreed alcove was not protected by		2: How other residents have the potential to be affected by	_
	sprinkler coverage.	1 7		the same deficient practice be identified and what	-
	_	riewed with the Regional VP,		corrective action will be take	
	the exit conference.	Maintenance Director during		Rounds were made on 8/14/2 and no other residents have t	he
	3.1-19(b)			potential to be affected by the alleged deficient practice as a	
				other are sprinklered per regulation.	
				3: What measures will be purinto place or what systemic	t
				changes will be made to ensure that the deficient	
				practice does not recur?	
				The Maintenance Director wa given education by the	S
				administrator regarding the requirement for ensuring all a	reas
				are completely covered by sprinkler protection.	
				Staff were reeducated on	
				8/30/2024 regarding the polic related to ensuring all areas a	-

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/13/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD			
ENVIVE (OF ANDERSON			RSON, IN 46012		
(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 APPROPRIA DEFICIENCY)	5.112	
				completely covered by sprinkly protection. The Maintenance Director will monitor the sprinkler system. This will be added to the preventative maintenance list 4: How the corrective action		
				will be monitored to ensure deficient practice will not re- i.e., what quality assurance program will be put into place The Maintenance Director will	the cur ce?	
				sprinkler system to his preventative maintenance checklist which will be comple weekly for 4 weeks and then two weeks for two months and then monthly for 3 months as of the preventative maintenants.	every d part	
				program moving forward. The results of these audits wi reviewed by the QA committe overseen by the Executive Director. If a threshold of 100 not achieved, an action plan who be developed. The facility the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for no than 6 months.	Il be e % is vill rough , the	
				5. Date of completion: 11/30/24 **Waiver requested		

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/13/2024 155690 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1821 LINDBERG RD **ENVIVE OF ANDERSON** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0353 **NFPA 101** SS=E Sprinkler System - Maintenance and Testing Bldg. 01 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 K 0353 Based on observation and interview, the facility **K353** – It is the practice of Envive 11/30/2024 failed to ensure 7 of 40 sprinklers in one smoke of Anderson to ensure sprinklers compartment were free of corrosion. NFPA 25, are free of corrosion. 2011 edition, at 5.2.1.1.1 sprinklers shall not show 1: What corrective action(s) will signs of leakage; shall be free of corrosion, be accomplished for those foreign materials, paint, and physical damage; and residents found to have been shall be installed in the correct orientation (e.g., affected by the deficient up-right, pendent, or sidewall). Furthermore, at practice? 5.2.1.1.2 any sprinkler that shows signs of any of The 20 residents who could have the following shall be replaced: (1) Leakage (2) been affected by the alleged Corrosion (3) Physical Damage (4) Loss of fluid in deficient practice had no negative the glass bulb heat responsive element (5) outcome. On 8/14/24 and ongoing, Loading (6) Painting unless painted by the this facility has requested a quote sprinkler manufacturer. This deficient practice from Elwood Fire system to could affect staff and up to 20 residents in one replace the 7 sprinkler heads that smoke compartment. have corrosion. We have been told that the item we require is on back

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order for a minimum of 6 weeks.

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155690	B. WING 08/13/2024			08/13/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	₹		1821 LINDBERG RD		
ENVIVE	OF ANDERSON				RSON, IN 46012	
			1		T	T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFECTION OF THE APPROPRIA	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		DATE
		on with the Maintenance			2: How other residents having	<u> </u>
		rator, and the Regional VP on .m., one sprinkler head in the			the potential to be affected be the same deficient practice w	
	_	sprinkler heads in the kitchen			be identified and what	/III
	_	wed signs of corrosion. Based			corrective action will be take	n
	_	time of observation, the			Rounds were made on 8/14/20	
		tor agreed the aforementioned			and no other residents have the	
		wed signs of corrosion.			potential to be affected by the	
	1	5			alleged deficient practice as all	ı
	The finding was rev	viewed with the Regional VP,			other sprinkler heads are free	
	_	Maintenance Director during			corrosion.	
	the exit conference.	•			3: What measures will be put	
					into place or what systemic	
	3.1-19(b)				changes will be made to	
					ensure that the deficient	
					practice does not recur?	
					The Maintenance Director was	;
					given education by the	
					administrator regarding the	
					requirement for ensuring sprin	
					are free of corrosion. Staff we	
					reeducated on 8/30/2024 rega	rding
					the policy related to ensuring	
					sprinklers are free of corrosior	l.
					The Maintananae Director will	
					The Maintenance Director will audit sprinkler heads for lack of	of
					<u> </u>	
				corrosion. This will be added to the preventative maintenance list.		
					l lo provontativo maintonanco	not.
					4: How the corrective action	
					will be monitored to ensure t	he
					deficient practice will not rec	ur
					i.e., what quality assurance	
					program will be put into plac	e?
					The Maintenance Director will	
					the lack of corrosion of sprinkle	er
					heads to his preventative	
					maintenance checklist which v	vill
					be completed weekly for 4 week	eks

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING <u>01</u> COMPLETED B. WING 08/13/2024				
		100000	D. W1	_		00/13/	72024
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD NDBERG RD		
ENVIVE	OF ANDERSON				RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting than required ence exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other closures of vertical openings, as areas resist the passage made of 1 3/4 inch a wood or other material of fire for at least 20 fully sprinklered smoke a only required to resist the expectation of the control of the cont		TAG	and then every two weeks for months and then monthly for a months as part of the prevent maintenance program moving forward. The results of these audits will reviewed by the QA committe overseen by the Executive Director. If a threshold of 1000 not achieved, an action plan vibe developed. The facility the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for not than 6 months. 5. Date of completion: 11/30/24 **Waiver requested	3 ative If be e % is vill rough f, the	DATE
	to rooms containi combustible mate hardware. Roller CMS regulation. apply to auxiliary						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155690		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/13/2024			
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	covering is not ex doors complying vif provided with a the door closed wapplied. There is closing of the doorelease when the permitted. Nonratunlimited height a meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARM fire protection ratic devices, etc. Based on observating failed to ensure 2 osouthwest 300 hall suitable for keeping impediment to close	fire window assemblies are a sprinklered compartments actions in area or fire is or frames in window Parts 403, 418, 460, 482, AS details of doors such as angs, automatics closing on and interview, the facility of 25 room corridor doors on the were provided with a means of the door closed, had no ing, latching and would resist is deficient practice.	K 0363	K363 – It is the practice of En of Anderson to ensure corridor doors latch effectively, have not impediment to closing and are provided with a means suitable keeping the door closed. 1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient	or no e le for will		
	Director, Regional 08/12/24 at 1:00 p.i	on with the Maintenance Director, and Administrator on m., the TV room and phone room ld not latch due to tape over		practice? The 13 residents who could h been affected by the alleged deficient practice had no nega outcome. On 8/14/2024 the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	COMPLETED	
		155690	B. WING		08/13/2024
	PROVIDER OR SUPPLIER		182	EET ADDRESS, CITY, STATE, ZIP COD 21 LINDBERG RD DERSON, IN 46012	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· · · · · · · · · · · · · · · · · · ·		PREFI	CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG	the strike plate. Base observation, the Maccorridor doors would when tested. This finding was re Director, Environm	sed on interview at the time of continuent into the door frame do not latch into the door frame wiewed with the Maintenance ental Services Director, and Administrator during the	TAG	Maintenance Director inspect the latch on the TV room and phone room and was able to remove the tape over the striplate so that the door would I effectively. The doors now cloorrectly. 2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be tak Rounds were made on 8/14/2 and no other residents have potential to be affected by the alleged deficient practice as a other resident doors latched no issues. 3: What measures will be puinto place or what systemic changes will be made to ensure that the deficient practice does not recur?	ted ke atch ose ing by will en. 2024 the eall with
				practice does not recur? The Maintenance Director was given education by the administrator regarding the requirement for ensuring corridors latch effectively, have a impediment to closing and an provided with a means suitable keeping the door closed. State were reeducated on 8/30/202 regarding the policy related to ensuring corridor doors latch effectively, have no impediment closing and are provided with means suitable for keeping the door closed.	ridor no e ele for ff 24 o ent to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/13/2024						
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	The Maintenance Director will audit corridor doors for effective latching. This will be added to preventative maintenance list. 4: How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The Maintenance Director will the latching of resident doors his preventative maintenance checklist which will be comple weekly for 4 weeks and then ensure two weeks for two months and then monthly for 3 months as of the preventative maintenant program moving forward. The results of these audits will reviewed by the QA committed overseen by the Executive Director. If a threshold of 1000 not achieved, an action plan will be developed. The facility that the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for not than 6 months. 5. Date of completion: 9/13/24	the cur te? add to ted every d part ce I be e % is vill rough , the			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulati Smoking Regulati Smoking regulation							

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shall include not less than the following

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/13/2024	
	OVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD LINDBERG RD RSON, IN 46012	
(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
(; w lii u k s p s s (; s p s s s (; r (; a s s) (; s v (; d s s))))	vard, or compartment of the comp	tients classified as not be prohibited. Int of 18.7.4(3) shall not atient is under direct incombustible material and be provided in all areas permitted. In with self-closing cover ashtrays can be emptied ailable to all areas where ed.			
f p n c	Pailed to ensure 2 of properly maintained noncombustible concover to dispose of coractice could affect	on and interview; the facility 2 smoking areas were and provided with a metal or tainers with self-closing cigarette butts. This deficient t staff by the employe exit and ourtyard smoking area.	K 0741	 K741 – It is the practice of En of Anderson to ensure smokin areas are properly maintained provided with a metal or or noncombustible container with self-closing cover devices. 1: What corrective action(s) be accomplished for those 	ng d and h
E	Director, Administra	on with the Maintenance ator, and the Regional VP on n., in the courtyard smoking		residents found to have bee affected by the deficient practice? The 10 residents who could have been affected by the alleged	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING B. WING	01	COMPLETED 08/13/2024	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD INDBERG RD	
ENVIVE	OF ANDERSON		ANDER	RSON, IN 46012	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	area there were 6 sn loose and not attach cigarette butts were employee exit, and with a self-closing I smoking areas. Base of observations, the the smoker's poles of and cigarette butts we the employee exit.	noker's poles with the covers ed to the buckets, at least 30 on the ground around the the required metal container id was not provided for both ed on an interview at the time Maintenance Director agreed lid not have the lids secured were on the ground outside iewed with the Regional VP, Maintenance Director during		deficient practice had no negation outcome. A metal container with self-closing cover device to dispose of cigarette butts wern placed in both smoking areas Maintenance Director also ensured that the 6 smoker's placed with the formation of the potential to be affected with the same deficient practice with the same deficient practice with the same deficient practice with the same deficient practice. The Maintenance Director provided metal contain with a self-closing cover deviction dispose of cigarette butts and ensured the smoker's poles with properly closed and latched in smoking areas. 3: What measures will be purint practice does not recur? The Maintenance Director was given education by the administrator regarding the requirement for ensuring smoareas are properly maintained provided with a metal or or noncombustible container with self-closing cover devices. Staff were reeducated on 8/30/2024 regarding the policing related to ensuring smoking are properly maintained and are properly mainta	ative ith a set one of the color of the colo

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2024			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION		
TAG	KEGULATURY OF	R LSC IDENTIFYING INFORMATION	TAG	provided with a metal or or noncombustible container with self-closing cover devices. The Maintenance Director will responsible for completing QA audit tool Smoking Area Assessment 5 x a week for the first month, 3 x a week for the second month and weekly for third month, then monthly for months. All cigarette butts have been removed and cleaned up new self-closing metal contain was provided in the 2 designal smoking areas. All smoker's pwere closed and latched proped. How the corrective action will be monitored to ensure deficient practice will not recise, what quality assurance program will be put into place. The Maintenance Director will responsible for completing QA audit tool Smoking Area Assessment 5 x a week for the first month, 3 x a week for the second month, and weekly for third month, then monthly for months. The results of these audits will reviewed by the QA committe overseen by the Executive Director. If a threshold of 1000 not achieved, an action plan vibe developed. The facility the QAPI program, will reviewed update, and make changes to	the API e the 3 we p; a ner ated poles erly. the cur ce? I be API e r the 3		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> B. WING		01	COMPLETED 08/13/2024	
155690			B. W.			08/13/	ZUZ 4
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	1	DATE
					substantial compliance for no than 6 months.	iess	
					5. Date of completion: 9/13/2024		
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects 2 residents.		K 0	920	K920 – It is the practice of Envor Anderson to ensure power strips in patient care locations the required UL rating of 1363 60601-1. 1: What corrective action(s)	met A or	09/13/2024

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER			COMPLETED			
155690		B. WING 08/13/2024			08/13/2024			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			-	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DLAN OF CORRECTION	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	Findings include:				be accomplished for those			
					residents found to have been	n		
		on with the Maintenance		affected by the deficient practice?				
		rator, and the Regional VP on						
	_	.m., a power-strip was attached			The surge protector was repla	iced		
	_	oom 118, was in use within 6 are area, and did not meet			on 8/14/24 in Room 118.			
		Based on interview at the time			2: How other residents havi	ng		
		Maintenance Director agreed			the potential to be affected by	<u> </u>		
		s part of the lamp, was use in a			the same deficient practice v	-		
	resident care area, a	and did not meet 1363A or			be identified and what			
	60601-1.			corrective action will be taken.				
					Rounds were made on 8/14/2	024		
	The finding was reviewed with the Regional VP,			and no other residents have the				
Administrator, and Maintenance Director during			potential to be affected by the					
the exit conference.				alleged deficient practice as the	I			
	2.1.10(b)				were no other power strips in	use		
3.1-19(b)				that did not meet the				
					requirements. Staff were	ardin a		
					reeducated on 8/30/2024 regather use of surge protectors wi	-		
					the facility.	u III		
					3: What measures will be pu	t		
					into place or what systemic			
				changes will be made to				
					ensure that the deficient			
					practice does not recur?			
					The Maintenance Director wa	s		
					given education by the			
					administrator regarding the us	sage		
					of surge protectors within the			
					facility. Staff were reeducated	I		
					8/30/2024 regarding the policy	/		
					related to surge protectors.			
					4: How the corrective action			
					will be monitored to ensure	the		
				deficient practice will not red	cur			
				i.e., what quality assurance				
					program will be put into place	e?		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2024			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
				Administrator and/or Design monitor 3 times per week all areas in the building to ensu devices are used per policy weeks, then 2 times per week 3 months, then monthly for 2 months.	ternate ire that for 4 ek for		
				The results of the monitoring be reviewed by the QA com overseen by the Executive Director. If a threshold of 10 not achieved, an action plan be developed. The facility the QAPI program, will revieupdate, and make changes POC as needed for sustaining substantial compliance for not than 6 months. 5. Date of completion: 9/13/2024	mittee 0% is will through w, to the		
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withi space of non- or li construction, with that can be secure	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an in an enclosed interior imited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING COMPLETED

AND PLAN OF CORRECTION 01 B. WING 08/13/2024 155690 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1821 LINDBERG RD **ENVIVE OF ANDERSON** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA

Based on observation and interview, the facility K 0923 **K923** – It is the practice of Envive failed to ensure 1 of 1 outside oxygen storage of Anderson to ensure outside areas were locked and provided with a oxygen storage areas are locked precautionary sign readable from 5 feet is on each and provided with precautionary door or gate of a cylinder storage room, where the sign readable from 5 feet on the sign includes the wording as a minimum door or gate of the cylinder "CAUTION: OXIDIZING GAS(ES) STORED storage room. WITHIN NO SMOKING." This deficient practice 1: What corrective action(s) will could affect staff, visitors, and 10 patients using be accomplished for those the 400-hall exit. residents found to have been

practice?

affected by the deficient

Findings include:

09/13/2024

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155690	A. BUILDING <u>01</u> CC		(X3) DATE SURVEY COMPLETED 08/13/2024
	PROVIDER OR SUPPLIER OF ANDERSON	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 1:00 p.m., the gate to the oxygen (O2) storage cage outside the 400-hall exit was not locked and secured. Also, the O2 cage was not provided with precautionary signs which states ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Based on interview at the time of observation, the Maintenance Director stated there was not a lock for the O2 gate and did not have precautionary signs indicating storage of oxidizing gasses and no smoking. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		The 10 residents who could habeen affected by the alleged deficient practice had no negate outcome. On 8/14/2024 the Maintenance Director ordered sign to be affixed to the gate at the door of the cylinder storage room with wording "No Flammables within 25 feet" and also put a lock on the gate to exploy the coxygen storage area. Staff we reeducated on 8/30/2024 on the policy regarding locking the oxygen storage as well as the signage requirement for the oxygen storage area. 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take Rounds were made on 8/14/2 and no other residents have the potential to be affected by the alleged deficient practice. Staff were reeducated on 8/30/2022 regarding locking the oxygen storage as well as the signage requirement for the oxygen storage area. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director was given education by the administrator regarding the requirement for locking the oxygen education by the administrator regarding the requirement for locking the oxygen equirement for locking	ave tive a ind e ind he ine ne ing y vill n. 024 ne f 4

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING <u>01</u>		3) DATE SURVEY COMPLETED 08/13/2024				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			1821	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
	OF ANDERSON SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1821	ERSON, IN 46012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) storage and the signage requirement for the oxygen storage area. Staff were reeducated on 8/30/2024 regard the policy related to locking the oxygen storage area as well as the signage requirement for the oxygen storage area. 4: How the corrective action will be monitored to ensure the deficient practice will not recurive., what quality assurance program will be put into place. The Maintenance Director will be responsible for completing QAF audit tool Oxygen Area. Assessment 5 x a week for the first month, 3 x a week for the first month, 3 x a week for the second month, and weekly for the third month, then monthly for 3 months. The results of the monitoring will be reviewed by the QA committed overseen by the Executive Director. If a threshold of 100% not achieved, an action plan will be developed. The facility throothe QAPI program, will review, update, and make changes to the second make changes to	ding e ur ? he ll ee is l ugh			
				POC as needed for sustaining substantial compliance for no le than 6 months. 5. Date of completion: 9/13/2024	ess			

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