STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/29/24 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Emergency Preparedness survey, Envive of Berne was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 43. Quality Review completed on 11/01/24	E 0000		
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: 10/29/24 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Life Safety Code survey, Envive of Berne was found not in compliance with Requirements	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Johns	HFA	11/15/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 80 and had a census of 43 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/01/24			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 6 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 7 residents that would use the therapy gym exit. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 at 11:55 a.m., the exit discharge from the therapy gym led to a 15ft wide asphalt walkway to the common way. The middle of the walkway to the common way was blocked by a parked car. Based on interview at the time of observation, the	K 0271	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -No residents were reported to be impacted, as the emergency exit was not required during the time the vehicle was parked for unloading items. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; -All exits examined and noted to be free of obstructions.	10/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director agreed the walkway was obstructed by a parked car. The finding was reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; -No parking signs posted at exit-drive/walkway. -Weekly inspections to be conducted of all entrance/exit pathways are free of obstruction weekly x6 months. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of 1 rooms greater than 50 square feet and being used for storage of large amounts of combustibles and 2 of 2 rooms with fuel fired equipment were protected as a hazardous area. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 at 11:40 a.m., the following rooms were not protected as hazardous areas: a.) The north supply room contained over 25 boxes of combustible supplies, was greater than 50 square feet, therefore making the room a hazardous area. The room was not protected as a	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - No residents were noted to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All rooms inspected to ensure all potentially hazardous and storage areas have the appropriate self-closure. What measures will be put into place and what systemic changes	11/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hazardous area because the corridor door to the room was not self-closing or automatic closing. b.) The north mechanical room contained a fuel fired water heater and a furnace, therefore making the room a hazardous area. The room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. c.) The laundry room contained fuel fired dryers, therefore making the room a hazardous area. The room was not protected as a hazardous area because the laundry room corridor door on the main hall was not self-closing or automatic closing and the laundry room door to the service hall did not latch into the frame when tested. Based on an interview at the time of observations, the Maintenance Director agreed all three aforementioned rooms were hazardous areas due to combustible storage or fuel fired equipment and stated the doors were not self-closing or did not latch into the frame. The findings were reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)		will be made to ensure that the deficient practice does not recur; - Inspection of storage areas to be conducted weekly x 6 months to ensure automatic self-closures are present. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observations, records review, and interview, the facility failed to ensure 4 of 4 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall,	K 0372	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - No residents were noted to be affected by the alleged deficient practice. How other residents having the potential to be affected by the	11/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice affects all residents in the facility. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 between 1:20 a.m. and 1:40 p.m., the following smoke walls with unsealed penetrations and/or caulk with an unknown ASTM listing were noted: a) In the 100-smoke wall there was an unsealed one-inch hole around a pipe. b) In the 400-smoke wall there was an unsealed one-inch hole around a wire and there was grey caulk around a pipe with an unknown ASTM listing. c) In the 300-smoke wall there was an unsealed 1/2-inch hole around a wire and there was joint compound around a pipe with an unknown ASTM listing. d) In the Envive smoke wall there was grey caulk around a pipe with an unknown ASTM listing. Based on records review at 1:45 p.m. there was no		same deficient practice will be identified and what corrective action(s) will be taken; -Inspection completed on all smoke barrier walls all unsealed penetrations sealed with appropriate rated fire caulk. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; -Education with post-test evaluation completed by maintenance personnel regarding sealing any penetration in smoke barriers. -Inspection to be conducted upon any renovations involving smoke barrier wall penetration weekly for 6 months to ensure appropriate sealed penetrations with fire rated sealant. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of the ASTM listing for the grey caulk and joint compound for review. Based on interviews at the time of observation, the Maintenance Director acknowledged each unsealed penetration and stated the ASTM listing for the grey caulk and joint compound could not be determined. The findings were reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 2 of 2 receptacles within 6 feet from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink.	K 0511	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - No residents were noted to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All sink/moisture areas inspected to identify electrical outlets within 6 feet. All other locations noted to have the correct GFCI protection. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; -Education with post-test provided to Maintenance personnel	11/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 7 residents in the therapy gym. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 at 12:00 p.m., in the therapy gym there were two electrical receptacles within 6 feet of a sink. When the receptacles were tested with a GFCI tester, power to the receptacles was not disconnected. Based on an interview at the time of observation, the Regional VP and the Maintenance Director agreed there were two receptacles with in 6 feet of a sink, and stated the sink was new and the contractors failed to install GFCI receptacles. The finding was reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)		to ensure any future renovation(s) involving electrical or "wet" areas have the required GFCI protection upon completion of project. -Inspection to be conducted upon any renovations involving electrical or wet areas weekly for 6 months to ensure appropriate GFCI protection if warranted. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas were provided with a metal or noncombustible	K 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect 15 residents using the east exit. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 at 12:21 p.m., outside the east exit there was a smoker's pole with a cover for the metal bucket that did not fit the bucket and fell off by touching the cover. Based on an interview at the time of observations, the Maintenance Director agreed the smoker's pole lid was not secured to the bucket. The finding was reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)		deficient practice; -No residents were noted to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; -Ash tray removed from area and disposed of. -Designated smoking areas inspected to ensure metal/noncombustible containers have self-closing cover in use. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; -Designated smoking areas to be inspected weekly x6 months to ensure ashtrays being utilized are constructed of metal material with self -closing lids. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels were in proper operating	K 0916	What corrective action(s) will be accomplished for those residents found to have been affected by the	11/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director, the Regional VP, and Administrator on 10/29/24 at 11:45 a.m., the generator's annunciator panel at the main nurse's station was not working when tested. This condition would not alert staff if there was a generator malfunction. Based on an interview at the time of observation, the Maintenance Director stated there was an electrical short to the annunciator panel, the facility's generator contractor is aware of the situation, but the annunciator panel cannot be repaired until the new parts arrive. There was no timeframe for the repairs. The finding was reviewed with the Regional VP, the Administrator, and the Maintenance Director during the exit conference. 3.1-19(b)		deficient practice; -No residents were noted to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; -All residents had the potential to be affected by the alleged deficient practice. -Contractor contacted for servicing/repair annunciator panel. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; -The annunciator panel will be inspected to ensure proper functioning weekly for the next 6 months. All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	