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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ				SURVEY ETED	
		155690	B. WI	ING		08/13/	2024
	PROVIDER OR SUPPLIER		•	1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD RSON, IN 46012	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	NTIFYING INFORMATION TAG DEFICIENCY)		DEFICIENCY)	112	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 Ferand State Law. The Plan of Correction is submitted to rest to 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							1
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 PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 65UP21 Facility ID: 000027 If continuation sheet Page 1 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

ENVIVE O (X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIE	18 Al	821 LIN	DDRESS, CITY, STATE, ZIP COD		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR				SON, IN 46012		
	Dequirements for Do	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Medicare/Medicaid, Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa This one story facili Type V111 construc sprinkleredwith exce kitchen alcove. The with smoke detectio to the corridors and detection in the 500 rooms. The facility to census of 49 at the t All areas where the access were sprinkle	eption of the back half of the facility has a fire alarm system 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 sidents have customary bred. 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.	n	
SS=E Bldg. 01	Building Construct 2012 EXISTING Building constructi Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5 Construc						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 2 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			
		155690	B. WING		08/13/2024	
NAME OF I	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP COD		
				INDBERG RD		
EINVIVE	OF ANDERSON		ANDER	RSON, IN 46012		
(X4) ID		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 DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
	non-sprinklered	Maximum 3 stories				
	sprinklered	Maximum 3 stones				
	oprimition ou					
	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 bar		
		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 ha	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	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $65 UP21 \qquad \text{Facility ID:} \quad 000027 \qquad \qquad \text{If continuation sheet} \qquad \text{Page 3 of 32}$

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			ETED	
		155690	B. W	ING		08/13/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
					NDBERG RD		
ENVIVE	OF ANDERSON			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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 interview 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, and stated the ceiling collapsed				the drywall to this area.	· ·	
	in early 2024 and h	as not yet been repaired.					
	·				2: How other residents having	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	ne	
					potential to be affected by the		
					alleged deficient practice as a		
					other areas meet the requirem		
					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		
					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	ire	
					resistance of the one-hour bar	rier.	
					The Maintenance Director will		
					audit the building for effective	fire	
					resistance. This will be added	l to	
					the preventative maintenance	list.	
					· ·		
					4: How the corrective action		

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	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 vibe developed. The facility that he 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 chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 5 of 32

09/03/2024 PRINTED: FORM APPROVED

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

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

given education by the administrator regarding the requirement for ensuring exit

If continuation sheet

Page 6 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF 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 COD INDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			e in y arge s to l o the cur ce? l add is eted every d part nce ll be e % is will rough y, o the g
i					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 7 of 32

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	î ´	LDING	nstruction 01	(X3) DATE COMPL 08/13 /	ETED
	PROVIDER OR SUPPLIEF			1821 LII	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	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0223 SS=E Bldg. 01		_			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	a enclosure are self-closing psed position, unless held device complying with smatically closes all such the smoke compartment or a activation of: all fire alarm system; and ectors designed to detect rough the opening or a etection system; and the system, if installed; and 12.8, 19.2.2.2.7, 19.2.2.2.8					
	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	23	 K223 – It is the practice of Envor Anderson to ensure corridor doors leading to hazardous an 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 er 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 negation outcome. Rooms 404, 405 and 407 were all cleaned out. Self-closing devices were plaction doors for Room 406, the 30 storeroom, the 600 clean storeroom and the PPE	tive d eed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 8 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) 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		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	•
ENVIVE (X4) ID PREFIX TAG	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	riewed with the Regional VP, Maintenance Director during		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) storeroom. 2: How other residents have the potential to be affected I the same deficient practice to be 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 a other corridor doors leading to hazardous areas are self-closts: What measures will be purinto place or what systemic	ing by will en. 2024 he elall bosing.
				changes will be made to ensure that the deficient practice does not recur? The Maintenance Director wa given education by the administrator regarding the requirement for corridor doors leading to hazardous area enclosures are self-closing arkept in the closed position. Staff were reeducated on 8/30/2024 regarding the polici related to corridor doors leadin hazardous area enclosures a self-closing and kept in the cliposition. The Maintenance Director will audit corridor doors that lead hazardous areas ensuring that they have self-closing devices are maintained in the closed position. This will be added to preventative maintenance list	y y y y y y y to re osed I to at s and o the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 9 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		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.	CI ANDLINOON			ANDEN	10012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ACH DEFICIENCY 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					
	1	vel walking surface meeting 7.1.7 with respect to					
	1	ion and shall be maintained					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 10 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155690	B. W	ING	_	08/13/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, S 1821 LINDBERG RD ANDERSON, IN 4601				
(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	en and interview, the facility of 12 exit discharges were constructed level walking on with NFPA 101 (2012). This deficient practice could that would use the 100-hall exit. The months of the walking of the walkway was uneven, had sowing through the cracks, at the time of observation, the cor agreed the walkway was in did not provide an walking surface. The exit discharge 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 discharge and provided with a discharge are provided wi	vive an will no he no is in es to vill en. 024 he	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21 Facility ID: 000027

If continuation sheet Page 11 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMPLETED 08/13/2024
	ROVIDER OR SUPPLIE	R	1821 L	ADDRESS, CITY, STATE, ZIP COI INDBERG RD RSON, IN 46012	D
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE
				unobstructed level walking surface. Staff were reeducated on 8/30/2024 regarding the related to ensuring exit of are provided with an unclevel walking surface. The Maintenance Direct audit exit discharges. The added to the preventative maintenance list. 4: How the corrective a will be monitored to endeficient practice will not i.e., what quality assurated program will be put into the Maintenance Direct auditing exit discharges preventative maintenance checklist which will be converted weekly for 4 weeks and two weeks for two months then monthly for 3 months of the preventative main program moving forward. The results of these auditing reviewed by the QA compoverseen by the Execution of the QAPI program, will reviewed, an action be developed. The facion the QAPI program, will reviewed to month achieved, an action be developed. The facion the QAPI program, will reviewed to months. 5. Date of completion:	n policy discharges obstructed or will his will be re cotton sure the rot recurance oplace? or will add to his ce completed then every and his as part tenance d. Lits will be mittee ve f 100% is plan will lity through eview, ges to the raining

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If

If continuation sheet Page 12 of 32

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690			r í	LDING	nstruction <u>01</u>	(X3) DATE COMPL 08/13 /	ETED
	PROVIDER OR SUPPLIEF OF ANDERSON	3		1821 LII	DDRESS, CITY, STATE, ZIP COD NDBERG RD SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	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 Illumination of Me				11/30/24 **Waiver requested		
Bldg. 01	discharge, is arrai and shall be eithe or capable of auto manual intervention 18.2.8, 19.2.8	ans of egress, including exit nged in accordance with 7.8 r continuously in operation matic operation without	K 02	01	K281 – It is the practice of En	vivo	09/13/2024
	failed to ensure con of 12 exits. For the exit access shall includes, corridors, ram passageways 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, clude only designated stairs, aps, escalators, and ag 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	81	K281 – It is the practice of Envive 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.1 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 in	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 we 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	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 13 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

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	
	PROVIDER OR SUPPLIEF		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 LISC 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	viewed 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 eeks two 3 ative 9 Il be e % is will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

27 If continuation sheet

Page 14 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING B. WING	01	COMPLETED 08/13/2024	
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
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 conprotection 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

)27

If continuation sheet Page 15 of 32

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	
	PROVIDER OR SUPPLIER 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	(X5) COMPLETION
TAG		s shall be provided to ensure	TAG	residents found to have bee	DATE n
		of the hazard. This deficient t 20 residents in one smoke		affected by the deficient practice? The 20 residents who could h	ave
	Findings include:			been affected by the alleged deficient practice had no negative outcome. On 8/14/24 and once	
	Director, Administr	on with the Maintenance ator, and the Regional VP on .m., in the kitchen there was an		this facility has requested a qualiform Elwood Fire system to	uote
	alcove that was not	completely covered by		replace the sprinkler head in the alcove in the laundry room. When have been told that the item versions are the sprinkler head in t	Ve
sprinkler protection. The front half of the alcove was protected by the sprinkler head near the alcove but the coverage for the back half was			require is on back order for a minimum of 6 weeks.	ve	
	of observation, the	Based on interview at the time Maintenance Director agreed		2: How other residents havi	ng
	the back half of the sprinkler coverage.	alcove was not protected by		the potential to be affected the same deficient practice	-
	_	viewed with the Regional VP, Maintenance Director during		be identified and what corrective action will be take Rounds were made on 8/14/2	
	the exit conference.			and no other residents have t potential to be affected by the	
	3.1-19(b)			alleged deficient practice as a other are sprinklered per	ıll
				regulation. 3: What measures will be puinto place or what systemic	t
				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 requirement for ensuring all a	reas
				are completely covered by sprinkler protection.	. 5 5 5 5
				Staff were reeducated on 8/30/2024 regarding the polic	-
				related to ensuring all areas a	re l

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	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 SUPPLIEF	ł		ADDRESS, CITY, STATE, ZIP COD INDBERG 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 APPROPRIV DEFICIENCY) completely covered by sprinkly	5.112
				protection. The Maintenance Director wil 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 relie.e., what quality assurance program will be put into place. The Maintenance Director will sprinkler system to his preventative maintenance checklist which will be completed weekly for 4 weeks and then two weeks for two months and then monthly for 3 months as of the preventative maintenary 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 where the QAPI program, will review update, and make changes to POC as needed for sustaining substantial compliance for no than 6 months.	the cur ce? I add eted every d part ice II be e % is will rough /, o the
				5. Date of completion: 11/30/24 **Waiver requested	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 65UP21 Facility ID: 000027 If continuation sheet Page 17 of 32

09/03/2024 PRINTED: FORM APPROVED

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

order for a minimum of 6 weeks.

Page 18 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155690	B. W	ING		08/13/	2024
			_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			NDBERG RD		
ENVIVE	OF ANDERSON			ANDERSON, IN 46012			
					T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		on with the Maintenance			2: How other residents having	_	
		rator, and the Regional VP on			the potential to be affected b	- 1	
	_	.m., one sprinkler head in the			the same deficient practice v	/111	
	_	sprinkler heads in the kitchen			be identified and what		
	_	wed signs of corrosion. Based time of observation, the			corrective action will be take		
					Rounds were made on 8/14/20	-	
		tor agreed the aforementioned wed signs of corrosion.			and no other residents have the	ie	
	sprinkler neads sno	wed signs of corrosion.			potential to be affected by the	.	
	The finding was	viewed with the Regional VP,			alleged deficient practice as a		
	_	Maintenance Director during			other sprinkler heads are free corrosion.	irom	
	the exit conference.						
	the exit conference.				3: What measures will be put		
	3.1-19(b)				into place or what systemic changes will be made to		
	3.1-19(0)				ensure that the deficient		
					practice does not recur?		
					The Maintenance Director was	,	
					given education by the	•	
					administrator regarding the		
					requirement for ensuring sprin	klore	
					are free of corrosion. Staff we		
					reeducated on 8/30/2024 rega		
					the policy related to ensuring	liuling	
					sprinklers are free of corrosion	,	
					Sprinkers are free or corresion	"	
					The Maintenance Director will		
					audit sprinkler heads for lack of		
					corrosion. This will be added		
					the preventative maintenance		
					4: How the corrective action		
					will be monitored to ensure t	he I	
					deficient practice will not rec	ur	
					i.e., what quality assurance		
					program will be put into place	e?	
					The Maintenance Director will		
					the lack of corrosion of sprinkl	er	
					heads to his preventative		
					maintenance checklist which w	vill	
					be completed weekly for 4 we	eks	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21 Facility ID: 000027

If continuation sheet Page 19 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING <u>01</u> COMPLETE B. WING 08/13/202				
		100000	D. W			00/13	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	ATE	COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors	A LOC IDENTIFY LING INFURMATION		IAU	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 will 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 not than 6 months. 5. Date of completion: 11/30/24 **Waiver requested	ative g II be e % is will rough f, the	DATE
Sidg. 01	Doors protecting than required end exits, or hazardou of smoke and are solid-bonded core capable of resisting minutes. Doors in compartments are passage of smok to rooms containing combustible mater hardware. Roller CMS regulation. apply to auxiliary	corridor openings in other closures of vertical openings, as areas resist the passage made of 1 3/4 inch e wood or other material ing fire for at least 20 fully sprinklered smoke e only required to resist the e. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain inbustible material.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 20 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/13/2024		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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		
	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 glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARM fire protection ratidevices, etc. Based on observatifailed to ensure 2 o southwest 300 hall suitable for keeping impediment to close	fire window assemblies are a sprinklered compartments ctions in area or fire sor 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 ling, latching and would resist as. This deficient practice	K 0363	K363 – It is the practice of En of Anderson to ensure corridor doors latch effectively, have n impediment to closing and are provided with a means suitable keeping the door closed. 1: What corrective action(s) be accomplished for those	o e e for		
	Findings include:			residents found to have bee affected by the deficient practice?	n		
	Director, Regional 08/12/24 at 1:00 p.1	on with the Maintenance Director, and Administrator on n., the TV room and phone room ld not latch due to tape over		The 13 residents who could h been affected by the alleged deficient practice had no negative outcome. On 8/14/2024 the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 21 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED		
		155690	B. WING		08/13/2024
	PROVIDER OR SUPPLIEF		1821	ADDRESS, CITY, STATE, ZIP COD LINDBERG RD RSON, IN 46012	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE .
	_	sed on interview at the time of unitenance Director stated the		Maintenance Director inspect	ed
	· · · · · · · · · · · · · · · · · · ·	ld not latch into the door frame		the latch on the TV room and phone room and was able to	
	when tested.	id not faten into the door frame		remove the tape over the strik	70
	when tested.			plate so that the door would la	
	This finding was re	viewed with the Maintenance		effectively. The doors now cle	
	_	ental Services Director,		correctly.	
		and Administrator during the			
	exit conference.			2: How other residents havi	ng
				the potential to be affected by	ру
	3.1-19(b)			the same deficient practice v	will
				be identified and what	
				corrective action will be take	
				Rounds were made on 8/14/2	
				and no other residents have t	
				potential to be affected by the alleged deficient practice as a	
				other resident doors latched v	
				no issues.	VIUI
				3: What measures will be pu	t l
				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	4
				requirement for ensuring corri	
				doors latch effectively, have n impediment to closing and are	
				provided with a means suitable	
				keeping the door closed. Staf	
				were reeducated on 8/30/202	
				regarding the policy related to	
				ensuring corridor doors latch	
				effectively, have no impedime	nt to
				closing and are provided with	а
				means suitable for keeping th	e
				door closed.	
	l		1	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 22 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 08/13/2024			
	PROVIDER OR SUPPLIER		1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD RSON, 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	(X5) COMPLETION
TAG	REGULATORY OF	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 redice, 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 complessed 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 who had 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 regulatio				

FORM CMS-2567(02-99) Previous Versions Obsolete

shall include not less than the following

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 23 of 32

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 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
	ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the interpretation of the smoking. (2) In health care a smoking is prohibited prominently placed secondary signs where smoking shall not (3) Smoking by paresponsible shall the supervision. (4) The requirement apply where the properties of the supervision. (5) Ashtrays of notes a design shall the where smoking is (6) Metal contained devices into which shall be readily away smoking is permitted.	d at all major entrances, with language that prohibits be required. Attents classified as not be prohibited. And of 18.7.4(3) shall not attent is under direct attent is under direct and be provided in all areas permitted. Are with self-closing cover an ashtrays can be emptied railable to all areas where sted.			
	failed to ensure 2 of properly maintained noncombustible cor cover to dispose of practice could affec	on and interview; the facility f 2 smoking areas were d and provided with a metal or ntainers with self-closing cigarette butts. This deficient t staff by the employe exit and courtyard smoking area.	K 0741	 K741 – It is the practice of En of Anderson to ensure smoking areas are properly maintained provided with a metal or or noncombustible container with self-closing cover devices. What corrective action(s) 	ng d and h
	Director, Administr	on with the Maintenance ator, and the Regional VP on		be accomplished for those residents found to have bee affected by the deficient practice? The 10 residents who could he	
	08/13/24 at 2:10 p.r	n., in the courtyard smoking		been affected by the alleged	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 24 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

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		ANDEF	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 twith a self-closing l smoking areas. Base of observations, the the smoker's poles dand cigarette butts we the employee exit. The finding was rev	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 wiself-closing cover device to dispose of cigarette butts were placed in both smoking areas. Maintenance Director also ensured that the 6 smoker's pwere properly closed and late. 2: How other residents having the potential to be affected by the same deficient practice with be identified and what corrective action will be take. All residents have the potential be affected by the alleged definance. The Maintenance Director provided metal contain with a self-closing cover deviced dispose of cigarette butts and ensured the smoker's poles with properly closed and latched in smoking areas. 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 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 policy related to ensuring smoking a are properly maintained and	ative ith a set of the color of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 25 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690			(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 08/13/2024	
	PROVIDER OR SUPPLIEF	3	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, 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 cur te? be API the cur te? be API e r the 3 I be e r the 3

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

POC as needed for sustaining

Page 26 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(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	<u> </u>			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		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			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		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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet

Page 27 of 32

ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER			COMPLETED		
155690		B. WING 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	SIIMMADV	STATEMENT OF DEFICIENCIE		ID.	T	(Y5)	
PREFIX		CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5)	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	1011
	Findings include:				be accomplished for those		
	8				residents found to have been	n	
	Based on observation	on with the Maintenance			affected by the deficient		
	Director, Administr	rator, and the Regional VP on			practice?		
		.m., a power-strip was attached			The surge protector was repla	ced	
	to a floor lamp in ro	oom 118, was in use within 6			on 8/14/24 in Room 118.		
	feet of a resident ca	re area, and did not meet					
	1363A or 60601-1.	Based on interview at the time			2: How other residents havi	ng	
		Maintenance Director agreed			the potential to be affected b	y	
		part of the lamp, was use in a			the same deficient practice v	vill	
		and did not meet 1363A or			be identified and what		
	60601-1.				corrective action will be take		
					Rounds were made on 8/14/2		
	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		
	2.1.10(1)				were no other power strips in	use	
	3.1-19(b)				that did not meet the		
					requirements. Staff were		
					reeducated on 8/30/2024 rega	-	
					the use of surge protectors wi	ruiu	
					the facility. 3: What measures will be pu	,	
					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	age	
					of surge protectors within the		
					facility. Staff were reeducated	l on	
					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	-		
				i.e., what quality assurance			
					program will be put into place	se?	
	I		1		1 . 5	1	

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

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	
	PROVIDER OR SUPPLIER	R	1821 I	ADDRESS, CITY, STATE, ZIP COD LINDBERG RD RSON, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Administrator and/or Designee monitor 3 times per week alter areas in the building to ensure devices are used per policy fo weeks, then 2 times per week 3 months, then monthly for 2 months.	rnate • that r 4
				The results of the monitoring of the reviewed by the QA commit overseen by the Executive Director. If a threshold of 100% not achieved, an action plan with 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: 9/13/2024	attee % is vill rough the
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or economic storage locations and ventilated in a storage locations and 5.1.3.3.3. >300 but <3,000 conomic storage locations enclosure or within space of non- or licenstruction, 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			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 29 of 32

09/03/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

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

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	(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 have been 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 expedit outcome. 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 8/30/2024 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 equirement for	a and e and the are th

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

65UP21

Facility ID: 000027

If continuation sheet Page 31 of 32

PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 08/13/2024				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			1821 L	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 LISC IDENTIFYING INFORMATION	1821 L	INDBERG RD RSON, 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 recur i.e., what quality assurance program will be put into place? The Maintenance Director will be responsible for completing QAPI 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 th third month, then monthly for 3 months. The results of the monitoring will be reviewed by the QA committe overseen by the Executive Director. If a threshold of 100% i not achieved, an action plan will be developed. The facility throu the QAPI program, will review, update, and make changes to the	ee s ugh			
				POC as needed for sustaining substantial compliance for no les than 6 months. 5. Date of completion: 9/13/2024	SS			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 65UP21 Facility ID: 000027 If continuation sheet Page 32 of 32