STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155690	A. BUILDING -- B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/13/24 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Emergency Preparedness survey, Envive of Anderson was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 97 and had a census of 49 at the time of this survey. Quality Review completed on 08/16/24	E 0000	**Plan of Correction FOR Envive of anderson** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey conducted August 13, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/13/24 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Life Safety Code survey, Envive of Anderson was found not in compliance with	K 0000	**Plan of Correction FOR Envive of anderson** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V111 construction and was fully sprinkleredwith exception of the back half of the kitchen alcove. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detection in the 500 and 600 hall resident sleeping rooms. The facility has a capacity of 97 and had a census of 49 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with exception of the back half of the kitchen alcove. Quality Review completed on 08/16/24		to the allegations of noncompliance cited during the Life Safety Code Recertification and Emergency Preparedness Survey conducted August 13, 2024.	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story			

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	non-sprinklered Maximum 3 stories sprinklered 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 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building type of V (111) by ensuring 1 of 1 one-hour ceiling smoke barrier between the attic and living areas were maintained to ensure the fire resistance of the one-hour barrier. This deficient practice affects all staff, visitors, and 30 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 12:10 p.m., in room 114 and the 114 storeroom, the one-hour fire-rated ceiling	K 0161	**K161 –** It is the practice of Envive of Anderson to maintain the building type of V (111) by ensuring smoke barriers are maintained to ensure the fire resistance of the one-hour barrier. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 30 residents who could have been affected by the alleged deficient practice had no negative outcome. On 8/29/24 contractors	09/13/2024

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	assembly collapsed in early 2024 due to a broken pipe. Based on interview at the time of observation, the Maintenance Director agreed the one-hour fire-rated ceiling assembly collapsed due to a broken pipe, and stated the ceiling collapsed in early 2024 and has not yet been repaired. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		repaired Room 114 and the 114 storeroom's collapsed ceiling in order to provide fire resistance of the one-hour barrier by replacing the drywall to this area. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other areas meet the requirements of the building type of V. **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 smoke barriers are maintained to ensure the fire resistance of the one-hour barrier. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring smoke barriers are maintained to ensure the fire resistance of the one-hour barrier. The Maintenance Director will audit the building for effective fire resistance. This will be added to the preventative maintenance list. **4: How the corrective action**	

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			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 add fire resistance to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/2024	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to maintain 1 of 12 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect 15 residents in the 200-hall. Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 1:10 p.m., the 300-hall exit door was equipped with panic hardware, but the door would not open on the first try. The Maintenance Director tried three times to open the door and with great force the door opened on the third try. Based on an interview at the time of observation, the Maintenance Director agreed it took excessive force to open the exit door. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	**K211 –** It is the practice of Envive of Anderson to ensure exit discharge doors are free of impediments to full instant use in case of fire. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 15 residents who could have been affected by the alleged deficient practice had no negative outcome. The Maintenance Director repaired the panic hardware to the 300-hall exit door allowing the door to provide full instant use in case of fire. The door now opens correctly. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other resident doors opened with no issues. **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	09/13/2024

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			discharge doors are free of impediments to full instant use in case of fire. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring exit discharge doors are free of impediments to full instant use in case of fire. The Maintenance Director will audit exit doors for effective opening. This will be added to the preventative maintenance list. **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 add the opening of exit doors to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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			5. Date of completion: 9/13/24	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure the corridor doors to 7 of 12 hazardous area enclosures were self-closing and kept in the closed position. This deficient practice could affect 30 residents in the 500-hall and 600-hall. Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 between 12:00 p.m. and 2:00 p.m., rooms 404, 407, 403, 406, the 300 storeroom, the 600 clean storeroom, and the PPE storeroom were larger than 50 square feet and contained over 15 boxes of supplies and other combustible storage making each room a hazardous area. All doors to the rooms were not equipped with a self-closing device or would not fully close and keep each	K 0223	**K223 –** It is the practice of Envive of Anderson to ensure corridor doors leading to hazardous area enclosures are self-closing and kept in the closed position. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 30 residents who could have been affected by the alleged deficient practice had no negative outcome. Rooms 404, 405 and 407 were all cleaned out. Self-closing devices were placed on doors for Room 406, the 300 storeroom, the 600 clean storeroom and the PPE	09/13/2024

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	door in the closed position. Based on interview at the time of observation, the Maintenance Director agreed all seven rooms were hazardous storage areas, the self-closing device on the doors were not functioning properly, or were not equipped with a self-closing device. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		storeroom. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other corridor doors leading to hazardous areas are self-closing. **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 corridor doors leading to hazardous area enclosures are self-closing and kept in the closed position. Staff were reeducated on 8/30/2024 regarding the policy related to corridor doors leading to hazardous area enclosures are self-closing and kept in the closed position. The Maintenance Director will audit corridor doors that lead to hazardous areas ensuring that they have self-closing devices and are maintained in the closed position. This will be added to the preventative maintenance list. **4: How the corrective action**	

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			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 audit corridor doors that lead to hazardous areas ensuring that they have self-closing devices and are maintained in the closed position to the preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/2024	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained			

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	free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 12 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 20 residents that would use the 100-hall exit. Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 12:28 p.m., the 100-hall exit discharge had a 20 ft. asphalt walkway leading to the common way. The walkway was uneven, had holes, and weeds growing through the cracks. Based on interview at the time of observation, the Maintenance Director agreed the walkway was in poor condition and did not provide an unobstructed level walking surface. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)	K 0271	**K271 –** It is the practice of Envive of Anderson to ensure exit discharges are provided with an unobstructed level walking surface. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 20 residents who could have been affected by the alleged deficient practice had no negative outcome. The facility is in the process of obtaining quotes to perform this job. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all 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 an	11/30/2024

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			unobstructed level walking surface. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring exit discharges are provided with an unobstructed level walking surface. The Maintenance Director will audit exit discharges. This will be added to the preventative maintenance list. **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 add auditing exit discharges to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:**	

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			11/30/24 ****Waiver requested**	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 12 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect up to 35 residents when using the 600 and 500 exit paths. Finding includes: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 2:00 p.m., the exit discharge sidewalks from the 600 and 500 halls exits did not have egress lighting for portions of the sidewalks from the 600-hall to the public way. Based on interview at the time of observations, the Maintenance Director confirmed there were no other lighting devices illuminating the sidewalks, and stated it was undetermined if all of the aforementioned exit paths were provided with complete egress	K 0281	**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. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other means of egress are lit.	09/13/2024

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	lighting. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		**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 continuity of egress lighting for all exits. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring continuity of egress lighting for all exits. The Maintenance Director will audit egress lighting. This will be added to the preventative maintenance list. **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 add egress lighting to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through	

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	155690	A. BUILDING 01 B. WING	08/13/2024

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			the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/2024	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of 1 kitchen alcoves were provided with adequate sprinkler coverage. NFPA 13, 2010 edition, section 8.7.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3, or	K 0351	**K351 –** It is the practice of Envive of Anderson to ensure all areas are completely covered by sprinkler protection. **1: What corrective action(s) will be accomplished for those**	11/30/2024

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	additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 12:50 p.m., in the kitchen there was an alcove that was not completely covered by 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 blocked by a wall. Based on interview at the time of observation, the Maintenance Director agreed the back half of the alcove was not protected by sprinkler coverage. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice?** The 20 residents who could have been affected by the alleged deficient practice had no negative outcome. On 8/14/24 and ongoing, this facility has requested a quote from Elwood Fire system to replace the sprinkler head in the alcove in the laundry room. We have been told that the item we require is on back order for a minimum of 6 weeks. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other are sprinklered per regulation. **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 all areas are completely covered by sprinkler protection. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring all areas are	

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			completely covered by sprinkler 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 the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Maintenance Director will add sprinkler system to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 11/30/24 ****Waiver requested**	

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 7 of 40 sprinklers in one smoke compartment were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment. Findings include:	K 0353	**K353 –** It is the practice of Envive of Anderson to ensure sprinklers are free of corrosion. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 20 residents who could have been affected by the alleged deficient practice had no negative outcome. On 8/14/24 and ongoing, this facility has requested a quote from Elwood Fire system to replace the 7 sprinkler heads that have corrosion. We have been told that the item we require is on back order for a minimum of 6 weeks.	11/30/2024

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	Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 12:10 p.m., one sprinkler head in the mop room and six sprinkler heads in the kitchen were green and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned sprinkler heads showed signs of corrosion. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other sprinkler heads are free from corrosion. **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 sprinklers are free of corrosion. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring sprinklers are free of corrosion. The Maintenance Director will audit sprinkler heads for lack of corrosion. This will be added to the preventative maintenance list. **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 add the lack of corrosion of sprinkler heads to his preventative maintenance checklist which will be completed weekly for 4 weeks	

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			and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 11/30/24 ****Waiver requested**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 25 room corridor doors on the southwest 300 hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 13 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director, Regional Director, and Administrator on 08/12/24 at 1:00 p.m., the TV room and phone room corridor doors would not latch due to tape over	K 0363	**K363 –** It is the practice of Envive of Anderson to ensure corridor doors latch effectively, have no impediment to closing and are provided with a means suitable for keeping the door closed. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 13 residents who could have been affected by the alleged deficient practice had no negative outcome. On 8/14/2024 the	09/13/2024

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	the strike plate. Based on interview at the time of observation, the Maintenance Director stated the corridor doors would not latch into the door frame when tested. This finding was reviewed with the Maintenance Director, Environmental Services Director, Regional Director, and Administrator during the exit conference. 3.1-19(b)		Maintenance Director inspected the latch on the TV room and phone room and was able to remove the tape over the strike plate so that the door would latch effectively. The doors now close correctly. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as all other resident doors latched with no issues. **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 corridor doors latch effectively, have no impediment to closing and are provided with a means suitable for keeping the door closed. Staff were reeducated on 8/30/2024 regarding the policy related to ensuring corridor doors latch effectively, have no impediment to closing and are provided with a means suitable for keeping the door closed.	

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			The Maintenance Director will audit corridor doors for effective latching. This will be added to the preventative maintenance list. **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 add the latching of resident doors to his preventative maintenance checklist which will be completed weekly for 4 weeks and then every two weeks for two months and then monthly for 3 months as part of the preventative maintenance program moving forward. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/24	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following			

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	provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were properly maintained and provided with a metal or noncombustible containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect staff by the employe exit and 10 residents in the courtyard smoking area. Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 2:10 p.m., in the courtyard smoking	K 0741	**K741 –** It is the practice of Envive of Anderson to ensure smoking areas are properly maintained and provided with a metal or or noncombustible container with self-closing cover devices. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 10 residents who could have been affected by the alleged	09/13/2024

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	area there were 6 smoker's poles with the covers loose and not attached to the buckets, at least 30 cigarette butts were on the ground around the employee exit, and the required metal container with a self-closing lid was not provided for both smoking areas. Based on an interview at the time of observations, the Maintenance Director agreed the smoker's poles did not have the lids secured and cigarette butts were on the ground outside the employee exit. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		deficient practice had no negative outcome. A metal container with a self-closing cover device to dispose of cigarette butts were placed in both smoking areas. The Maintenance Director also ensured that the 6 smoker's poles were properly closed and latched. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director provided metal containers with a self-closing cover device to dispose of cigarette butts and ensured the smoker's poles were properly closed and latched in 2 smoking areas. **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 smoking areas are properly maintained and 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 areas are properly maintained and	

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			provided with a metal or or noncombustible container with self-closing cover devices. The Maintenance Director will be responsible for completing QAPI audit tool Smoking Area Assessment 5 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. All cigarette butts have been removed and cleaned up; a new self-closing metal container was provided in the 2 designated smoking areas. All smoker's poles were closed and latched properly. **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 Smoking Area Assessment 5 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 these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining	

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			substantial compliance for no less than 6 months. **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 0920	**K920 –** It is the practice of Envive of Anderson to ensure power strips in patient care locations met the required UL rating of 1363A or 60601-1. **1: What corrective action(s) will**	09/13/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation with the Maintenance Director, Administrator, and the Regional VP on 08/13/24 at 12:10 p.m., a power-strip was attached to a floor lamp in room 118, was in use within 6 feet of a resident care area, and did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed the power-strip was part of the lamp, was use in a resident care area, and did not meet 1363A or 60601-1. The finding was reviewed with the Regional VP, Administrator, and Maintenance Director during the exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** The surge protector was replaced on 8/14/24 in Room 118. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 and no other residents have the potential to be affected by the alleged deficient practice as there were no other power strips in use that did not meet the requirements. Staff were reeducated on 8/30/2024 regarding the use of surge protectors within the facility. **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 usage of surge protectors within the facility. Staff were reeducated 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 recur i.e., what quality assurance program will be put into place?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155690	A. BUILDING 01 B. WING	08/13/2024

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			Administrator and/or Designee will monitor 3 times per week alternate areas in the building to ensure that devices are used per policy for 4 weeks, then 2 times per week for 3 months, then monthly for 2 months. The results of the monitoring will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/2024	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated			

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	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 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 outside oxygen storage areas were locked and provided with 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." This deficient practice could affect staff, visitors, and 10 patients using the 400-hall exit. Findings include:	K 0923	**K923 –** It is the practice of Envive of Anderson to ensure outside oxygen storage areas are locked and provided with precautionary sign readable from 5 feet on the door or gate of the cylinder storage room. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	09/13/2024

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	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 negative outcome. On 8/14/2024 the Maintenance Director ordered a sign to be affixed to the gate and the door of the cylinder storage room with wording “No Flammables within 25 feet” and also put a lock on the gate to the oxygen storage area. Staff were 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 will be identified and what corrective action will be taken.** Rounds were made on 8/14/2024 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	

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			storage and the signage requirement for the oxygen storage area. Staff were reeducated on 8/30/2024 regarding 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 second month, and weekly for the third month, then monthly for 3 months. The results of the monitoring will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 9/13/2024	