	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 09/23/2022	
		100000	1 B. WI		ADDRESS, CITY, STATE, ZIP COD	081231	
	PROVIDER OR SUPPLIER OF ANDERSON	R	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 DEFICIENCY)	ATE	COMPLETION
TAG E 0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
Bldg		paredness Survey was diana Department of Health in	E 00	000			
	Survey Date: 09/23						
	Facility Number: 0 Provider Number: AIM Number: 100	155690					
	of Anderson was fo with Emergency Pro	Preparedness survey, Envive und in substantial compliance eparedness Requirements for caid Participating Providers FR 483.73					
	The facility has 97 of the survey, the cens	certified beds. At the time of ous was 44.					
	Quality Review con	npleted on 09/28/22					
E 0035 SS=C Bldg	483.475(c)(8), 483 LTC and ICF/IID S §483.73(c)(8); §48	Sharing Plan with Patients					
	maintain an emerg communication pla Federal, State and reviewed and upd	es at §483.73(c):] ty must develop and gency preparedness an that complies with d local laws and must be ated at least annually. The an must include all of the					
	,	(483.475(c):] lust develop and maintain an redness communication					

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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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i i i i i i i i i i i i i i i i i i i		A. BUILDING B. WING	UN51 RUC HUN	COMPLETED 09/23/2022	
	PROVIDER 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	local laws and mu at least every 2 ye plan must include (8) A method for semergency plan, to determined is apportional contained to ensure the (EPP) includes a method for the emergency determined is approfamilies or represent CFR 483.75(c)(8). The affect all occupants. Findings include: Based on records read Administrator and the emergency Prepared address a method for contained within the deems appropriate were representatives. Based records review, the aforementioned policity of the policy of the property of the aforementioned policity. This finding was accompliant and forministrator and f	ropriate, with residents [or amilies or representatives. riew and interview, the facility emergency preparedness plan ethod for sharing information or plan that the facility has priate with residents and their tatives in accordance with 42. This deficient practice could eview and interview with the the Maintenance Supervisor on ex45 a.m. and 11:45: a.m., the dness Binder provided did not for sharing information to EPP Binder that the facility with clients, their families or seed on interview at the time of Administrator agreed the facility was not in the provided	E 0035	E 035 • what corrective action will be accomplished for those residents found to have been affected by the deficient pract. A notice for the emergency preparedness location will be posted at the entrance of the facility with the notice for the survey binder for visitors are family members to see. • how other residents having the potential to be affected by the same deficient practice be identified and what correct action(s) will be taken. The emergency binder notification will be made available to all the new admissions and all the familiand who visits the facility. • what measures will be made to ensure that the deficient practice does recur. The notification will be added to the ISDH survey binder notification where to locate	e in tice. De e e e e e e e e e e e e e e e e e e

PRINTED: 10/19/2022 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690			ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/23/2022	
	ROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
					emergency preparedness binder. • how the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be purplace; and The administrator or maintenance director will aucompliance of the sign daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks and weekly for 4weeks be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	t into dit r cks will s s	
K 0000							
Bldg. 01	Licensure Survey v		K 00	000			

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Event ID:

 $6TWE21 \quad \ \ {\rm Facility\ ID:} \quad \ 000027$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>		COMPL	ETED
		155690	B. WI	NG			09/23/	2022
			<u> </u>	STREET A	ADDRESS	CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			NDBER			
ENVIVE (OF ANDERSON				SON, IN			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF C		ROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATION.	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
	Provider Number:							
	AIM Number: 100266180							
	And: Tic C.C.							
	-	Code survey, Envive of						
	Requirements for Pa	d not in compliance with						
	-	, 42 CFR Subpart 483.90(a),						
		re, and the 2012 edition of the						
		etion Association (NFPA) 101,						
		SC), Chapter 19, Existing						
	•	ancies and 410 IAC 16.2.						
	•	ity was determined to be of						
		ruction and was fully						
	-	cility has a fire alarm system						
		on in the corridors, spaces						
	-	s and battery powered smoke						
		t rooms on 100, 500 and 600						
	census of 44 at the t	has a capacity of 97 and had a						
	census of 44 at the t	inie of this survey.						
	All areas where the	residents have customary						
	-	ered and all areas providing						
	-	re sprinklered except for one						
	detached garage wh	ich was not sprinklered.						
	Quality Review con	npleted on 09/28/22						
K 0100	NFPA 101							
SS=E	General Requirem	nents - Other						
Bldg. 01	General Requirem							
	List in the REMAR	RKS section any LSC						
	Section 18.1 and	19.1 General Requirements						
		ssed by the provided						
	-	ficient. This information,						
		olicable Life Safety Code or						
		tation, should be included						
	on Form CMS-256	on and interview, the facility	IZ A	100	K400			00/20/2022
		atching hardware on 2 of 2	K 0	100	K100	what corrective action)(c)	09/30/2022
	rancu to maintain là	mening naraware on 2 or 2	1		•	what corrective action	1(2)	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/23/2022 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 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 will be accomplished for those requires existing life safety features obvious to residents found to have been the public if not required by the Code, shall be affected by the deficient practice. either maintained or removed. This deficient The 300 hall and the 400-hall practice could affect staff and at least 20 door latching system will be residents. repaired so that they can closed appropriately Findings include: how other residents Based on observations and interview during a having the potential to be affected tour of the facility with the Administrator and the by the same deficient practice will Maintenance Supervisor on 09/23/22 between be identified and what corrective 11:45: a.m. and 3:15 p.m., the set of smoke barrier action(s) will be taken. doors in the (1) 400 hall and (2) 300 hall was All other fire doors in the provided with latching hardware but failed to latch facility will be checked for when tested. The door coordinators were not proper closure allowing the doors to close. Based on interview at the time of observation, the Administrator and the what measures will be Maintenance Supervisor agreed the doors were put into place and what systemic not properly latching when tested and that they changes will be made to ensure needed attention. that the deficient practice does not recur. This finding was acknowledged by the The administrator or the Administrator and Maintenance Supervisor at the maintenance director will time of observation and again at the exit routinely check all the door for conference. proper closure how the corrective 3.1-19(b) action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The administrator or maintenance director will audit these doors daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits will

be reviewed by the QAPI committee overseen by the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUIL	A. BUILDING <u>01</u> COM		(X3) DATE S COMPL 09/23/	ETED	
	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	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	ss	
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 1.					
	failed to ensure 1 of continuously mainta or impediments to f fire or other emerge	on and interview, the facility a means of egress was ained free of all obstructions full instant use in the case of ancy. This deficient practice b residents, staff and visitors if acility.	K 021	11	 what corrective action will be accomplished for those residents found to have been affected by the deficient practi. The grill will be removed from the sidewalk to clear the path for easy access. 	ce. n	09/30/2022
	tour of the facility v Maintenance Super 11:45: a.m. and 3:1 Exit, on the patio a in such a way block discharge sidewalk.	ons and interview during a with the Administrator and the visor on 09/23/22 between 5 p.m., Outside the TV Lounge large gas grill was positioned ing access to the exit The Maintenance Supervisor nationed means of egress was annually and the supervisor and the supervisor of the sup			 how other residents having the potential to be affect by the same deficient practice be identified and what correctified action(s) will be taken. All the other exit side walks will be inspected and make sure they are free from any obstruction. 	will	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	LETED
		155690	B. W	ING		09/23/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			NDBERG RD		
ENVIVE	OF ANDERSON			ANDERSON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ediments to full instant use in					
	the case of fire or o	ther emergency.			what measures will b		
	TEL : C' 1:	1 1 1 11 4			put into place and what syster		
	_	cknowledged by the			changes will be made to ensu		
		Maintenance Supervisor at the and again at the exit			that the deficient practice does	s not	
	conference.	and again at the exit			recur.	.II.	
	conference.				The exit doors to the side wa	IIK	
	3.1-19(b)				will be inspected during the facility walk through and any	,	
	3.1-17(0)				objects obstructing exits wil		
					addressed.	ı De	
					dudicescu.		
					how the corrective		
					action(s) will be monitored to		
					ensure the deficient practice v	vill	
					not recur, i.e., what quality		
					assurance program will be put	t into	
					place; and		
					The administrator or		
					maintenance director will au	dit	
					compliance of the exits for		
					4weeks, 3 time a week for		
					4weeks and weekly for 4wee	ks	
					The results of these audits w	/ill	
					be reviewed by the QAPI		
					committee overseen by the		
					Executive Director for no les	-	
					than six months. The results		
					will be reviewed for patterns	,	
					trends and continued		
					recommendations for proces		
					monitoring and improvemen	τ	
					until 100% compliance is		
					achieved.		
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
g. v i	1 ~	ed means of egress shall not					
	_	a latch or a lock that					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			C	OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COM	PLETED
		155690	B. WING	-	09/2	23/2022
			- CTD FEE	A DDDDGG CHTM CTATE TID CO	-	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO	D.	
ENIVIVE	OF ANDERSON			LINDBERG RD		
CINVIVE	OF ANDERSON		ANDE	RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP)ULD BE 'PROPRIATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	requires the use	of a tool or key from the				
	egress side unles	ss using one of the following				
	special locking a	rrangements:				
	CLINICAL NEED	S OR SECURITY THREAT				
	LOCKING					
	Where special lo	cking arrangements for the				
	clinical security n	eeds of the patient are				
	used, only one lo	cking device shall be				
	permitted on eac	h door and provisions shall				
	be made for the i	rapid removal of occupants				
	by: remote control of locks; keying of all					
	locks or keys car	ried by staff at all times; or				
	other such reliab	le means available to the				
	staff at all times.					
	18.2.2.2.5.1, 18.2	2.2.2.6, 19.2.2.2.5.1,				
	19.2.2.2.6					
	SPECIAL NEEDS	S LOCKING				
	ARRANGEMENT	rs				
	Where special lo	cking arrangements for the				
	safety needs of the	he patient are used, all of				
	the Clinical or Se	curity Locking requirements				
	are being met. In	addition, the locks must be				
	electrical locks th	at fail safely so as to				
	release upon los	s of power to the device; the				
	building is protect	ted by a supervised				
	automatic sprinkl	er system and the locked				
	space is protecte	d by a complete smoke				
	detection system	(or is constantly monitored				
	at an attended lo	cation within the locked				
	space); and both	the sprinkler and detection				
	systems are arra	nged to unlock the doors				
	upon activation.					
	18.2.2.2.5.2, 19.2	2.2.2.5.2, TIA 12-4				
	DELAYED-EGRE					
	ARRANGEMENT					
	Approved listed	delayed-egress locking				1

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systems installed in accordance with 7.2.1.6.1 shall be permitted on door

assemblies serving low and ordinary hazard contents in buildings protected throughout by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING			ETED
		155690	B. W	ING		09/23/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		1821 LI	INDBERG RD		
ENVIVE	OF ANDERSON			ANDER	RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle	_					
	18.2.2.2.4, 19.2.2						
	LOCKING ARRAI	OLLED EGRESS					
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.	iance with 7.2.1.0.2 Shall					
	1 .	2.4					
	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS						
	LOCKING ARRANGEMENTS						
	Elevator lobby exit access door locking in						
	accordance with 7.2.1.6.3 shall be permitted						
		es in buildings protected					
		approved, supervised					
		ection system and an					
	approved, superv	ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		on and interview, the facility	K 0	222	K222		09/30/2022
		means of egress through 3 of			what corrective action	` '	
	-	accessible for residents without			will be accomplished for those		
	_	requiring specialized security			residents found to have been		
		vithin a required means of			affected by the deficient practi		
	-	equipped with a latch or lock			The code to open all the exit		
	_	e of a tool or key from the			doors will be posted where		
	~	otherwise permitted by LSC			specialized skills will not be		
		ocking arrangements shall be			needed to locate the code an	ıa	
	_	ance with 19.2.2.2.5.2. This			to use it.		
	visitors if needing t	ould affect over 15, staff and			how other residents		
	visitors if needing t	o ear the facility.				etad	
	Findings include:				having the potential to be affect by the same deficient practice		
	i manigs meiude.				be identified and what correcti		
	Based on observations and interview during a tour of the facility with the Administrator and the				action(s) will be taken.	VC	
					All the doors in the facility		
		visor on 09/23/22 between			will be checked to make sure		
	_	5 p.m., the following facility exits			that they have the codes	•	
		nce exit door, marked as a			posted visibly where no spec	cial	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/23/2022	
	PROVIDER OR SUPPLIER OF ANDERSON		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)	
TAG	facility exit, was may opened by entering was not posted at the would not require secode. The code producer was hidden be frame and was not so of the code keypad, marked as a facility and could be opened but the code was not TV Lounge Exit do magnetically locked entering a four-digit posted anywhere. This finding was ac Administrator and I	agnetically locked and could be a four-digit code but the code e exit in a manner which pecial knowledge to find the wided at the aforementioned thind a board on the aluminum wisible when standing in front (2) The Employee entrance, exit, was magnetically locked do by entering a four-digit code at posted anywhere. (3) At the or, marked as a facility exit, was all and could be opened by the code but the code was not the Maintenance Supervisor at the and again at the exit	TAG	skills will be needed to oper the door. • what measures will be put into place and what syste changes will be made to ensure that the deficient practice does recur. The maintenance director whose educated on where to plat the door codes for easy accessibility by visitors and everyone coming into the facility. • how the corrective action(s) will be monitored to ensure the deficient practice who to recur, i.e., what quality assurance program will be purplace; and The administrator or maintenance director will audit the exit doors codes daily for 4weeks, 3 time a work for 4weeks and weekly for 4weeks The results of these audits whose reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for proce monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each	DATE De mic lire is not will lice will tinto pek will is

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EPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICA	AID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						

	OF CORRECTION			COMPLETED 09/23/2022			
	ROVIDER OR SUPPLIER			1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divis needs to be contacted as soor possible. The facility will need submit an amended plan of correction with the updated plat correction date.	will sion n as to	
K 0232 SS=E Bldg. 01	unobstructed) servat least 4 feet and convenient remove	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by					
	failed to ensure 1 of in building 1 were constructions. LSC 1 into the required with wheeled equipment following condition (a) The wheeled equipment clear unobstructed constructed constr	on and interview, the facility is 8 corridor means of egresses continuously maintained free of 9.2.3.4 (4) states projections dth shall be permitted for provided that all of the sare met: uipment does not reduce the corridor width to less than 60 occupancy fire safety plan and dress the relocation of the during a fire or similar ipment is limited to the	K 02	232	• what corrective action will be accomplished for those residents found to have been affected by the deficient practic. The pallet and beds that were obstructing the 600 hallways have been removed and the hallway is clear. • how other residents having the potential to be affect by the same deficient practice be identified and what correction.	ce.	09/30/2022

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		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/23/2022			
		ROVIDER OR SUPPLIEI	· ·	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012					
PI	(4) ID REFIX 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
		i. Equipment in use ii. Medical emerger iii. Patient lift and t This deficient pract facility. Findings include: Based on observative tour of the facility o	e and carts in use ancy equipment not in use ransport equipment ice affects 30 residents in the cons and interview during a with the Administrator and the visor on 09/23/22 between 5 p.m., the 600 Hall corridor allet, 2 beds which were		action(s) will be taken. All other hallways in the fact will be inspected for any obstruction. • what measures will be put into place and what syste changes will be made to ensut that the deficient practice doe recur. We will educate the maintenance director to do facility walk through to make sure the halls are not obstructed. • how the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be puplace; and The administrator or maintenance director will check on obstruction of the halls daily for 4weeks, 3 tim week for 4weeks • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divineeds to be contacted as soo possible. The facility will nee submit an amended plan of correction with the undated of correction	ility De mic ure es not a e will It into e a y e n will ision on as d to			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 09/23/2022			ETED	
	PROVIDER OR SUPPLIEF	2		1821 L	REET ADDRESS, CITY, STATE, ZIP COD 321 LINDBERG RD NDERSON, 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 APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Exit discharge is a 7.7, provides a lev the provisions of 7 changes in elevat free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure exit around the facility leads of the free of obstruction and staff when exit in the facility of the facility providing expanding lots. Where the blacktop pathway which could be a traforementioned blacktop base of the facility providing expanding lots. Where the facility providing expanding lots of the facility providing expanding lots. Where the blacktop pathway which could be a traforementioned blacktop base of the facility providing expanding lots.	xits xits arranged in accordance with yel walking surface meeting 7.1.7 with respect to ion and shall be maintained as. Additionally, the exit a hard packed all-weather on and interview, the facility at discharge passageways and a level walking surface, ctions, and constructed of hard travel surface in accordance and Certification Letter 05-38. ice could affect all residents	K 0			n(s) cted will ive e mic re s not	DATE 04/30/2023
	Weeds and grass ha	es during an evacuation. Ive grown up through the Placktop creating additional trip			not recur, i.e., what quality assurance program will be pur place; and	t into	

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ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155690	B. WING		09/23/2022	
	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
K 0291 SS=E Bldg. 01	they have been attered pathways, but fund and acknowledged were in need of repeathing surface that leading to the public This finding was at Administrator and time of observation conference. 3.1-19(b) NFPA 101 Emergency Lighti Emergency Lighti Emergency lightir	eknowledged by the Maintenance Supervisor at the and again at the exit and gain at the exit		by what date the systemic changes for each deficiency will be completed. After submitting an acceptabl Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divineeds to be contacted as soo possible. The facility will nee submit an amended plan of correction with the updated procorrection date.	n will e ision on as ed to	
	interview; the facilitesting for all batter with LSC 7.9. Sectemergency lighting be conducted as fol (1) Functional testiwith a minimum of weeks between test seconds, except as 7.9.3.1.1(2). (2) The test interval extended beyond 30 authority having juic (3) Functional testi	ng shall be conducted monthly, 3 weeks and a maximum of 5 s, for not less than 30 otherwise permitted by I shall be permitted to be O days with the approval of the risdiction. ng shall be conducted annually 1/2 hours if the emergency	K 0291	what corrective action will be accomplished for those residents found to have been affected by the deficient praction. The 90 minutes test will be conducted and documented Also, the exterior emergence lighting will be checked and make sure they are connect to the emergency generator. how other residents having the potential to be affected by the same deficient practice be identified and what corrections.	e deted e will	

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(4) The emergency lighting equipment shall be

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action(s) will be taken.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155690	B. Wl	ING		09/23/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			INDBERG RD		
ENVIVE	OF ANDERSON			ANDERSON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fully operational for the tests required by 7.9.3.1.1(1) and (3).				All the exits have the potent		
					to be affected by the alleged	I	
		s of visual inspections and tests			deficiency		
		e owner for inspection by the			The administrator or the		
	authority having ju				maintenance director will		
	_	tice could affect over 15			inspect all the doors to ensu		
	residents, staff and	VISILOTS.			all the lights are connected	το	
	Findings include:				the emergency generator.		
	Based on records review and interview with the Administrator and the Maintenance Supervisor on				what measures will I	ре	
					put into place and what syste	mic	
					changes will be made to ensu		
	09/23/22 between 9:45 a.m. and 11:45: a.m., annual				that the deficient practice doe		
	90-minute testing documentation for all battery				recur.		
	backup lights was	not available for review.			The lighting at the exits will	be	
	Monthly testing do	ocumentation was available but			inspected during load testing		
	there was no record	d of an annual 90-minute test.			the generator to make sure	all	
					the exits are equipped with		
	This finding was a	cknowledged by the			enough light in case of pow	er	
	Administrator and	Maintenance Supervisor at the			outage.		
	time of observation	n and again at the exit					
	conference.				how the corrective		
					action(s) will be monitored to		
		ew and observation, it was			ensure the deficient practice	will	
		e facility failed to provide			not recur, i.e., what quality		
		lighting for all exits. LSC			assurance program will be pu	ıt into	
	_	uires emergency lighting			place; and		
		s of egress shall be provided for			The administrator or		
		exit discharge. This deficient			maintenance director will au		
	•	ct all occupants in the facility			the lights daily for 4weeks,		
	_	itors and residents if the facility			time a week for 4weeks and		
	_	vacuate in an emergency and			weekly for 4weeks		
		providing electricity at that			The results of these audits	will	
		nt practice could affect everyone			be reviewed by the QAPI		
	in the facility.				committee overseen by the		
	E' 1' ' 1 7				Executive Director for no les		
	Findings include:				than six months. The results		
		ions and interview during a			will be reviewed for patterns	5,	
	_	with the Administrator and the			trends and continued		
Maintenance Supervisor on 09/23/22 between				recommendations for proce	SS		

92: (12:0)	THE WINDER	TID BERTTEES			01.12 1 (0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155690	B. WING		09/23/2022	
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
ENVIVE (OF ANDERSON			INDBERG RD 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	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
	11:45: a.m. and 3:1	5 p.m., it was unknown if the		monitoring and improvement		
	exterior lights for th	he exit discharge for all of the		until 100% compliance is		
	facility exits were c	connected to the generator. The		achieved.		
	Maintenance Super	visor and the Administrator				
	_	further verification or				
	documentation to v	erify the facility's exit lighting		by what date the		
		ne generator and could		systemic changes for each		
		ent of a power outage.		deficiency will be completed.		
		1 8		After submitting an acceptable		
	This finding was ac	knowledged by the		Plan of Correction, if it is		
	_	Maintenance Supervisor at the		determined that the correction	will	
		and again at the exit		not be completed by the date		
	conference.			previously submitted, the Divisi	on	
				needs to be contacted as soon		
	3.1-19(b)			possible. The facility will need		
	211 17(0)			submit an amended plan of		
				correction with the updated plan	n of	
				correction date.	101	
K 0300	NFPA 101					
SS=E	Protection - Other	•				
Bldg. 01	Protection - Other	•				
	List in the REMAF	RKS section any LSC				
	Section 18.3 and	19.3 Protection				
	requirements that	are not addressed by the				
	provided K-tags, b	out are deficient. This				
	information, along	with the applicable Life				
	_	FPA standard citation,				
	should be include	d on Form CMS-2567.				
	Based on interview	, and observation, the facility	K 0300		09/30/2022	
	failed to ensure pro	pane tanks were stored		what corrective action		
	properly away from	all ignition sources. NFPA 58		will be accomplished for those		
	specifies storage re-	quirements including required		residents found to have been		
		s for LP gas containers. This		affected by the deficient practic	e.	
	deficient practice co			The gas grill has been		
	*			removed and that area is clea	r	
	Findings include:			without any obstruction.		
	S					
	Based on observation	ons and interview during a		how other residents		

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tour of the facility with the Administrator and the

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having the potential to be affected

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING B. WING	01	COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER OF ANDERSON		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)	(X5) COMPLETION DATE
	11:45: a.m. and 3:15 the TV Lounge Exit which were consiste residential gas fired This finding was ac Administrator and M	-		by the same deficient practice be identified and what correct action(s) will be taken. All other doors will be inspected to make sure there are no other gas grills locate outside the facility exits. What measures will be put into place and what system changes will be made to ensure that the deficient practice doe recur. A routine walk through will be done in the facility to make sure no other items are left at the exits. how the corrective action(s) will be monitored to ensure the deficient practice where the deficient practice will be puplace; and the deficient practice will be puplace; and the facility daily for 4weeks, time a week for 4weeks and weekly for 4weeks. The results of these audits where the previewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	e edd De mic lire s not De at will t into alk 3 will ss 5 s; ss

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2022		
	PROVIDER OR SUPPLIER	1	1821 L	ADDRESS, CITY, STATE, ZIP COI 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automatic option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 5.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4.		by what date the systemic changes for ear deficiency will be comple After submitting an acception of Correction, if it is determined that the correction to be completed by the previously submitted, the needs to be contacted as possible. The facility will submit an amended plan correction with the update correction date. 09/30/2022	ch eted. ptable ection will date e Division s soon as I need to	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPLETED
		155690	B. WIN	IG		09/23/2022
NAME OF I	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD	•
					NDBERG RD	
ENVIVE	OF ANDERSON			ANDER	SON, IN 46012	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	_	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI I	DATE
	Area	Automatic Sprinkler				
	'	N/A -Fired Heater Rooms				
		er than 100 square feet)				
	, -	er than 100 square leet) nance, and Paint Shops				
	1	ooms (exceeding 64				
	gallons)	Doma (exceeding 04				
	e. Trash Collectio	n Rooms				
	(exceeding 64 gal					
		orage Rooms/Spaces				
	(over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility					
			K 03	21	K321	09/30/2022
		corridor doors to 8 of over 12			what corrective action	
		rere provided with a			will be accomplished for those	` '
		which would cause the door to			residents found to have been	
	_	and latch into the door frame.			affected by the deficient pract	tice.
	1	cice could affect 40 residents in			The following rooms will be	
	three smoke compa	rtments.			equipped to self-close or all	the
					extra items In the rooms	
	Findings include:				removed therapy room, roor	ms
					606,608,607 and 609.	
		ons and interview during a				
		with the Administrator and the			how other residents	
	_	visor on 09/23/22 between			having the potential to be affe	
		5 p.m., the corridor doors to the			by the same deficient practice	
	_	s areas, larger than 50 square			be identified and what correct	tive
		he requirements for protection			action(s) will be taken.	
		and were not equipped with			All the other rooms will be	
	self-closing devices				inspected routinely and mak	(e
	1	les/Therapy contained lots of			sure there are combustible	
	_	supplies and was not			items are accumulated in the	e
	self-closing.	606, 610, 609, 608, 607			rooms,	
	1 '	of chairs, beds and lots of			what measures will be not into place and what system	
	boxes.	chairs, beds and lots of			put into place and what systel changes will be made to ensu	
	OUACS.				that the deficient practice doe	
	Based on interview	at the time of observation, the			recur.	.s not
	Maintenance Super				All the rooms that are being	1
	I Super	· ·· · · · · · · · · · · · · · · · · ·	1)

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF aforementioned roc areas, and the doors self-closing. This finding was ac Administrator and	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION oms were hazardous storage is to the rooms were not eknowledged by the Maintenance Supervisor at the and again at the exit	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIENCY) used a storage will be equipped with self-closure system and the rooms will monitored for any hazardo materials. • how the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be place; and The administrator or maintenance director inspit the rooms daily for 4week time a week for 4weeks and weekly for 4weeks. The results of these audit be reviewed by the QAPI committee overseen by the Executive Director for not than six months. The result will be reviewed for patter trends and continued recommendations for program until 100% compliance is achieved.	DATE COMPLETION DATE D
				by what date the systemic changes for each deficiency will be completed. After submitting an accepta Plan of Correction, if it is determined that the correction to be completed by the dapreviously submitted, the D.	ion will te

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needs to be contacted as soon as

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING B. WING	01	COMPLETED 09/23/2022	
	PROVIDER OR SUPPLIER		1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG 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)	(X5) COMPLETION DATE
				possible. The facility will need submit an amended plan of correction with the updated plat correction date. 09/30/2022	
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cooking residential cooking appliances such a toasters) are used cooking in accordance 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer part conditions under 11 Cooking facilities part of the cordinary of th	and Fire Protection of and Fire Protection of and Fire Protection of and Operations, unless: and equipment (i.e., small is microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, and open to the corridor in ants with 30 or fewer the the conditions under 5.3, or an in smoke compartments attents comply with 8.3.2.5.4, 19.3.2.5.4. For the total according to 3 are not required to be dous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1, 9.2.3, TIA 12-2 and interview, the facility of were instructed in the use of stem in 1 of 1 Kitchen. NFPA tructions for manually tinguishing system shall be yin the kitchen and shall be objected by management. This and affect staff in the kitchen	K 0324	K324 • what corrective action will be accomplished for those residents found to have been affected by the deficient praction. All the dietary staff will be educated on the actions to taif there is a grease fire in the kitchen.	ce.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/23/2022			LETED		
	PROVIDER OR SUPPLIER		18	821 LIN	DDRESS, 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		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	tour of the facility we Maintenance Super 11:45: a.m. and 3:1 UL 300 hood systemextinguisher with pointerview, the facility asked; what is the confidence of the grease fire underned Manager replied "the Manager failed to in hood extinguishing fire extinguisher for Administrator and the acknowledged the restaff will be information." This finding was ac Administrator and Maintenance Super	osted instructions. Based on ty's only Dietary Manager was orrect response if there was a ath the hood. The Dietary arow water on it." The Dietary indicate activating the UL 300 system and using the correct a hood grease fire. The the Maintenance Supervisor esponse and stated all kitchen and on proper response.			 how other residents having the potential to be affee by the same deficient practice be identified and what correct action(s) will be taken. The dietary manager will be educated on all other equipment's that are being used in the kitchen for life safety. what measures will be put into place and what system changes will be made to ensure that the deficient practice does recur. During orientation, the maintenance director will do walkthrough into the kitchen identify the life safety equipment's that are being used in the kitchen. how the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e., what quality assurance program will be purplace; and The administrator or maintenance director will quested the dietary staff on life safety equipment's in the kitchen daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The results of these audits were the deficient practice of the safety equipment's in the kitchen daily for 4weeks and weekly for 4weeks The results of these audits were the deficient practice of the safety equipment's in the kitchen daily for 4weeks and weekly for 4weeks The results of these audits were the deficient practice of the safety equipment's in the kitchen daily for 4weeks and weekly for 4weeks 	e will ive e mic ire is not a i to vill it into	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	A. BUILDING <u>01</u> COMPLET		(X3) DATE SURVEY COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER OF ANDERSON	2	1821	T ADDRESS, CITY, STATE, ZIP COD LINDBERG RD ERSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved by what date the system changes for each deficiency be completed. After submittil acceptable Plan of Correction is determined that the correct will not be completed by the opreviously submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated procorrection date.	mic will ng an n, if it tion date rision on as ed to
K 0341 SS=F Bldg. 01	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system transmission path integrity. 18.3.4.1, 19.3.4.1.	n - Installation m is installed with systems approved for the purpose in NFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously on is installed at each fire In new occupancy, nstalled at notification ower extenders, and on transmitting equipment. wiring or other s are monitored for	K 0341	 what corrective action 	on(s) 09/30/2022

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failed to ensure 1 of 1 fire alarm control panels was

protected. NFPA 72, National Fire Alarm and

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will be accomplished for those

residents found to have been

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155690	B. W	ING		09/23	/2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			NDBERG RD		
ENIVIVE	OF ANDERSON						
EINVIVE	OF ANDERSON			ANDER	SON, 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Signaling Code Sec	etion 10.10.1 states a means for			affected by the deficient practi	ce.	
	turning off activate	d alarm notification			The fire alarm control panel		
	appliance(s) shall b	e permitted only if it complies			has been locked.		
	with 10.10.3 throug	gh 10.10.7. Section 10.10.3 states					
	the means shall be	key-operated or located within			how other residents		
	a locked cabinet, or	arranged to provide			having the potential to be affe	cted	
	equivalent protection	on against unauthorized use.			by the same deficient practice	will	
	This deficient pract	ice could affect all occupants.			be identified and what correcti	ve	
					action(s) will be taken.		
	Findings include:				The fire control panels in the		
					facility will be checked to		
	Based on observations and interview during a				make sure they are equipped	i	
	tour of the facility with the Administrator and the				with secure locks and the ke	ys	
	Maintenance Supervisor on 09/23/22 between				are available.		
		5 p.m., the fire alarm control					
		was not locked. During the			 what measures will b 	е	
	_	the main FACP was not			put into place and what systemic		
		enance Supervisor stated that			changes will be made to ensu		
	_	tion the FACP was being			that the deficient practice does	s not	
		d with the dust and they had			recur.		
	left it open to conve	eniently reset.			The fire panels will be		
					included on the daily		
	This finding was ac				walk-through inspection of t	he	
		Maintenance Supervisor at the			facility by the maintenance		
		and again at the exit			director or designee.		
	conference.						
					how the corrective		
	3.1-19(b)				action(s) will be monitored to		
					ensure the deficient practice v	/ill	
					not recur, i.e., what quality		
					assurance program will be put	into	
					place; and		
					The administrator or		
					maintenance director will au		
					compliance for 4weeks, 3 tin		
					a week for 4weeks and week	ly	
					for 4weeks		
					The results of these audits v	VIII	
			1		be reviewed by the QAPI		

committee overseen by the

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	01 (X.	O9/23/2022
NAME OF P	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 R 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
				Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	
				• by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction w not be completed by the date previously submitted, the Division eeds to be contacted as soon a possible. The facility will need to submit an amended plan of correction with the updated plan correction date.	n s
K 0345 SS=E Bldg. 01	in accordance with complying with the National Electric C National Fire Alarn Records of system and testing are rea 9.6.1.3, 9.6.1.5, N	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	K345	09/30/2022
	failed to ensure 1 of	f 1 fire alarm systems was per operating condition.	12 0373	what corrective action(s will be accomplished for those	

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						PRIN	TED:	10/19/2022
DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOI	RM APP	PROVED
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0	938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVE	Y
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	01	COMPL	ETED		
		155690	B. W	ING		09/23	2022	
	PROVIDER OR SUPPLIEI	R		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMI	PLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D.	ATE
	NFPA 72, National	Fire Alarm and Signaling Code,			residents found to have been			
	2010 Edition, 17.2	Purpose states, Automatic and			affected by the deficient prac	tice.		
	manual initiating d	evices shall contribute to life			The tape has been removed	t		
	safety, fire protecti	on, and property conservation			from all the smoke alarms.			
	by providing a relia	able means to signal other			how other residents			
	equipment arranged	d to monitor the initiating			having the potential to be affe	ected		
	devices and to initi	ate a response to those			by the same deficient practice	e will		
	signals. This defici	ent practice could affect up to			be identified and what correc	tive		
	30 residents, staff a	and visitors.			action(s) will be taken.			
					All other emoles clerms in t	l		

Findings include:

Based on observations and interview during a tour of the facility with the Administrator and the Maintenance Supervisor on 09/23/22 between 11:45: a.m. and 3:15 p.m., the following smoke detectors were taped up and completely closed

- 1. The 200 Hall storage area.
- 2. The Dining Room Hall corridor.
- 3. The Housekeeping Supply area on 400 Hall.
- 4. Resident Room 407.

The Maintenance Supervisor stated that the smoke detectors were taped closed due to the dust generated by the construction renovation project.

This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference.

3.1-19(b)

All other smoke alarms in the facility have the potential to be affected. The alarms in all the rooms will be inspected and any tape around the alarms will be removed.

what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.

We will implement a routine audit of the fire alarms in the facility for compliance and this will be on the daily facility walk-through.

how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: and

The administrator or maintenance director will audit compliance of the fire alarm compliance daily for 4weeks, 3 time a week for 4weeks and weekly for 4week The results of these audits will

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DEPARTMEN CENTERS FOI	OMB NO. 0938-039						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	A. BUILDING <u>01</u> COM		COMPL	DATE SURVEY COMPLETED 19/23/2022	
	PROVIDER OR SUPPLIE	R	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD			
ENVIVE	OF ANDERSON		ANDE	RSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	ATE	(X5) COMPLETION DATE	
				be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	s, ss		
				by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated placorrection date.	n will sion n as d to		
K 0346 SS=C Bldg. 01	Fire Alarm - Out of Where required fit services for more period, the author be notified, and the evacuated or an approvided for all parts.	m - Out of Service of Service ire alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall he building shall be approved fire watch shall be arties left unprotected by the e fire alarm system has					

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9.6.1.6

been returned to service.

Based on record review and interview, the facility

failed to provide a complete 1 of 1 written policy

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K 0346

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K346

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CENTERS FO	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155690	B. WING		09/23/2022
			<u> </u>		
NAME OF	PROVIDER OR SUPPLIEI	R		Γ ADDRESS, CITY, STATE, ZIP COD	
111111111111111111111111111111111111111	no (ibbit on boll bib		1821	LINDBERG RD	
ENVIVE	OF ANDERSON		ANDE	RSON, IN 46012	
(VA) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE	ID.		(V5)
(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)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	_	of residents indicating		what corrective action	
		llowed in the event the fire		will be accomplished for those	•
	alarm system has to	be placed out of service for		residents found to have been	
	four hours or more	in a twenty four hour period in		affected by the deficient practi	ce.
	accordance with LS	SC, Section 9.6.1.6. This		The fire watch program will b	oe e
	deficient practice a	ffects all occupants.		activated whenever the fire	
	1	•		alarms will be covered.	
	Findings include:			How other residents	
				having the potential to be affe	cted
	Based on records re	eview and interview with the		by the same deficient practice	
		the Maintenance Supervisor on		be identified and what correcti	
		9:45 a.m. and 11:45: a.m., the fire			ve
				action(s) will be taken.	
	_	o include contacting the		All other fire alarm related	
	_	t of Health via the ISDH		constructions will be reporte	
		ps://gateway.isdh.in.gov as the		to the isdh when ever they a	
		by the secondary method when		going to be covered for over	4
		is nonoperational by		hours.	
	completing the Inci	ident Reporting form and			
	e-mailing it to incid	dents@isdh.in.gov. The		what measures will b	e
	provided plan also	failed to include the		put into place and what syster	nic
	non-emergency pho	one numbers for contacting the		changes will be made to ensu	re
	local fire departmen	nt. Based on interview during		that the deficient practice does	
	_	the Maintenance Supervisor		recur.	
		fire watch documentation		The fire watch plan will be	
	provided stated to d			updated to include the	
		Ith at a phone number, and not		notification of the isdh throu	ah
	_	way link or at the e-mail address		gateway and the secondary	a
		d not provide the contact		mothed that is through emai	.
		local fire departments		_	'
		-		incase the gateway is not	
	non-emergency nur	HIUCI.		operational.	
	TEL : C' 1:	1 1 1 1 1			
	_	cknowledged by the			
		Maintenance Supervisor at the		how the corrective	
		and again at the exit		action(s) will be monitored to	
	conference.			ensure the deficient practice v	vill
				not recur, i.e., what quality	
	3.1-19(b)			assurance program will be put	tinto
				place; and	
				The administrator or	

maintenance director will audit

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING B. WING	01	COMPLETED 09/23/2022
	PROVIDER 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, ar by construction typ throughout by an a sprinkler system ir 13, Standard for tr Systems. In Type I and II co protection measur substituted for spri areas where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and	Installation Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA are Installation of Sprinkler Instruction, alternative es are permitted to be inkler protection in specific or local regulations prohibit alternative are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers as required by NFPA 13, llation of Sprinkler		the plan daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks The result of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no let than six months. The result will be reviewed for patternst trends and continued recommendations for procemonitoring and improvement until 100% compliance is achieved.	its ss s s,

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155690	B. Wl	NG		09/23/2022		
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			NDBERG RD			
ENI\/I\/E	OF ANDERSON				RSON, IN 46012			
LINVIVL	OI ANDERGON			ANDLIV				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		19.3.5.10, 9.7, 9.7.1.1(1)						
		on and interview, the facility	K 0	351	K351		09/30/2022	
		spray pattern for sprinkler			what corrective action	. ,		
		tructed in the Nurses Supply			will be accomplished for those			
		te with 19.3.5.1. NFPA 13, 2010			residents found to have been			
		5.1 states sprinklers shall be			affected by the deficient practi			
		nimize obstructions to			The maintenance office and			
	1	d in 8.5.5.2 and 8.5.5.3 or			the other areas will be cleare			
	_	rs shall be provided to ensure			of any items stacked within 1	18		
		of the hazard. Sections 8.5.5.2			inches of the ceiling			
		permit continuous or						
		tructions less than or equal to			how other residents			
	18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the				having the potential to be affect			
					by the same deficient practice			
	_	that prevent the spray pattern			be identified and what correcti	ve		
		ng. This deficient practice		action(s) will be taken. All other areas in the facility				
	could affect up to 6	starr.						
	Eindings in abida.				have the potential to be			
	Findings include:				affected by the allege			
	Rosed on observati	ons and interview during a			deficiency.			
		with the Administrator and the			The office and storage area will be inspected for items			
		visor on 09/23/22 between			stored 18 inches from the			
	_	5 p.m., the Maintenance Office			ceiling in any area of the			
		within 18 inches of the			facility			
		nterview at the time of			lacinty			
		aintenance Supervisor			what measures will b	e		
		aforementioned sprinkler heads			put into place and what system			
	were obstructed.				changes will be made to ensur			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				that the deficient practice does			
	This finding was ac	knowledged by the			recur.	3 1101		
	_	Maintenance Supervisor at the			All the staff will be educated			
		and again at the exit			on the storage policies in the			
	conference.	S			facility regarding items near			
					the sprinkler heads cleaning			
	3.1-19(b)				and making sure items are			
					18inches from the ceilings.			
					I			
					how the corrective			

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	OF CORRECTION OF CORRECTION 155690	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER OF ANDERSON	1821 LI	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
			action(s) will be monitored to ensure the deficient practice wonot recur, i.e., what quality assurance program will be purplace; and The administrator or maintenance director will check on the sign daily for 4weeks, 3 time a week for 4weeks and weekly for 4weeks and weekly for 4weeks and weekly for 4weeks be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	ks will ss
K 0353	NFPA 101		by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated placorrection date. 09/30/2022	sion n as d to
SS=F	Sprinkler System - Maintenance and Testing			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155690	B. W	NG		09/23/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			NDBERG RD		
ENVIVE	OF ANDERSON				RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01		- Maintenance and Testing					
	•	er and standpipe systems					
	•	ted, and maintained in					
		NFPA 25, Standard for the					
	*	g, and Maintaining of					
		Protection Systems.					
	-	n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
		<u> </u>					
	c) Water system	supply source					
		RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8						
		on and interview, the facility	K 0	353	K353		10/30/2022
	-	inkler heads in the kitchen			The latest completion date on	an	
		ded or covered with foreign			acceptable POC will be		
		nce with LSC 9.7.5. NFPA 25,			considered the date the facility	/	
		.1.1.1 sprinklers shall not show			has alleged compliance.		
	-	all be free of corrosion, aint, and physical damage; and			The sprinkler head in the walk-in closet will be cleaned	ı	
		the correct orientation (e.g.,			and dusted to eliminate any	,	
		r sidewall). Furthermore, at			<u>-</u>		
		eler that shows signs of any of			sign of loading.		
		be replaced: (1) Leakage (2)			.• what corrective action	n(s)	
	_	cal Damage (4) Loss of fluid in			will be accomplished for those	` '	
		responsive element (5)			residents found to have been		
		g unless painted by the			affected by the deficient practi	ce.	
		rer. This deficient practice			All sprinkler heads in the facilit		
	could affect 7 staff				will be inspected for dust signs	•	
					corrosion and signs of loading		
	Findings include:						
	n 1 1	1			how other residents		
		ons and interview during a			having the potential to be affect		
	tour of the facility v	vith the Administrator and the	- 1		by the same deficient practice	WIII	

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 $6TWE21 \quad \ \ {\rm Facility\ ID:} \quad \ 000027$

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 155690 NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012 DEATH PROPERTY (EACH DEPICIENCY MUST BE PRECEDED BY PULL) FREETY (EACH DEPICIENCY MUST BE PRECEDED BY PULL) TAG (REQULATORY OR ISC IDENTIFYING NORMATION TAG) Maintenance Supervisor on 09/23/22 between 11-45; a.m. and 3:15 p.m., the sprinkler head in the kitchen walk-in cooler was covered in dust or showed signs of loading. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b) - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The inspection of the sprinkler heads in our monthly quality improvement plan. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur. The inspection of the sprinkler heads in our monthly quality improvement plan. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur. The inspection of the sprinkler heads will be included in our monthly quality improvement plan. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur. Level the place and The administrator or maintenance director will audit the sprinkler heads daily for avweeks and weekly for 4weeks The results of these audits will be reviewed by the CAPI committee overseen by the Executive Director for no less than six months. The results	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012 (X4) ID PREFIX (EACH DEPTICENCY MIST BE PRECEDED BY PULL TAG Maintenance Supervisor on 092,322 between 11:45: a.m. and 3:15 p.m., the sprinkler head in the kirchen walk-in cooler was covered in dust or showed signs of loading. This finding was acknowledged by the Administrator and Maintenance Supervisor at the time of observation and again at the exit conference. 3.1-19(b) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The inspection of the sprinkler heads will be included in our monthly quality improvement plan. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The administrator or maintenance director will audit the sprinkler heads daily for Aweeks, 3 time a week for Aweeks and weekly for Aweeks The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The ressults	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
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						trends and continued		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		DNSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155690	B. W	ING		09/23/	/2022
	PROVIDER OR SUPPLIER			1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD RSON, IN 46012	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEARLOS 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)		DATE
TAG K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Sprinkler System - Where the sprinkle extent and duratio	- Out of Service		TAG	recommendations for proces monitoring and improvemen until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divis needs to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date.	ss t will sion n as	DATE
	are inspected and recommendations management or de and the fire depart having jurisdiction the sprinkler syste than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record revialled to provide 1 or	risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0	354	what corrective action(s) will be accomplished for those reside found to have been affected be	nts	09/30/2022

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

Event ID:

6TWE21

Facility ID: 000027

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BU	A. BUILDING <u>01</u> B. WING		COMPLETED 09/23/2022	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD NDBERG RD		
ENVIVE	OF ANDERSON				RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ce for 10 hours or more in a		TAG	deficient practice.		DATE
	_	ccordance with LSC, Section			All the sprinklers in the facili	tv	
	_	quires sprinkler impairment			will be serviced to put all of	·y	
		with NFPA 25, 2011 Edition,			them back in service.		
		Inspection, Testing and			how other residents		
		ter-Based Fire Protection			having the potential to be affe	cted	
	Systems. NFPA 25	, 15.5.2 requires nine			by the same deficient practice		
	procedures that the	impairment coordinator shall			be identified and what correcti	ve	
	follow. A.15.5.2 (4)) (b) states a fire watch should			action(s) will be taken.		
	consist of trained po	ersonnel who continuously			All other sprinklers in the		
	patrol the affected area. Ready access to fire				facility have the potential to	be	
	_	ne ability to promptly notify			affected. The sprinkler in all		
	_	are important items to			the rooms will be inspected		
	_	e patrol of the area, the person			any deficiencies.		
		looking for fire, but making			what measures will b		
		ire protection features of the			put into place and what syster		
		ress routes and alarm systems			changes will be made to ensu		
		nctioning properly. This			that the deficient practice does	s not	
	-	ould affect all occupants in the			recur.		
	facility.				The functionality of all the		
	Findings include:				sprinkler systems will be		
	Findings include.				inspected and the		
	Based on records re	eview and interview with the			management of the facility notified of any deficiencies.		
		the Maintenance Supervisor on			The policy of the facility will	ha	
		2:45 a.m. and 11:45: a.m., the fire			update to include what to do		
		include contacting the			when the automatic sprinkle		
	_	t of Health via the ISDH			system has to be placed on o		
		ps://gateway.isdh.in.gov as the			of service for more than ten		
		by the secondary method when			hours.		
	the ISDH Gateway	is nonoperational by					
	completing the Inci	dent Reporting form and			how the corrective		
		lents@isdh.in.gov. The			action(s) will be monitored to		
	provided plan also				ensure the deficient practice w	/ill	
		one numbers for contacting the			not recur, i.e., what quality		
	_	nt. Based on interview during			assurance program will be put	into	
		he Maintenance Supervisor			place; and		
		ire watch documentation			The administrator or		
	provided stated to c				maintenance director will au		
	Department of Heal	Ith at a phone number, and not			the sprinkler system daily fo	r	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER OF ANDERSON	2	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG 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
	listed above and did information for the non-emergency nur. This finding was ac Administrator and It time of observation conference. 3.1-19(b)			4weeks, 3 time a week for 4weeks and weekly for 4wee The results of these audits wat be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction not be completed by the date previously submitted, the Divisioneds to be contacted as soot possible. The facility will need submit an amended plan of correction with the updated placorrection date. 09/30/2022	s s s will sion n as d to
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in	corridor openings in other losures of vertical openings, as areas resist the passage made of 1 3/4 inch wood or other material and fire for at least 20 fully sprinklered smoke conly required to resist the			

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING B. WING	01	COMPLETED 09/23/2022
NAME OF P	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
	to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary suffammable or combustible materials in the door closed what applied. There is a closing of the door release when the dopermitted. Nonrate unlimited height armeeting 19.3.6.3.6 frames shall be lated the the suffammaterials in the suffammaterials i	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	what corrective action will be accomplished for those residents found to have been affected by the deficient praction. The door in the electrical roce.	ce.
	Findings include:			on the 100 hall, central nursi station, laundry closet on 60	_

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/23/2022
	OF PROVIDER OR SUPPLIED OF ANDERSON	R	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) DE COMPLETION DATE
	tour of the facility Maintenance Super 11:45: a.m. and 3:1 doors equipped wit to close and latch p a) Electrical Roo b) Central Nurse c) Clean Laundr d) 400 hall soiled on the floor. This finding was ac Administrator and	ons and interview during a with the Administrator and the rvisor on 09/23/22 between 5 p.m., the following corridor h a self-closing devices, failed positively into the door frame: om on the 100 hall. s Station, both doors. y Closet 600 Hall. d utility closet, door was sticking eknowledged by the Maintenance Supervisor at the hand again at the exit		hall and soiled utility doo 400 halls will be repaired how other resident having the potential to be aby the same deficient practice identified and what correction(s) will be taken. All other doors in the facility with inspected by the alleged deficiency. All doors in the facility with inspected for proper functionality what measures we put into place and what systemages will be made to enthat the deficient practice of the recur. The maintenance director implement a monitoring program to inspect the dot the facility for proper late and closure into the door frame. how the corrective action(s) will be monitored ensure the deficient practice not recur, i.e., what quality assurance program will be place; and The administrator or maintenance director will compliance of all the door daily for 4weeks, 3 time a	affected tice will ective will be stemic insure does not in hing et to be will put into audit rs

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING B. WING	01	COMPLETED 09/23/2022
		100000	<u> </u>	ET ADDRESS, CITY, STATE, ZIP COD	00/20/2022
NAME OF I	PROVIDER OR SUPPLIE	2		LINDBERG RD	
ENVIVE	OF ANDERSON			ERSON, IN 46012	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	for 4weeks and weekly for	DATE
				Aweeks The results of these audits be reviewed by the QAPI committee overseen by the Executive Director for no lest than six months. The results will be reviewed for patterns trends and continued recommendations for proce monitoring and improvement until 100% compliance is achieved. by what date the system changes for each deficiency with the completed. After submitting acceptable Plan of Correction is determined that the correct will not be completed by the compossible. The facility will need submit an amended plan of correction with the updated procorrection date.	ss s s s s s s s s s s s s s s s s s s
K 0511 SS=E Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1	l Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0511	09/30/2022 K511 .	09/30/2022
	failed to ensure all	electrical panels in the	K USII	what corrective action will be accomplished for those.	on(s)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/23/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE personnel. NFPA 70, 2011 edition states 230.62 residents found to have been Energized parts of service equipment shall be affected by the deficient practice enclosed as specified in 230.62(A) or guarded as The electrical panels in all the specified in 230.62(B). hallways will be locked (A) Enclosed. Energized parts shall be enclosed how other residents so that they will not be exposed to accidental having the potential to be affected contact or shall be guarded as in 230.62(B). by the same deficient practice will (B) Guarded. Energized parts that are not enclosed be identified and what corrective shall be installed on a switchboard, panelboard, or action(s) will be taken. control board and guarded in accordance with The electrical panels in the 110.18 and 110.27. Where energized parts are entire facility will be inspected guarded as provided in 110.27(A)(1) and (A)(2), a if they are locked and have means for locking or sealing doors providing functional locking systems access to energized parts shall be provided. This what measures will be deficient practice could affect staff and over 40 put into place and what systemic residents in 4 corridors. changes will be made to ensure that the deficient practice does not Findings include: There will be a regular routine Based on observations and interview during a inspection of all the electrical tour of the facility with the Administrator and the panels for proper locking Maintenance Supervisor on 09/23/22 between system. 11:45: a.m. and 3:15 p.m., electrical panels on the 600 hall, Dining Hall, and 500 hall were unlocked how the corrective when tested. The Maintenance Supervisor stated action(s) will be monitored to he will need to have keys made for the electrical ensure the deficient practice will panels throughout the facility. not recur, i.e., what quality assurance program will be put into This finding was acknowledged by the place: and Administrator and Maintenance Supervisor at the The administrator or time of observation and again at the exit maintenance director will conference. check on the sign daily for 4weeks, 3 time a week for 3.1-19(b) 4weeks and weekly for 4weeks The results of these audits will be reviewed by the QAPI committee overseen by the **Executive Director for no less** than six months. The results will be reviewed for patterns,

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2022
NAME OF F	PROVIDER OR SUPPLIEF			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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
				trends and continued recommendations for procomonitoring and improvementil 100% compliance is achieved.	
				by what date the systemic changes for each deficiency will be completed. After submitting an accepta Plan of Correction, if it is determined that the correction to be completed by the darpreviously submitted, the Doneeds to be contacted as suppossible. The facility will nesubmit an amended plan of correction with the updated correction date. 09/30/2022	ble fon will te ivision oon as eed to
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib used or stored and location, and such signs that read NC posted with the instance smoking. (2) In health care smoking is prohibited.	be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no			

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STATEMEN	NT OF DEFICIENCIES	ENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTI		ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED	
		155690	B. W	ING		09/23/	09/23/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>		
NAME OF 1	PROVIDER OR SUPPLIE	R			INDBERG RD			
ENI\/I\/E	OF ANDERSON				RSON, IN 46012			
LINVIVL	OI ANDLINGON			ANDLI				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		with language that prohibits						
	smoking shall not	•						
		atients classified as not						
	responsible shall							
	1 ' '	ent of 18.7.4(3) shall not						
	apply where the patient is under direct supervision.							
	, ,	oncombustible material and						
		be provided in all areas						
	where smoking is	-						
	· ·	ers with self-closing cover						
		h ashtrays can be emptied						
		vailable to all areas where						
	smoking is permit	ited.						
	18.7.4, 19.7.4							
		on and interview, the facility	K 0	741	K741.		09/30/2022	
		oking materials were deposited						
		netal containers with			what corrective actio			
	_	levices into which ashtrays			will be accomplished for those	}		
	-	noncombustible material and			residents found to have been			
	_	oor areas where smoking was			affected by the deficient pract			
	20 residents.	deficient practice could affect			All the entrances of the facil	-		
	20 residents.				will be cleared of any cigare	ite		
	Findings include:				butts			
	i manigs include:				how other residents			
	Based on observati	ons and interview during a			having the potential to be affe	cted		
		with the Administrator and the			by the same deficient practice			
	-	rvisor on 09/23/22 between			be identified and what correct			
	•	5 p.m., the following was			action(s) will be taken.	IVC		
	observed:	s pinni, the following was			All other areas of the facility			
		t entrance there were over 30			that have the potential to be			
		osed on the ground in the			affected will be inspected of			
	mulch near the buil				cigarette butts.			
		ndry Exit door, there were over						
		n the ground, in and near the			what measures will be	e		
	rock landscaping.	<i>G</i> ,			put into place and what syster			
		Lounge exit door, in the			changes will be made to ensu			
		g area, there were cigarette			that the deficient practice doe			
	butts on the ground	-			recur.			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/23/2022
	PROVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF e) In and around the	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Re parking lot, near the sidewalk	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) All the staffs in the facility	BE COMPLETION DATE
	were numerous cigar Maintenance Super asked to get all the occasionally uses a and then collect the This finding was ac	left side of the building, there arette butts on the ground. The visor stated that he has been cigarette butts up and blower to push then together m. knowledged by the Maintenance Supervisor at the		be educated on where to smoke and the need to us ashtrays that are located outside the facility exits for their cigarette butts • how the corrective action(s) will be monitored ensure the deficient practice.	or e to
		and again at the exit		not recur, i.e., what quality assurance program will be place; and The administrator or maintenance inspect all the exits of the facility daily for 4weeks, 3 time a week for 4weeks and weekly for patter to a weekly for patter to a weekly for patter trends and continued recommendations for promonitoring and improvemental 100% compliance is achieved.	put into ne or veeks s will ne less ults rns, cess
				 by what date the systemic changes for each deficiency will be complete. After submitting an accepta Plan of Correction, if it is determined that the correct not be completed by the da previously submitted, the D 	d. able ion will ate

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155690	B. WING		09/23/2022
	PROVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
				needs to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date. 09/30/2022	d to
K 0761 SS=E Bldg. 01					
	interview, the facili inspection and testi assembly was comp 19.1.1.4.1.1 commu fire barriers require permitted only in compare by approved self-cl (See also Section 8 required to have a fact 8.3.4.2 shall be probabled fire door as assemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protective specified in this Compare door assemblies shall be sides to assess the compare to assembly the AHJ. NFPA assemblies shall be sides to assess the compare to the following items (1) No open holes of	or breaks exist in surfaces of	K 0761	what corrective action will be accomplished for those residents found to have been affected by the deficient praction and documented how other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken. All the doors in the facility where inspected for fire rating what measures will be put into place and what system changes will be made to ensure that the deficient practice does recur. All the doors will be inspected by a certified inspector and documented for ratings how the corrective	cted cted will ive rill re mic re s not
	sides to assess the cassembly. NFPA 80 the following items (1) No open holes ceither the door or fr	overall condition of door 0, 5.2.4.2 states as a minimum, shall be verified: or breaks exist in surfaces of		by a certified inspector and documented for ratings	

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are intact and securely fastened in place, if so

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not recur, i.e., what quality

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLI	ETED
		155690	B. W	ING		09/23/2	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			NDBERG RD		
	OF ANDEDCON						
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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	equipped.				assurance program will be put	into	
	(3) The door, frame	e, hinges, hardware, and			place; and		
	noncombustible thr	eshold are secured, aligned,			The administrator or		
		er with no visible signs of			maintenance director will au	dit	
	damage.	<u> </u>			the inspection of the doors		
	(4) No parts are mis	ssing or broken.			4weeks, 3 time a week for		
	(5) Door clearances do not exceed clearances				4weeks and weekly for 4week	ks	
listed in 4.8.4 and 6.3.1.7.				The results of these audits w			
(6) The self-closing device is operational; that is,					be reviewed by the QAPI		
the active door completely closes when operated				committee overseen by the			
from the full open position.				Executive Director for no les	s l		
(7) If a coordinator is installed, the inactive leaf				than six months. The results			
	closes before the active leaf.				will be reviewed for patterns,		
(8) Latching hardware operates and secures the				trends and continued			
	door when it is in th	ne closed position.			recommendations for proces	s	
	(9) Auxiliary hardw	vare items that interfere or			monitoring and improvement		
	prohibit operation a	are not installed on the door or			until 100% compliance is		
	frame.				achieved.		
	(10) No field modif	fications to the door assembly			by what date the		
	have been performe	ed that void the label.			systemic changes for each		
	(11) Gasketing and	edge seals, where required, are			deficiency will be completed.		
	inspected to verify	their presence and integrity.			After submitting an acceptable	,	
	This deficient pract	ice could affect 20 residents.			Plan of Correction, if it is		
					determined that the correction	will	
	Findings include:				not be completed by the date		
					previously submitted, the Divis	sion	
		eview and interview with the			needs to be contacted as soor	n as	
	Administrator and t	the Maintenance Supervisor on			possible. The facility will need	l to	
	09/23/22 between 9	9:45 a.m. and 11:45: a.m., no			submit an amended plan of		
	documentation of a	n annual inspection for the fire			correction with the updated pla	an of	
	door assembly at th	e Oxygen Transfilling room			correction date.		
	was available for re	eview. Based on observation			09/30/2022		
	during the facility to	our the Oxygen Transfilling					
	room has one 90-m	inute fire door assembly. Based					
	on interview at the	time of records review and					
	observation, the Ma	aintenance Supervisor stated					
	the annual fire door	inspection was not completed					
		and was previously unaware a					
	fire door inspection	was needed on the					
	Transfilling Room						
	l						

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	T OF HEALTH AND HU R MEDICARE & MEDIC					ORM APPROVED MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULT A. BUILD B. WING	TPLE CONSTRUCTION DING 01	COM	(X3) DATE SURVEY COMPLETED 09/23/2022	
	PROVIDER OR SUPPLIE	R	1	TREET ADDRESS, CITY, STATE, ZIP 821 LINDBERG RD INDERSON, IN 46012	COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF CO CEFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
< 0781 SS=E Bldg. 01	Administrator and time of observation conference. 3.1-19(b) NFPA 101 Portable Space H Portable Space H Portable space he prohibited in all he except, unless us employee areas who not exceed 21 degrees Celsius). 18.7.8, 19.7.8 Based on observating failure to ensure 1 dewere not used in the practice could affect visitors in the MDS. Findings include: Based on observating tour of the facility of the facil	leaters leating devices shall be leating devices shall be leating devices. Shall be leating elements lead of the leating elements leading elements elements leading elements elements leading elements elemen	K 0783		ve been ent practice. es been esidents o be affected t practice will at corrective n. e facility r space er	09/30/2022	

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This finding was acknowledged by the

time of observation and again at the exit

Administrator and Maintenance Supervisor at the

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what measures will be

put into place and what systemic

changes will be made to ensure

that the deficient practice does not

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155690	B. W			09/23/	/2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		<u> </u>
FNVIVE	OF ANDERSON			1	NDBERG RD SON, IN 46012		
	T	OTHER DESIGNATION OF PRESENTATION	-		I		I aus
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	conference. 3.1-19(b)				recur. All the staff will be educated on what items are not to be used in the facility that can cause a fire • how the corrective action(s) will be monitored to ensure the deficient practice wont recur, i.e., what quality assurance program will be put place; and The administrator or maintenance director will authe inspection of the doors 4 weeks, 3 time a week for 4 weeks and weekly for 4 weeks and weekly for 4 weeks and weekly for 4 weeks be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns trends and continued recommendations for process monitoring and improvement until 100% compliance is	vill t into dit ks vill s	
					achieved.		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble	ent - Power Cords and ent - Power Cords and eatient care vicinity are only nts of movable ed electrical equipment les that have been elified personnel and meet					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/23/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0920 09/30/2022 Based on observation and interview, the facility K920 failed to ensure 2 of 2 power strips were not used what corrective action(s) as a substitute for fixed wiring to provide power will be accomplished for those equipment with a high current draw. residents found to have been NFPA-70/2011, 400.8 state unless specifically affected by the deficient practice. permitted in 400.7 flexible cords and cables shall All the electrical items have not be used for (1) as a substitute for fixed wiring. been plugged directly into the This deficient practice could affect up to 2 wall outlet residents and 4 staff. how other residents having the potential to be affected Findings include: by the same deficient practice will be identified and what corrective Based on observations and interview during a action(s) will be taken. tour of the facility with the Administrator and the All the areas of the facility will be Maintenance Supervisor on 09/23/22 between inspected to make sure they are 11:45: a.m. and 3:15 p.m., (1) in the Reception Area no extension cords. a power strip was being used to power a dorm style refrigerator (high power draw equipment). what measures will be And (2) in the Medical Room near the nurses put into place and what systemic station, a refrigerator (high power draw changes will be made to ensure equipment) was plugged into a power strip. The that the deficient practice does not

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Nurse stated that the location of the refrigerator

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recur.

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		E CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	vG <u>01</u>		COMPLETED
		155690	B. WING			09/23/2022
NAME OF D	PROVIDER OR SUPPLIER	}		REET ADDRESS, CITY, S	STATE, ZIP COD	
		·		21 LINDBERG RD		
ENVIVE	OF ANDERSON		AN	DERSON, IN 4601	2	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'	'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREF	IX (EACH CORREC' CROSS-REFEREN	TIVE ACTION SHOULD BE NCED TO THE APPROPRIAT	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	G D	DEFICIENCY)	DATE
	didn't allow the core	d to go directly into the outlet.			I be educated on	
	TE1 ' C' 1'	1 1 1 11 1			xtension cords in	
	This finding was ac	- ·			y the administrat	or
		Maintenance Supervisor at the		or designee		. (-)
		and again at the exit			at corrective action	
	conference.				nplished for those and to have been	
	3.1-19(b)				ind to nave been he deficient practi	20
	J.1-17(0)				rs will be inspect	
				and docume		
				• how	other residents	
				having the po	otential to be affec	eted
				by the same	deficient practice	will
				be identified	and what corrective	ve
				action(s) will	be taken.	
				All the doors	s in the facility wi	ill
				be inspected	d for fire rating	
				, who	ot magaziraa will bi	
					at measures will be	
				1 '	e and what systen be made to ensur	
				_	cient practice does	
				recur.	nont practice dues	, 1101
					s will be inspecte	d
					d inspector and	_
				documented	-	
					-	
				• how	the corrective	
				1 ' '	be monitored to	
					eficient practice w	rill
					., what quality	
					rogram will be put	into
				place; and	44	
				The adminis		114
					e director will aud	JIC
				I	on of the doors	
				I	me a week for	.
					weekly for 4weel	
			1	i ne results o	of these audits w	III

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155690	B. WING		09/23/2022	
	ROVIDER OR SUPPLIER		1821 LI	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				be reviewed by the QAPI		
				committee overseen by the		
				Executive Director for no less		
				than six months. The results		
				will be reviewed for patterns,		
				trends and continued		
				recommendations for process	s	
				monitoring and improvement		
				until 100% compliance is		
				achieved.		
				by what date the		
				systemic changes for each		
				deficiency will be completed.		
				After submitting an acceptable		
				Plan of Correction, if it is		
				determined that the correction	will	
				not be completed by the date		
				previously submitted, the Divisi	on	
				needs to be contacted as soon		
				possible. The facility will need		
				submit an amended plan of		

correction date.

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