DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COM		COMPL	ETED
		155690	B. W	NG		08/01/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				NDBERG RD		
ENVIVE	OF ANDERSON			ANDER	SON, IN 46012		
(X4) ID	SUMMARY S	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	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in		E 00	000	Preparation or execution of this plan of correction does not		
	accordance with 42	CFR 483.73.			constitute admission or agreer	nent	
					of provider of the truth of the fa		
	Survey Date: 08/01	/23			alleged or conclusions set fortl the Statement of Deficiencies.		
	Facility Number: 00	00027			Plan of Correction is prepared		
	Provider Number: 1				executed solely because it is	anu	
					required by the position of Fed	eral	
	AIM Number: 100266180				and State Law. The Plan of	Cidi	
	At this Emergency Preparedness survey, Envive				Correction is submitted to resp	ond	
	of Anderson was found not in compliance with				to the allegation of noncomplia		
		dness Requirements for			cited during the Emergency		
		caid Participating Providers			Preparedness and Life Safety		
		FR 483.73. The facility has a			Survey conducted August 1, 2	023.	
	capacity of 97 and h	and a census of 47 at the time			Please accept this Plan of		
	of this survey.				Correction as the provider's		
					credible allegation of complian	ce	
	Quality Review con	npleted on 08/09/23			as of September 8, 2023. The		
					provider respectfully requests		
					review with paper compliance		
					be considered in establishing t	hat	
					the provider is in substantial		
					compliance.		
E 0007	// // // // // // // // // // // // //	5.54(a)(3), 418.113(a)(3),					
SS=F	` ' ' '	2.15(a)(3), 418.115(a)(3),					
Bldg		102(a)(3), 485.625(a)(3),					
Diag.	. , , ,	727(a)(3), 485.920(a)(3),					
	491.12(a)(3), 494.						
	EP Program Patie	. , . ,					
	•	116.54(a)(3), §418.113(a)(3),					
	. , , , .	§460.84(a)(3), §482.15(a)(3),					
	. , , , ,	33.475(a)(3), §484.102(a)					
	(3), §485.68(a)(3)	. , , , =					
		185.920(a)(3), §491.12(a)(3),					
	§494.62(a)(3).	• • • •					

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/01/2023		
	OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	(X5) COMPLETION DATE		
	develop and mair preparedness pla and updated at le must do the follow (3) Address [patie including, but not the type of service ability to provide it continuity of oper of authority and s *[For LTC facilitie Emergency Plan. develop and mair preparedness pla and updated at le must do all of the (3) Address resid but not limited to, services the LTC provide in an emergency include and succession p *NOTE: ["Persons ASC, hospice, PARHC/FQHC, or Emased on record refailed to ensure the addressed resident limited to, persons LTC facility has the emergency; and co including delegation plans in accordance.	ent/client] population, limited to, persons at-risk; es the [facility] has the in an emergency; and ations, including delegations uccession plans.** s at §483.73(a):] The LTC facility must ntain an emergency in that must be reviewed, east annually. The plan following: ent population, including, persons at-risk; the type of facility has the ability to ergency; and continuity of ling delegations of authority lans. s at risk" does not apply to: ACE, HHA, CORF, CMCH,	E 0007	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? All residents had the potential be affected, however no resident were affected. The resident population information has been included in the emergency	to ents		

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Event ID:

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Facility ID: 000027

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	of correction identification number 155690	A. BUILDING B. WING		COMPI 08/01	ETED	
	PROVIDER OR SUPPLIER OF ANDERSON	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE	
E 0039	During record review with the Director of Facilities (DF) at 10:30 a.m. on 08/01/23, no documentation could be found ensuring the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on interview at the time of record review, the DF stated the policies regarding the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans could not be found. This finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)	2: the the be con All be we por inc pre 3: int cha en: pra The Pre qua tha 4: will def i.e. pro The the Pla mo	How other residents he potential to be affected as same deficient practice identified and what rective action will be a residents had the potential to he affected, however no recreased and information has bluded in the emergency exparedness plan. What measures will be no place or what system anges will be made to sure that the deficient actice does not recur? The information has arterly and on-going, to the action of the exparedness plan at least arterly and on-going, to the tall requirements are not exparedness. The information has action to the corrective action of the executive Director will be monitored to ensure the executive Director will be executive Director will be the executive Director will b	ed by ce will taken. ntial to esidents ent s been e put nic nergency st ensure net. tion ure the t recur nees place? Il present neess the review		
E 0039 SS=F Bldg	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155690	B. W	ING		08/01/	2023
	PROVIDER OR SUPPLIER	2		1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD SON, 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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	486.360(d)(2), 49: EP Testing Requires \$416.54(d)(2), \$4: \$460.84(d)(2), \$4: \$483.475(d)(2), \$4: \$485.625(d)(2), \$4: \$485.625(d)(2), \$4: \$491.12(d)(2) \$4: \$491.12, and ESF \$491	1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d), §494.62(d)(2). 6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan illity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is induct a facility-based every 2 years; or lity] experiences an actual ade emergency plan, the [facility] gaging in its next required or individual, facility-based exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based exercise that is or individual.		TAG	DEPICIENCY		DATE
	(C) A tableton exe	ercise or workshop that is	1				

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690		JILDING	NSTRUCTION	COME	E SURVEY PLETED 1/2023	
	OF PROVIDER OR SUPPLIES VE OF ANDERSON	R	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	led by a facilitator discussion using clinically-relevant set of problem star messages, or preto challenge an eliii) Analyze the [finaintain docume exercises, and enthe [facility's] emethe [facility hashed facility hashed functional emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full community-based functional exercise functional exercise (B) A mock disast (C) A tabletop exempted for the emergency exempted functional exercise functional exercise functional exercise functional exercise functional exercise (B) A mock disast (C) A tabletop exercise functional exercise (B) A mock disast (C) A tabletop exercise functional exercise (B) A mock disast (C) A tabletop exercise functional exercise (B) A mock disast (C) A tabletop (C)	rand includes a group a narrated, emergency scenario, and a atements, directed epared questions designed mergency plan. facility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed. 418.113(d):] Despices that provide care in e. The hospice must is to test the emergency ually. The hospice must do a full-scale exercise that is dievery 2 years; or inunity based exercise is not fuct an individual facility exercise every 2 years; or experiences a natural or expensive that requires activation or plan, the hospital is aging in its next required full rebased exercise or individual ctional exercise following the ergency event. dditional exercise every 2 fue year the full-scale or fue under paragraph (d)(2)(i) conducted, that may to limited to the following: e-scale exercise that is d or a facility based fie; or					DATE	

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690		UILDING	NSTRUCTION	(X3) DATE COMPL 08/01/	ETED
	PROVIDER OR SUPPLIER	3	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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	discussion using a clinically-relevant set of problem sta	a narrated, emergency scenario, and a tements, directed pared questions designed					
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engatull-scale community (ii) Conduct an activat may include, following:	nunity-based exercise is not an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the					
	community-based functional exercise (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain document exercises, and emergency and emergency plan.	ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	ľ	JILDING ING	ONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 08/01/2023	
	PROVIDER OR SUPPLIE	R		1821 LI	ADDRESS, CITY, STATE, ZIP COD NDBERG RD SON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	§482.15(d), CAHs (2) Testing. The [conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based fund (B) If the [PRTF, an actual natural that requires activ plan, the [facility] its next required f or individual, facil following the onse (ii) Conduct exercise or and th limited to the follo (A) A second full- community-based facility-based fund (B) A mo (C) A tableto is led by a facilitar discussion, using clinically-relevant set of problem sta messages, or pre to challenge an e (iii) Analyze t and maintain doc tabletop exercises	PRTF, Hospital, CAH] must is to test the emergency ar. The [PRTF, Hospital, et following: an annual full-scale exercise is an annual full-scale exercise is not uct an annual individual, etional exercise; or Hospital, CAH] experiences or man-made emergency vation of the emergency is exempt from engaging in ull-scale community based ity-based functional exercise et of the emergency event. an [additional] annual nat may include, but is not wing: -scale exercise that is a or individual, a etional exercise; or pock disaster drill; or prevention exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atternents, directed pared questions designed						

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	JILDING	NSTRUCTION	COMPL 08/01/	ETED
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF ANDERSON			SON, IN 46012		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	*[For PACE at §46	R LSC IDENTIFYING INFORMATION 60.84(d):]	TAG	DE POLICIE I		DATE
	(2) Testing. The P conduct exercises plan at least annu organization must (i) Participate in a that is community. (A) When a commaccessible, condufacility-based function of the ending exempt from enfull-scale communifacility-based functionset of the emery (ii) Conduct a 2 years opposite the functional exercise of this section is cobut is not limited to (A) A second full-	ACE organization must to test the emergency ally. The PACE do the following: an annual full-scale exercise abased; or annual individual, attional exercise; or aperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required aity based or individual, attional exercise following the gency event. In additional exercise every he year the full-scale or a under paragraph (d)(2)(i) onducted that may include, to the following: scale exercise that is or individual, a facility exercise; or				
	(C) A tabletop excled by a facilitator discussion, using	ercise or workshop that is and includes a group a narrated,				
	clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze the P maintain documer exercises, and em	emergency scenario, and a tements, directed pared questions designed				
	*[For LTC Facilitie (2) The [LTC facili	s at §483.73(d):] ty] must conduct exercises				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/01/2023
	PROVIDER OR SUPPLIE	R	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
1AG	to test the emergy year, including ur the emergency policified in that is community (A) When a community (A) When a community (A) When a community (B) If the [LTC factual natural or requires activation LTC facility is exercived a full-social individual, facility following the onsocial (B) Conduct an authat may include, following: (A) A second full community-based functional (B) A mock disast (C) A tabletop expled by a facilitation discussion, using clinically-relevant set of problem stamessages, or preto challenge and (iii) Analyze the response to and all drills, tabletop	ency plan at least twice per nannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise y-based; or munity-based exercise is not uct an annual individual, ctional exercise. Cility] facility experiences an man-made emergency that nof the emergency plan, the empt from engaging its next ale community-based or eleased functional exercise et of the emergency event. In other exercise is donal annual exercise but is not limited to the exercise; or ster drill; or exercise or workshop that is a rincludes a group a narrated, a emergency scenario, and a stements, directed exercise, and emergency et the [LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's	TAG	DEFICIENCE	DATE
	exercises to test	§483.475(d)]: CF/IID must conduct the emergency plan at least ne ICF/IID must do the			

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	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	i '	JILDING	NSTRUCTION	(X3) DATE COMPL 08/01/	ETED
	F PROVIDER OR SUPPLIED E OF ANDERSON	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	following: (i) Participate in a that is community (A) When a commaccessible, conducted facility-based function of the example from enditivation of the example from enditive following: (A) A second full-community-based facility-based function on the example from enditive following: (A) A second full-community-based facility-based function following: (A) A second full-community-based facility-based function following: (B) A mock disast (C) A tabletop example facility-based function following: (I) Analyze function for the example for the following: (II) Analyze function for the example for the following: (III) For HHAs at \$44 (d)(2) Testing. The exercises to test the least annually. The following: (II) Participate in a community-based for the example for the following: (II) Participate in a community-based for the following: (III) Participate in a community-based for the follo	n annual full-scale exercise -based; or nunity-based exercise is not act an annual individual, ctional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID agaging in its next required nity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise that is I or an individual, ctional exercise; or are drill; or excise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and attation of all drills, tabletop mergency events, and revise rgency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the					

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		OF CORRECTION	IDENTIFICATION NUMBER 155690	ľ í	UILDING	nstruction 	COMPL 08/01/	ETED
		PROVIDER OR SUPPLIEF			1821 LII	NDBERG RD		
EN	/IVE	OF ANDERSON			ANDER	SON, IN 46012		
(X4) PREI TA	FIX	(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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		individual, facility-every 2 years; or. (B) If the HH. natural or man-material activation of the exempt from engate full-scale community based functional exercise of this section is conclude, but is not (A) A second community-based facility-based functional exercise of this section is conclude, but is not (B) A mock diacility-based functional exercise facility-based functional exercise is led by a facilitate discussion, using clinically-relevant set of problem state of problem	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The					

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8TH821

Facility ID: 000027

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/01/2023
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON		3	1821	ET ADDRESS, CITY, STATE, ZIP COD LINDBERG RD ERSON, 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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
IAU	problem statement prepared question emergency plan. It actual natural or requires activation OPO is exempt for required testing exempt for the emergency (ii) Analyze the Olimaintain document for the exempt for the e	ats, directed messages, or as designed to challenge an afthe OPO experiences an anan-made emergency that a first of the emergency plan, the comengaging in its next exercise following the onset event. PO's response to and antation of all tabletop ergency events, and revise OPO's] emergency plan, as 3.748]: Re RNHCI must conduct the emergency plan. The efollowing: Portion of all tabletop exercise and for the emergency plan. The efollowing: Portion of a facilitator, using a exercise and the emergency et of problem statements, and revise enge an emergency plan. The enge an emergency plan. The enge and emergency plan and revise ergency plan, as needed. Enge and interview, the facility engels and interview engels and intervi	E 0039	1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice? A facility event that occurred 7/29/2023, has been added to Emergency Preparedness Planting Fig. 1.	will 09/08/2023 In on on the
	accessible, conduct facility-based funct	an annual individual, ional exercise.		2: How other residents have	ing

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORFICTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) COMPANY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) EXAMPLE: PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY	
	(X5) OMPLETION DATE
the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had the potential to be affected, however no residents were affected. The facility levent occurring 7/29/20/23 has been added to the Emergency a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency secnario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483-73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Director of Facilities (DF) on 08/01/23 at 12:10 p.m., documentation of a fall chilly based annual exercise completed on 09/12/22 was available for review, the DF stated the facility based annual exercise on interview at the time of records review, the DF stated the facility completed one facility based exercise within the last 12 months. There was no documentation provided of a second exercise. This finding was reviewed with the Administrator and DF at the exit conference.	

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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	(X3) DATE SURVEY COMPLETED 08/01/2023	
	PROVIDER OR SUPPLIER OF ANDERSON	1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0000					
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/01/2023 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 At this Life Safety Code survey, Envive of Anderson was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detection in the 500 and 600 hall resident sleeping rooms. The facility has a capacity of 97 and had a census of 47 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/09/23	K 0000	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fedand State Law. The Plan of Correction is submitted to rest to the allegation of noncomplicited during the Emergency Preparedness and Life Safety Survey conducted August 1, 2 Please accept this Plan of Correction as the provider's credible allegation of compliant as of September 8, 2023. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	ment facts th on . The d and deral pond ance 2023.	
K 0100 SS=E	NFPA 101 General Requirements - Other				

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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 08/01/2023 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 Bldg. 01 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility K 0100 09/08/2023 1: What corrective action(s) will failed to maintain latching hardware on 2 of 2 be accomplished for those smoke barrier doors. LSC 4.6.12.3 requires existing residents found to have been life safety features obvious to the public if not affected by the deficient required by the Code, shall be either maintained or practice? removed. This deficient practice could affect staff The smoke barrier doors to the and up to 30 residents. 300 Hall have been adjusted to close and latch. Findings include: 2: How other residents having Based on observation with the Director of the potential to be affected by Facilities (DF) on 08/01/23 at 12:35 p.m. and 12:50 the same deficient practice will p.m., the set of smoke barrier doors to the 300 Hall be identified and what and by the Therapy room were provided with corrective action will be taken. latching hardware but failed to close and latch All residents had the potential to when tested. Based on interview at the time of be affected, however no residents observation, the DF agreed the smoke doors were were affected. All smoke barrier equipped with latching devices, but the doors did doors have been reviewed to not properly close and latch when tested. ensure proper closure and adjustments have been made The finding was reviewed with the Administrator where warranted. and DF during the exit conference. 3: What measures will be put 3.1-19(b) into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will check for proper closure and latch of all smoke barrier doors monthly, ongoing. Any doors found to not close, and

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	OF CORRECTION	IDENTIFICATION NUMBER 155690	A. BUILDING B. WING	01	COMPLETED 08/01/2023
	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0271 SS=F Bldg. 01	NFPA 101 Discharge from Ex Discharge from Ex Exit discharge is a 7.7, provides a lev the provisions of 7 changes in elevation discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure all e facility had a level w obstructions, and co all-weather travel su Survey and Certifica	cits cits cranged in accordance with rel walking surface meeting contains and shall be maintained so Additionally, the exit a hard packed all-weather contains and interview, the facility exit discharges around the valking surface, were free of constructed of hard packed contains accordance with CMS contains and contains and	K 0271	latch properly will be immediated adjusted, if an outside vendor needed for any concerns the Maintenance Director will notific Executive Director immediated. 4: How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The Maintenance Director or designee will utilize the facility TELS system to monitor smoke barrier doors and will report monthly to the QAPI Committed any findings. 1: What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? The sidewalk is scheduled for repairs. A waiver for extension resurface pathway is being submitted. Low hanging limbs have been removed.	rely is fy the y. the eur e? the eur ee the eur eur eur eur eur eur eur eur eur eu

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/01/2023	
	PROVIDER OR SUPPLIER		1821 L	ADDRESS, CITY, STATE, ZIP COD LINDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation tour of the facility was (DF) on 08/01/23 at the (1) TV Lounger concrete pad and side blacktopped path was around the facility problem of the facility problem of the uneven surface which additionally, the affine pathways were crace places, narrowed, or obstacles during an limbs hanging down the smoke shack. The unaware of the tree them trimmed to cleat they have been blacktop pathways, replace it has been of the blacktop walkway have a complete lever free of obstructions.	ons and interview during a with the Director of Facilities 01:00 p.m., immediately outside Exit and (2) 500 Hall exit, a dewalk terminated onto a hich leads both directions providing exit discharge to the lots. Where the concrete blacktop pathways there is an ech could be a trip hazard. Forementioned blacktop ked, broken, uneven, and in reating trip hazards and evacuation. There were tree in and obstructing the path by the DF said that he was limb obstacle and will have the ear the pathway. The DF stated attempting to correct the but finding a contractor to difficult. He acknowledged that anys were in need of repair to the element of the public way.		2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be tall All residents that use the side had the potential to be affect however no residents were affected. 3: What measures will be positive into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director of designee will audit the pathylobstructions monthly, to ensure deficient practice will not relieve, what quality assurance program will be put into plate., what quality assurance program will be put into plate. The Maintenance Director of designee will utilize the facility TELS system to monitor facility egress and will report month the QAPI Committee any fin	ving by will ken. dewalk deted, ut c r vay for ure a n e the ecur e ace? r ity dility uly to
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/01/2023	
		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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	from other spaces partitions and doc Doors shall be se automatic-closing nonrated or field-do not exceed 48 the door. Describe the floor hazardous areas REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel b. Laundries (larg c. Repair, Mainter d. Soiled Linen Regallons) e. Trash Collectio (exceeding 64 ga f. Combustible St. (over 50 square from g. Laboratories (if Hazard - see K32 Based on observatifailed to ensure the rooms which is a hecombustible storage feet was provided would cause the dolatch into the door could 20 residents the oxygen storage. Based on observatifailed:	and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) mance, and Paint Shops booms (exceeding 64 In Rooms llons) brage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility corridor doors to 2 of 10 azardous area containing e and greater than 50 square with a self-closing device which or to automatically close and frame. This deficient practice in the corridor by laundry and area.	K 0321	1: What corrective action(s) be accomplished for those residents found to have be affected by the deficient practice? The doors to the laundry and oxygen storage room have h self-closing device adjusted to ensure that the door latches properly within the door fram 2: How other residents have the potential to be affected	en ad the to e. ing by
	with the Director of	f Facilities (DF) on 08/01/23 at		the same deficient practice	will

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	IT 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 08/01/2023
	PROVIDER OR SUPPLIEF OF ANDERSON		1821 L	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	hazardous storage r square feet and the equipped with a sel latch into the frame	55 p.m., the laundry room, a coom that was greater than 50 oxygen storage room, were f-closing device but did not when tested. Based on		be identified and what corrective action will be tak An audit was conducted, and other areas were identified.	
	agreed that when te was larger than 50 s storage room is a ha self-closing device the frame.	e of observation, the DF sted, the laundry room which square feet and the oxygen azardous area, each with a on the door did not latch into e reviewed with the DF at the exit conference.		3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will conduct monthly audits of all self-closing device ensure they are in proper wo	ly ces to rking
	3.1-19(b)			order so that the door latches properly into the frame, ongo 4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into pla The Maintenance Director or designee will utilize the facility TELS system to monitor self-closing devices and will monthly to the QAPI Commit any findings.	ing. the ecur ce? y report
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		<u>01</u> COMPLETED					
		155690	B. W	NG		08/01/	2023
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	smoke compartments patients comply with 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer productions under a Cooking facilities in NFPA 96 per 9.2.3 enclosed as hazar be open to the correct per conditions under a considerable open to the correct per conditions under a cooking facilities in NFPA 96 per 9.2.3 enclosed as hazar be open to the correct per conditions in the correct per considerable in the UL 300 hood sy 96, 11.1.4 states in soperating the fire exposted conspicuous reviewed with employed deficient practice conditions in the correct practice of and 25 residents in Findings include: Based on observation facilities (DF) on 0 kitchen contained a K-class fire extinguished and the hood the fire extinguished indicate activating the system and using the a hood grease fire. The conditions is the correct per conditions the correct per conditions are considerable to the fire extinguished indicate activating the system and using the ahood grease fire. The conditions is the correct per conditions are conditionally as the correct per conditions are conditionally	atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be rdous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility if were instructed in the use of extern in 1 of 1 Kitchen. NFPA structions for manually extinguishing system shall be layin the kitchen and shall be layees by management. This build affect staff in the kitchen	K 0	324	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? Dietary staff were immediately inserviced regarding the ansul system and the K-class fire extinguisher. All staff were inserviced on the Ansul System K-class fire extinguisher, ABC extinguishers and pull station activation on 8.2.2023. 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take All residents have the potential be affected, however no reside were affected. 3: What measures will be put into place or what systemic changes will be made to	n m, y vill n. ol to ents	09/08/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/01/2023
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This finding was re and DF at the exit c 3.1-19(b)	viewed with the Administrator onference.		ensure that the deficient practice does not recur? Fire Safety has been added to general orientation for all staff ongoing.	
				4: How the corrective action will be monitored to ensure a deficient practice will not redice, what quality assurance program will be put into place. The facility will review Fire Saduring All Staff Meetings for the next 6 months, while continuing conduct random audits of employee knowledge. The redof the training / audits will be reviewed monthly for 6 months the QAPI committee. If substantial compliance is achieved the audits may be lessened or removed by recommendation of the committee.	the cur ce? fety ne ng to sults
K 0341 SS=C 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	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment.			

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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	A. BUILDING <u>01</u>			ETED
		155690	B. W	ING		08/01/	2023
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
END (I) (E	OF ANDEDOON				NDBERG RD		
ENVIVE OF ANDERSON			ANDER	RSON, IN 46012			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	transmission path	s are monitored for					
	integrity.						
	18.3.4.1, 19.3.4.1	, 9.6, 9.6.1.8					
	Based on observation	on and interview, the facility	K 0	341	1: What corrective action(s)	will	09/08/2023
	failed to ensure 1 of	f 1 fire alarm systems was			be accomplished for those		
	continuously in pro	per operating condition.			residents found to have beer	1	
	NFPA 72, National	Fire Alarm and Signaling Code,			affected by the deficient		
		on 14.2.1.2.2 states system			practice?		
	defects and malfund	ctions shall be corrected. This			The fire panel date and time w	as as	
	deficient practice co	ould affect all residents, staff			reset.		
	and visitors.						
					2: How other residents having		
	Findings include:		the potential to be affected		у		
		the same deficient practice will				/ill	
		on of the fire alarm control			be identified and what		
	•	ctor of Facilities (DF) on			corrective action will be take		
	-	.m., the time on the display of			All residents have the potentia		
		ol panel indicated the time to be			be affected, however no reside	ents	
		ecked at 02:20 p.m. and the date			were affected. The Maintenan		
		0 on 08/01/23 Based on			Director has been educated in	how	
		e of observation, the DF		to reset the date/time			
	_	n control panel had the wrong			control if necessary.		
		vill need to be changed. The					
		a power outage a few days			3: What measures will be put	:	
	earlier and probably	caused this to happen.			into place or what systemic		
		e a cara sa esta .			changes will be made to		
		viewed with the Administrator			ensure that the deficient		
	and DF during the 6	exit conference.			practice does not recur?		
	2.1.10(1)				The Maintenance Director or		
	3.1-19(b)				designee will complete an aud	ıt at	
					least monthly during the		
					scheduled fire drill, and/or afte		
					any loss of power to ensure the fire panel has the correct date		
					time. Any concerns will be no		
					in the fire drill documentation		
					immediately corrected.	ariu	
					Initinediately corrected.		
					4: How the corrective action		
					will be monitored to ensure t	ho	
					wiii be ilioliitorea to efisure t	ii e	

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CENTERS FOI	R MEDICARE & MEDIC	CAID 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		08/01/2023
NAME OF 1	PROVIDER OR SUPPLIEI	· }		ADDRESS, CITY, STATE, ZIP COD	
		-		INDBERG RD	
ENVIVE	OF ANDERSON		ANDEI	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 APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				deficient practice will not rec	ur
				i.e., what quality assurance	-2
				The results of the Monthly aud	
				will be reviewed by the QAPI	11.5
				committee monthly, on-going.	
				Committee monthly, on-going.	
K 0345	NFPA 101				
SS=F	Fire Alarm Syster	n - Testing and			
Bldg. 01	Maintenance				
	Fire Alarm Syster	n - Testing and			
	Maintenance				
	A fire alarm syste	m is tested and maintained			
	in accordance wit	h an approved program			
		e requirements of NFPA 70,			
	National Electric (Code, and NFPA 72,			
	National Fire Alar	m and Signaling Code.			
		n acceptance, maintenance			
	and testing are re				
		IFPA 70, NFPA 72			
		view and interview, the facility	K 0345	1: What corrective action(s) v	will 09/08/2023
		f 1 fire alarm systems was		be accomplished for those	
		rdance with LSC 9.6.1.3. LSC		residents found to have been	1
	_	re alarm system to be installed,		affected by the deficient	
	· ·	ned in accordance with NFPA		practice?	
	· ·	ical Code and NFPA 72,		Pull Station #1 has been repai	
		n Code. NFPA 72, Section		and the three smoke detectors	;
	_	that system defects and		have had the tape removed.	
		be corrected. This deficient		1	
	practice could affect	et all occupants.		2: How other residents havin	_
	F: 1:			the potential to be affected by	
	Findings include:			the same deficient practice w	/III
	n .	i id d. Di i e		be identified and what	
		view with the Director of		corrective action will be take	
	· · ·	08/01/23 at 10:30 a.m. the Annual		All residents had the potential	
	Fire Alarm Report	from their vendor, dated	1	be affected, however no reside	ents I

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06/22/23, stated deficiencies of a broken pull

station #1 and 3 smoke detectors covered with tape but there was no documentation of the pull

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were affected.

3: What measures will be put

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	î ,	JILDING	onstruction 01	(X3) DATE COMPL 08/01/	ETED
	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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
	on interview at the confirmed the issue documentation of redetectors found dur covered with tape. If at the time of observity	viewed with the Administrator			into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director of designee will complete more audits of all smoke detectors pull stations, ongoing. 4: How the corrective action will be monitored to ensure deficient practice will not relie, what quality assurance program will be put into play the Maintenance Director of designee will utilize the facil TELS system to monitor pull stations and smoke detector will report monthly to the QAC Committee any findings.	r thly s and n e the ecur e ace? r	
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system	<u> </u>					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155690	B. W	ING		08/01/2	2023
NAME OF I	DDOMINED OD GUDDI IEI)		STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	T			INDBERG RD		
	OF ANDERSON				RSON, IN 46012	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION DATE	
TAG		non-required or partial		TAG			DATE
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8						
	Based on observation and interview, the facility		K 0	353	1: What corrective action(s)	will	09/08/2023
	failed to ensure 1 or	f 1 sprinkler head by room 210			be accomplished for those		
	_	paint accordance with LSC 9.7.5.			residents found to have bee	n	
		tion, at 5.2.1.1.1 sprinklers shall			affected by the deficient		
		eakage; shall be free of			practice?	40:	
		naterials, paint, and physical be installed in the correct			The sprinkler head by room 2	10 IS	
		p-right, pendent, or sidewall).			scheduled to be repaired or replaced.		
		.1.1.2 any sprinkler that shows			replaced.		
		following shall be replaced: (1)			2: How other residents havi	ng	
	-	ion (3) Physical Damage (4)			the potential to be affected b	-	
	Loss of fluid in the	glass bulb heat responsive			the same deficient practice v	will	
		g (6) Painting unless painted by			be identified and what		
	-	acturer. This deficient practice			corrective action will be take	en.	
		nd up to 4 residents in two					
	rooms.				All residents had the potential		
	Findings include:				be affected, however no residuel were affected.	ents	
	1 manigs merade.				were arrected.		
		on with the Director of			3: What measures will be pu	t	
		08/01/23 at 12:55 p.m., the			into place or what systemic		
		oom 210 had paint on it. Based			changes will be made to		
		time of observation, the DF kler head by room 210 had			ensure that the deficient		
	paint on the it.	•			practice does not recur? Education has been provided	to	
	Paint on the it.				the Maintenance Director		
	This finding was re	viewed with the Administrator			regarding keeping sprinkler he	eads	
	and DF during the				free of any debris. The		
					Maintenance Director will mor	nitor	
	3.1-19(b)				all painting projects to ensure		
					paint that gets on the sprinkle		
					head is removed immediately		
					4: How the corrective action		
					will be monitored to ensure	the	
					deficient practice will not red	cur	
					i.e., what quality assurance		

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DEPARTMENT OF HEALTH AND HUMAN SERVI	CES
CENTERS FOR MEDICARE & MEDICAID SERVI	CES

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/01/2023
	ROVIDER OR SUPPLIER DF ANDERSON		1821 I	ADDRESS, CITY, STATE, ZIP COD LINDBERG RD RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir Portable Fire Extir Portable fire exting installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observatio failed to inspect 3 or each month. NFPA Extinguishers, Secti extinguishers shall by means of an elec minimum of 30-day periodic inspection of extinguishers shall i following items: (1) Location in designation of the companion of t	aguishers aguishers are selected, d, and maintained in IFPA 10, Standard for aguishers. I2, NFPA 10 on and interview, the facility of 15 portable fire extinguishers 10, Standard for Portable Fire on 7.2.1.2 states fire oe inspected either manually or tronic device / system at a intervals. Section 7.2.2 states or electronic monitoring of fire nelude a check of at least the gnated place o access or visibility reading or indicator in the osition ned by weighing or hefting for extinguishers, axtinguishers, and pump tanks as, wheels, carriage, hose, and	K 0355	program will be put into place. The Maintenance Director or designee will utilize the facility. TELS system to sprinkler head and will report monthly to the QAPI Committee any findings. The Maintenance Director will report any sprinkler heads with paint on them to the ED who warrange for prompt repair or replacement. 1: What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice? All fire extinguishers were inspected, and inspection tags updated. 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take All residents had the potential be affected, however no reside were affected. 3: What measures will be put into place or what systemic.	e? ds hyill 09/08/2023 n s ng y vill n. to ents

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/01/2023
	PROVIDER OR SUPPLIEI OF ANDERSON	3	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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) EE COMPLETION DATE
	inspections shall ke extinguishers inspered require corrective a where at least montoconducted, the date performed and the performing the inspection 7.2.4.4 requare conducted, reconshall be kept on a treatinguisher, on an maintained on file, Section 7.2.4.5 required demonstrate that at inspections have be practice could affect. Findings include: Based on observative with the Director of between 1:05 p.m. inspection tag on the smoke shack (redocumentation of a 2023. The monthly extinguisher at the documentation of a and July 2023 and Activities office lact monthly inspection interview at the time confirmed the fire of missing the stated in these findings were required.	ressure indicators. res personnel making manual per records of all fire cted, including those found to action. Section 7.2.4.3 requires they manual inspections are the manual inspection was initials of the person pection shall be recorded. The person rection checklist or by an electronic method. The person records shall be kept to resident the last 12 monthly ren performed. This deficient ret 20 residents in the facility of Facilities (DF) on 08/01/23 and 2:25 p.m., the monthly refer extinguisher located in resident smoking area lacked monthly inspection for July inspection tag on the fire employee smoking area lacked monthly inspection for June the fire extinguisher in the recked documentation of a resident smoking area. Based on the of observation, the DF extinguishers mentioned were monthly visual inspections.		changes will be made to ensure that the deficient practice does not recur? The Maintenance Director of designee will inspect and document the inspection of extinguishers Monthly, ongothers will be monitored to ensure deficient practice will not rive., what quality assurance program will be put into plus the Maintenance Director of designee will utilize the facily TELS system to monitor fire extinguisher inspections and report monthly to the QAPI Committee any findings.	all fire ping. en e the ecur e ace? 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 01	(X3) DATE SURVEY COMPLETED 08/01/2023
	PROVIDER 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE COMPLETION COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enciexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary a flammable or complying to a complying the doors complying the doors complying the door closed when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri	rials have positive latching atches are prohibited by these 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 then 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,			

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ſ	A. BU	ILDING	nstruction <u>01</u>	(X3) DATE S COMPL 08/01/	ETED
		1821 LII	NDBERG RD		
E PRECEDED BY FULL IFYING INFORMATION	Ī	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
of doors such as natics closing rview, the facility door was provided ing the door closed, latching and would this deficient is in the area of the Director of o.m., the corridor in would not close sed on interview at F stated the corridor door frame because in the door latch. In the Administrator	K 03		be accomplished for those residents found to have been affected by the deficient practice? The tape was removed from the wound supply door to ensure proper closing and latching. 2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be taken all residents had the potential be affected, no other residents were affected. All doors have been inspected to ensure they free of any impediment to closs. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will complete a monta audit to ensure that all doors a free of any impediment to closs ongoing. 4: How the corrective action will be monitored to ensure the deficient practice will not recomplete.	ng y y iiii n. are ing. hly re ing,	09/08/2023
n en ro, I mad o esti	CATION NUMBER	A. BU B. WII TOF DEFICIENCIE BE PRECEDED BY FULL FIFYING INFORMATION B. 418, 460, 482, of doors such as matics closing erview, the facility r door was provided bing the door closed, , latching and would This deficient ats in the area of the e Director of p.m., the corridor m would not close ased on interview at F stated the corridor door frame because g in the door latch. time of observation. th the Administrator	A. BUILDING B. WING STREET A 1821 LII ANDER T OF DEFICIENCIE BE PRECEDED BY FULL FIFYING INFORMATION B. 418, 460, 482, of doors such as matics closing erview, the facility r door was provided bing the door closed, latching and would This deficient ats in the area of the e Director of p.m., the corridor m would not close ased on interview at F stated the corridor door frame because g in the door latch. time of observation. th the Administrator	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012 TOF DEFICIENCIE BE PRECEDED BY FULL TIFYING INFORMATION 3, 418, 460, 482, of doors such as matics closing Priview, the facility of door was provided by the deficient practice? The tape was removed from the would apply door to ensure proper closing and latching. 2 Director of p.m., the corridor movel of the same deficient practice was ased on interview at F stated the corridor door frame because gin the door latch. The door latch latch and the door latch latch and the door latch. The door latch latch and the door latch latch and the door latch. The door latch latch and the door latch latch and the door latch latch and the door latch. The door latch latch and the potential latc	STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012 TOF DEFICIENCIE BE PRECEDED BY FULL TIETYING INFORMATION 3, 418, 460, 482, of doors such as matics closing erview, the facility of door was provided this deficient ats in the area of the Director of p.m., the corridor mould not close assed on interview at F-stated the corridor door frame because in the door latch, time of observation. By Director of p.m., the corridor mould not close assed on interview at F-stated the corridor door frame because in the Administrator ence. A BUILDING BROWNESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012 ID PREFIX TAG 1.* What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The tape was removed from the wound supply door to ensure proper closing and latching. 2.* How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had the potential to be affected, no other residents were affected. All doors have been inspected to ensure they are free of any impediment to closing. 3.* What measures will be put into place or what systemic changes will be made to ensure that all doors are free of any impediment to closing, ongoing. 4.* How the corrective action will be monitored to ensure the deficient practice will not recur

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			ON	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD	TIPLE CONSTRUCTION DING 01	(X3) DATE	E SURVEY LETED
11112 12111		155690	B. WING			1/2023
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP COI 821 LINDBERG RD INDERSON, IN 46012)	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		EFIX (EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE ROPRIATE	COMPLETION DATE
				program will be put into The Maintenance Director designee will utilize the for TELS system to monitor are free of any impediment close and latch properly, results will be reported in the QAPI Committee.	or or acility all doors ent and The	
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 2 of	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511	1: What corrective action be accomplished for the residents found to have	ose	09/08/2023
	requires utilities con 9.1.2 requires electromply with NFPA NFPA 70, NEC 2010 Circuit-Interrupter states, ground-fault personnel shall be personne	lectric shock. LSC 19.5.1.1 mply with Section 9.1. LSC ical wiring and equipment to 70, National Electrical Code. 1 Edition at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault hall be installed in a readily relling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault rotection for personnel.		affected by the deficient practice? The identified receptacle been replaced with proper receptacles. 2: How other residents the potential to be affect the same deficient practive action will be All residents have the potential be affected, however nowere affected. All recept have been inspected to eather the proper type.	s have er GFCI having ted by tice will e taken. tential to residents tacles ensure	

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(1) Bathrooms

(2) Kitchens

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proximity to a water source.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155690	JILDING	onstruction 01	(X3) DATE COMPL 08/01/	ETED
	PROVIDER OR SUPPLIEF		1821 LI	ADDRESS, CITY, STATE, ZIP COD INDBERG RD RSON, IN 46012		
ENVIVE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessib branch circuit dedic deicing, or pipeline shall be permitted to with 426.28 or 427. Exception No. 2 to only, where the con supervision ensure are involved, an ass conductor program shall be permitted fo outlets used to supp create a greater haz having a design tha protection. (5) Sinks - where re 1.8 m (6 ft.) of the con Exception No. 1 to receptacles used to removal of power value hazard shall be perm GFCI protection. Exception No. 2 to patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet local (7) Locker rooms was facilities (8) Garages, service (8) Garages	(4): In industrial establishments ditions of maintenance and that only qualified personnel sured equipment grounding as specified in 590.6(B)(2) for only those receptacle oly equipment that would ard if power is interrupted or t is not compatible with GFCI exceptacles are installed within outside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without (5): For receptacles located in s of general care or critical care facilities other than those protection shall not be required.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) 3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur? An audit was conducted of all receptacles to ensure all receptacles within three feet of water source were equipped the proper GFCI receptacle. Maintenance Director or designate will oversee the repair or replacement of all receptacles ensure the right type is in plant. 4: How the corrective action will be monitored to ensure deficient practice will not reile., what quality assurance program will be put into plant. The Maintenance Director or designee will utilize the facility TELS system to monitor receptacles for correct type a will report monthly to the QAR Committee any findings.	of a with The gnee s to ce. the cur ce?	(X5) COMPLETION DATE
	used.	ghting equipment are to be				

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NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of

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	PROVIDER OR SUPPLIER OF ANDERSON			1821 LII	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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	interrupter (GFCI) preduce the contact relectrical insulation. This deficient pract visitors while at the restroom and staff at the sink.	nave ground-fault circuit protection. Note: Moisture can esistance of the body, and is more subject to failure. ice could affect staff and hand washing sink in the and residents in therapy using					
	and 12:45 p.m. duri DF, there was one of feet of the hand was restroom and one el of a sink in Therapy were not provided v	on on 08/01/23 at 12:35 p.m. ng a tour of the facility with the electric receptacle within three shing sink at the 200 Hall ectrical receptacle within 3 feet of the two electric receptacles with ground fault circuit. This was confirmed when tester at the time of					
	This finding was re and DF at the exit c 3.1-19(b)	viewed with the Administrator onference.					
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulati Smoking Regulati Smoking regulation shall include not be provisions: (1) Smoking shall ward, or comparte liquids, combustib used or stored and location, and such signs that read NO						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLETED
		155690	B. W	ING	<u> </u>	08/01/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	8				
END /D /E	OF ANDEDOON				NDBERG RD	
ENVIVE	OF ANDERSON			ANDER	RSON, IN 46012	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	smoking.					
	_	occupancies where				
	smoking is prohibited and signs are					
		d at all major entrances,				
		vith language that prohibits				
	smoking shall not					
	_	atients classified as not				
	responsible shall					
		ent of 18.7.4(3) shall not				
		atient is under direct				
	supervision.	ation is ander ancer				
		ncombustible material and				
		be provided in all areas				
	where smoking is	-				
		ers with self-closing cover				
		ashtrays can be emptied				
		rashinays can be emplied railable to all areas where				
	smoking is permit					
	18.7.4, 19.7.4	leu.				
		ation and interview; the facility	K 0	741	1: What corrective action(s)	will 09/08/2023
		f 3 smoking areas were	K U	/ /1 1	be accomplished for those	WIII 09/08/2023
		osing cigarette butts in a metal			residents found to have been	_
		container with self-closing			affected by the deficient	•
		deficient practice could affect			practice?	
		g areas and 10 residents in the			All staff were inserviced on the	_
	smoking exit areas.				smoking policy on 8.2.2023.	
	Silloking Calt areas.				Smoking policy on 0.2.2023.	
	Findings include:				2: How other residents havi	na
	I manigo morado.				the potential to be affected by	-
	Based on observation	on during a tour of the facility			the same deficient practice v	-
		f Facilities (DF) on 08/01/23 at			be identified and what	·*···
		10 p.m., in the two back			corrective action will be take	an l
	*	areas there were over 30			All residents had the potential	
		osed on the ground in and			be affected, however no resid	
		g area. Based on interview at			were affected.	CIIIO
					were arrected.	
		tions, the DF agreed there were			2. What maggings will be more	
	cigarette butts on the				3: What measures will be pu	۱
	aforementioned foc	ations.			into place or what systemic	
	2 D1	41-0-04-04-04-0-0-04-0-04-0			changes will be made to	
	2. Based on observa	ation and interview; the facility			ensure that the deficient	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155690	B. W.	ING		08/01/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				NDBERG RD		
ENI\/I\/E /	OF ANDERSON				SON, IN 46012		
CINVIVE	OF ANDERSON			ANDEN	30N, IN 40012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		3 smoking areas were			practice does not recur?		
		osing cigarette butts in the			All staff were inserviced on the	;	
	-	oncombustible containers with			smoking policy which includes	the	
	self-closing cover de	evices. This deficient practice			proper disposal of cigarette bu	tts.	
	could affect staff in	the smoking area and 5					
	residents in the smoking exit area. Findings include: Based on observation during a tour of the facility				4: How the corrective action		
					will be monitored to ensure t	he	
					deficient practice will not rec	ur	
		i.e., what quality assurance					
	Based on observation	on during a tour of the facility			program will be put into plac	e?	
	with DF on 08/01/23	3 at 01:40 p.m., In the staff			The Maintenance Director or		
	smoking area outsid	le the 500 hall exit there were			designee will make daily round	ds of	
	over 20 cigarette bu	tts disposed in a trash can			all smoking areas and look for	and	
	containing combust	ible materials. Based on			properly dispose of any cigare	tte	
	interview at the time	e of observation, the DF			butts. The maintenance Direct	or	
	agreed the cigarette	butts were in a trash can			will present his findings to the	IDT	
	along with trash.				during the morning meeting.		
					Positive findings will result in		
	These findings was	reviewed with the			additional staff inservicing.		
	Administrator and I	OF during the exit conference.					
	3.1-19(b)						
K 0754	NFPA 101						
SS=E	Soiled Linen and 1						
Bldg. 01	Soiled Linen and T						
		sh collection receptacles					
		2 gallons in capacity. The					
	average density of	f container capacity in a					
	room or space sha						
		t. A total container					
		ons shall not be exceeded					
	•	are feet area. Mobile soiled					
		ction receptacles with					
		than 32 gallons shall be					
		protected as a hazardous					
	area when not atte						
		olely for recycling are					
	permitted to be ex	cluded from the above					
	requirements whe	re each container is less					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. W	JILDING DIC	01	COMPLETED	
		155690	B. W.			08/01/2023	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD INDBERG RD		
ENVIVE	OF ANDERSON				RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETI	ION
TAG		R LSC IDENTIFYING INFORMATION 6 gallons unless attended,		IAG	Birtoniker,	DATE	
	•	combustibles are labeled					
		ting FM Approval Standard					
	6921 or equivalent.						
	18.7.5.7, 19.7.5.7						
		on and interview, the facility	K 0	754	1: What corrective action(s)	will 09/08/20	023
		h receptacles in 1 of 1			be accomplished for those		
		ntained in accordance with			residents found to have been	1	
	and up to 10 resider	ient practice could affect staff			affected by the deficient practice?		
	and up to 10 resider	its in the 100-han.			The soiled linen/trash cart has		
	Findings include:				been stored in a proper location		
	-				, ,		
		ons during a tour of the facility			2: How other residents havi	ng	
		Facilities (DF) on 08/01/23 at			the potential to be affected by		
	_	as a soiled linen/trash barrel			the same deficient practice v	/ill	
	-	er 32 gallon total capacity in			be identified and what		
		100-hall that was not attended. at the time of observation, the			corrective action will be take		
		d not know the capacity of the			All residents had the potential be affected, however no resid		
		art but agreed it was not			were affected.	51113	
	attended.	5					
					3: What measures will be pu	:	
	_	viewed with the Administrator			into place or what systemic		
	and the DF during t	he exit conference.			changes will be made to		
	2.1.10(1)				ensure that the deficient		
	3.1-19(b)				practice does not recur?	the	
					All staff were inserviced about proper usage and storage of t		
					soiled linen/trash cart.		
					4: How the corrective action		
					will be monitored to ensure		
					deficient practice will not red	ur	
					i.e., what quality assurance		
					program will be put into place	e ⁻ ?	
					The Executive Director or designee will audit weekly for	the	
					proper storage of soiled linen/		
					cart for 6 months. The results		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING B. WING	01	COMPLETED 08/01/2023			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R LSC IDENTIFYING INFORMATION TAG CONTROL OF THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
				the audit will be presented mo to QAPI Committee, once substantial compliance has be achieved the QAPI Committee may discontinue the audit.	een		
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, respectively. Additional testing in defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, alless than or equal the LIM test switch activates both visual LIM circuits with all manual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the expectation requires containing date, results. 6.3.4 (NFPA 99) Based on observation interview, the facility grade electrical receivors were tested as	a - Maintenance and beptacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. Is performed at intervals rented performance data. Is sted as hospital-grade at releasted at intervals not this. Line isolation monitors are tested at intervals of to 1 month by actuating reper 6.3.2.6.3.6, which real and audible alarm. For automated self-testing, this formed at intervals less remonths. LIM circuits are replacement or repair or relectric distribution system. reained of required tests and remodifications, remodifications	K 0914	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice?			
	6.3.4.1.3 states rece	ptacles not listed as		Annual receptacle testing will	be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/01/2023		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON				STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
	SUMMARY: (EACH DEFICIEN REGULATORY OR hospital-grade, at particular locations where deed anesthesia is adminimitervals not exceed Section 6.3.3.2, Rec Rooms requires the receptacle shall be a The continuity of the electrical receptacle polarity of the hot a each electrical receptacle receptacles) shall be ounces). This deficit residents. Findings include: Based on observation with the Director of between 12:20 p.m. resident sleeping ro non-hospital-grade on records review a was available to shor receptacles in reside but it lacked a date interview at the tim records review, the receptacles in the re not hospital-grade a last time the annual because there is no provided.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION attient bed locations and in p sedation or general istered, shall be tested at ling 12 months. Additionally, reptacle Testing in Patient Care physical integrity of each confirmed by visual inspection. regrounding circuit in each reshall be verified. Correct and neutral connections in rotacle shall be confirmed; and regrounding blade of each reflexcept locking-type renot less than 115 grams (4 rent practice could affect all rons during a tour of the facility reacilities (DF) on 08/01/23 and 3:35 p.m., the facility's resons contained four to eight relectrical receptacles. Based to 11:30 a.m., documentation row the last time the electrical rent sleeping rooms were tested for inspector name. Based on renot of the observation and renot of the observation and renot sleeping rooms were rend stated it is unknown the restring was completed date on the documentation				ing by will en. I to dents acle the e	(X5) COMPLETION DATE	
	3 1-19(b)							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING 01 COMPLETED B. WING 08/01/2023					
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vin non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3(Based on observation failed to ensure 1 of a substitute for fixed equipment with a hi NFPA-70/2011, 400 permitted in 400.7 fi not be used for (1) a This deficient praction	d electrical equipment es that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), n care resident rooms that E. Power strips for PCREE oulties UL 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed e. Extension cords used moved immediately upon curpose for which it was sten the conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 on and interview, the facility T power strip was not used as d wiring to provide power	K 0920	1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? The plug in was relocated to a the refrigerator to be directly plugged into the wall receptace. The power strip was removed. 2: How other residents having the potential to be affected by the complete the compl	n allow cle.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155690		A. BUILDING 01 B. WING		COMPLETED 08/01/2023					
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE				
K 0923	with the Director of 02:30 p.m., a refrige equipment) was plu by a power strip in toffice. Based on into observation, the DF was supplying power equipment. This power equipment in the next hole drilled through strip cord was ran the	viewed with the Administrator		the same deficient practice be identified and what corrective action will be take All residents had the potential be affected, however no resilower affected. An audit was conducted to ensure that any power strip in use was the contype and used in a proper make the proper will be made to ensure that the deficient practice does not recur? All staff were inserviced regative proper usage of properly power strips, and that high control of the proper usage of properly power strips, and that high control of the viral plugged into	en. al to dents vorrect anner. ut rated urrent ust vall n the ecur ce? nthly wer				
SS=F		Cylinder and Container							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	li i			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			01			
	155690		B. WI	NG		08/01/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
				1821 LINDBERG RD				
ENVIVE	OF ANDERSON			ANDER	RSON, IN 46012			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CO			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
Bldg. 01	Storag							
		Cylinder and Container						
	Storage							
		qual to 3,000 cubic feet						
	-	are designed, constructed,						
		accordance with 5.1.3.3.2						
	and 5.1.3.3.3.	1: 6 (
	>300 but <3,000 c							
	Storage locations							
		n an enclosed interior						
	•	mited- combustible						
		door (or gates outdoors)						
		ed. Oxidizing gases are not ables, and are separated						
		by 20 feet (5 feet if						
		closed in a cabinet of						
		onstruction having a						
		re protection rating.						
	Less than or equa							
		compartment, individual						
	-	e for immediate use in						
	_ ·							
	patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not							
	required to be stored in an enclosure.							
	Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is							
		ate of a cylinder storage						
	_	ign includes the wording as						
	· ·	TION: OXIDIZING GAS(ES)						
	STORED WITHIN NO SMOKING."							
	Storage is planned	d so cylinders are used in						
		y are received from the						
	supplier. Empty cylinders are segregated							
	from full cylinders. When facility employs							
	-	gral pressure gauge, a						
		e considered empty is						
	established. Emp	ty cylinders are marked to						
		Cylinders stored in the open						
	are protected from weather.							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
155690		B. WING 08/01/2023			/2023		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen containers was secured against unauthorized access. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect any resident, staff or visitor in the vicinity of 100 Hall. Findings include: Based on observation on 08/01/23 during the tour of the facility with the Director of Facilities (DF) at 09:15 a.m., an oxygen tank used for transfilling portable oxygen cannisters was located in the 100 Hall corridor. Based on interview at the time of		K 0923		1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The oxygen container was being exchanged and was removed after replacing it with a new cylinder. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents had the potential to be affected, however no residents were affected. 3: What measures will be put		
		acknowledged the oxygen the corridor, unsecured but			into place or what systemic changes will be made to		
		t was there. At the final			ensure that the deficient		
	inspection of the da	y it was observed that the			practice does not recur?		
		longer in the 100 Hall			All staff were inserviced regard	ding	
	corridor.				the proper securing and storag	ge of	
	771 ' C' 1'	the state of the s			oxygen.		
	_	viewed with the Administrator			A. Hamidha aanna athaa aa d		
	DF at the exit confe	erence.			4: How the corrective action will be monitored to ensure t	ho	
	3.1-19/b)				deficient practice will not rec		
	3.1-19(b)				i.e., what quality assurance program will be put into place. The Maintenance Director or designee will audit the storage oxygen containers weekly for months, and report to the QAF Committee. Once substantial compliance has been achieve	e? e of 6 Pl	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED		
	155690		B. WING			08/01/2023		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 1821 LINDBERG RD ANDERSON, IN 46012					
(X4) ID	SUMMARY S	TATEMENT 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		TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG CK050-KL		DEFICIENCY)		DATE	
					the QAPI Committee may rem the audit.	ove		

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