STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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: 000437 Provider Number: 155520 AIM Number: 100273770 At this Emergency Preparedness survey, Envive of River City was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 71 certified beds. At the time of the survey, the census was 31. Quality Review completed on 10/31/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety visit of October 29, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was completely reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include:	E 0004	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial	11/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Levi Back	VP of Clinical Services	11/20/2024

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
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	Based on review of the Emergency Preparedness Plan on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, the facility did provide an emergency preparedness manual with a review date of 09/26/24, however, there was no name(s) provided to show who did the review, and in the comments section it said no updates were required. Furthermore, the name of the facility changed February 1, 2024, to Envive of River City, however, the former name of the facility, Braun's Nursing Home, was named on the cover of the manual and mentioned throughout the entire emergency preparedness manual with no mention of Envive of River City. Based on interview at the time of review, the Administrator confirmed the name of the person or persons that performed the review on 09/26/24 was not included in the manual, and further confirmed the current name of the facility is not mentioned in the emergency preparedness manual. The Administrator also said she has only been the Administrator at the facility for less than a month and was not sure who performed the review. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference.		compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual visit of October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Plans Policies and Procedures were reviewed and updated. A new cover sheet with signatures of reviewers was added. 2.) How other residents have 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 this alleged deficient practice. The Emergency Plans Policies and Procedures were reviewed and updated. A new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			cover sheet with signatures of reviewers was added. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur again? The Director of Maintenance was educated by the Executive Director on E004-Emergency Plan review and update. An annual review of the Emergency Plan was added to the task section of the TELS building system. This task will auto populate annually, asking for a review and required documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends, and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Plan on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, the facility did provide an emergency preparedness manual, which included the plan for policies and procedures, with a review date of 09/26/24, however, there was no name(s) provided to show who did the review, and in the comments section it said no updates were required. Furthermore, the name of the facility changed February 1, 2024, to Envive of River City, however, the former name of the facility, Braun's Nursing Home, was named on the cover of the manual and mentioned throughout the entire emergency preparedness manual with no mention of Envive of River City. Based on interview at the time of review, the Administrator confirmed the name of the person or persons that performed the review on 09/26/24 was not included in the manual, and further confirmed the current name of the facility is not mentioned in the emergency preparedness manual. The Administrator also said she has only been the Administrator at the facility for less than a month and was not sure who performed the review.	E 0013	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual visit on October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Plans Policies and Procedures were reviewed and updated. A new cover sheet with signatures of reviewers was added.	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference.		2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had potential to be affected by this alleged deficient practice. The Emergency Plan was reviewed and updated. A new cover sheet with signatures of reviewers was added. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again? The Director of Maintenance was educated by the Executive Director on E013 - Emergency Plan review and update. An annual review of the Emergency Plan was added to the Task section of the TELS building system. This task will auto populate annually, asking for a review and required documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not reur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			led by the the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, the facility did provide an emergency preparedness manual that did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws with a review date of 09/26/24, however, there was no name(s) provided to show who did the review, and in the comments section it said no updates were required. Furthermore, the name of the facility	E 0029	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	changed February 1, 2024, to Envive of River City, however, the former name of the facility, Braun's Nursing Home, was named on the cover of the manual and mentioned throughout the entire emergency preparedness manual with no mention of Envive of River City. Based on interview at the time of review, the Administrator confirmed the name of the person or persons that performed the review on 09/26/24 was not included in the manual, and further confirmed the current name of the facility is not mentioned in the emergency preparedness manual. The Administrator also said she has only been the Administrator at the facility for less than a month and was not sure who performed the review. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference.		cited during the Life Safety Survey visit conducted October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Plans Communication Plans were reviewed and updated. A new cover sheet with signatures of reviewers was added. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had potential to be affected by this alleged deficient practice. The Emergency Plans Communication Plan was reviewed and updated. A new cover sheet with signatures of reviewers was added. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur again? The Director of Maintenance was educated by the Executive Director on E029 - Emergency Plan review and update. An annual review of the Emergency Plan was added to the Task section of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			TELS building system. This task will auto populate annually, asking for a review and requires documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance	E 0036	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	Director, and Maintenance Director from a sister facility present, the facility did provide an emergency preparedness manual that included a training and testing program with a review date of 09/26/24, however, there was no name(s) provided to show who did the review, and in the comments section it said no updates were required. Furthermore, the name of the facility changed February 1, 2024, to Envive of River City, however, the former name of the facility, Braun's Nursing Home, was named on the cover of the manual and mentioned throughout the entire emergency preparedness manual with no mention of Envive of River City. Based on interview at the time of review, the Administrator confirmed the name of the person or persons that performed the review on 09/26/24 was not included in the manual, and further confirmed the current name of the facility is not mentioned in the emergency preparedness manual. The Administrator also said she has only been the Administrator at the facility for less than a month and was not sure who performed the review. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference.		constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Survey visit conducted on October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Plans Training and Testing were reviewed and updated. A new cover sheet with signatures of reviewers was added. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Training and Testing was reviewed and updated. A new cover sheet with signatures of reviewers was added. 3.) What measures will be put into place or what systemic changes will be made to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			deficient practices do not occur? The Director of Maintenance was educated by the Executive Director on E036-Emergency Plan review and update. An annual review of the Emergency Plan was added to the Task section of the TELS building system. This task will auto populate annually, asking for a review and requiring documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility	E 0039	Please accept this Plan of	11/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: 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 scenario, 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 in the facility. Findings include: Based on review of the Emergency Preparedness		Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual visit conducted on October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The campus has had an unannounced elopement drill which staff implemented the Emergency Plan. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	Plan on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, the facility was able to provide documentation of an actual event (near by fire that created a power outage) that happened on 09/04/24, however, there was no documentation of a second exercise conducted by the facility during the past 12 month period. This was confirmed by the Administrator at the time of record review. This finding was reviewed with the Administrator, and both Maintenance Director's during the exit conference.		action will be taken? All residents had potential to be affected by this alleged deficient practice. The campus has had an unannounced elopement drill which staff implemented the Emergency Plan. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on E039-Emergncy testing requirements. An annual emergency/disaster drill were added to the Task section of the TELS building system. This task will auto populate annually and require documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			5.) Date of Completion: November 15, 2024	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, there was no	E 0041	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Annual visit conducted on October 29, 2024. 1.) What corrective action(s) will be accomplished for those	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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 on the generator monthly load test log for percentage of load for the past 12 month period. Based on interview at the time of record review, the facility Maintenance Director confirmed there was no percentage of load on the monthly generator log for the past 12 month period. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference.		residents found to have been affected by the deficient practice? The Maintenance Director now documents load bank monthly. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents had potential to be affected by this alleged deficient practice. The Maintenance Director now documents load bank monthly. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on E041- Hospital CAH and LTC Emergency Power. Two annual tasks have been added to the TELS building system. These tasks will auto populate monthly and requires documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING -- B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/29/24 Facility Number: 000437 Provider Number: 155520 AIM Number: 100273770 At this Life Safety Code survey, Envive of River City 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 with two separate basements was determined to be of Type V (000) construction and was fully sprinklered. The	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety visit of October 29, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and both basements, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 31 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached garage used for facility storage. Quality Review completed on 10/31/24		compliance.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 8 of 8 battery backup lights that were tested annually for 90 minutes during the past 12 months to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include:	K 0291	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegations of	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	Based on record review on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the facility Maintenance Director and Maintenance Director from a sister facility present, the facility did have a preventative maintenance (PM) report that the eight battery powered emergency lights throughout the facility were tested monthly for 30 seconds during the past 12 month period. However, there was no documentation available to show the eight battery powered emergency light was tested annually for 90 minutes during the past 12 month period. The most recent 90 minutes annual test was dated 03/21/23. Based on an interview at the time of record review, this was confirmed by the facility Maintenance Director. During a tour of the facility with both Maintenance Director's between 1:15 p.m. and 3:15 p.m., the facility was equipped with eight emergency battery powered light units located throughout the facility. This finding was not reviewed during the exit conference. 3.1-19(b)		noncompliance cited during the Life Safety Annual visit conducted on October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The campus has tested and documented the 90-minute test on the emergency lights. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had potential to be affected by this alleged deficient practice. The campus has tested and documented the 90-minute test on the emergency lights. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K291- Emergency Lighting. These tasks have been added to the TELS building system. These tasks will auto populate monthly for a 30 sec test and annually for a 90-minute test and requires documentation upload before task can be signed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all 43 resident sleeping rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors.	K 0300	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance (this date of compliance is to be determined in the future since we have ordered the item and waiting delivery).	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the facility Maintenance Director and Maintenance Director from a sister facility present, the battery operated smoke alarm maintenance documentation failed to indicate battery replacement during the past 12 month period or prior. Based on interview at the time of record review, the facility Maintenance Director said he was not sure if the batteries in the resident room smoke alarms had been replaced, but agreed it was not listed on the preventative maintenance documentation. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual visit October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Campus has ordered all new battery-operated smoke detectors to be replaced upon delivery immediately. 2.) How other residents have the potential by this alleged deficient practice will be identified and what corrective action will be taken? All residents had potential to be affected by this alleged deficient practice. The Campus has ordered and will replace all battery-operated smoke detectors immediately upon delivery. 3.) What measures will be put into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K300-Protection other. Smoke detectors need weekly testing along with annual battery change. The task have been added to the TELS building system for annual battery change. Weekly documentation of the testing will be kept by the maintenance director. This task will auto populate Annual Battery change and require documentation upload before task can be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recure i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: Weekly Battery testing - November 8, 2024 New	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			Battery-Operated Smoke Detectors - Upon arrival from vendor.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for the equivalent of 2 of 4 quarters for 1 of 1 sprinkler system. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the	K 0353	**K353 Sprinkler System - Mtn and Testing** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *(1) The Campus has contracted Koorsen Fire and security to inspect our systems on as required* *(2) Sprinkler gauge and control valve inspections are now done weekly. The documentation is kept on a clipboard next to the riser.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *The Campus has contracted Koorsen Fire and security to inspect our systems on as required*	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the facility Maintenance Director and Maintenance Director from a sister facility present, there were no quarterly sprinkler system inspection reports available between 01/05/24 and 09/04/24. Based on interview at the time of record review, the facility Maintenance Director confirmed the lack of quarterly sprinkler system inspection reports between 01/05/24 and 09/04/24. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and the normal water pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its		*Sprinkler gauge and control valve inspections are now done weekly. The documentation is kept on a clipboard next to the riser.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K353 Sprinkler System - Mtn and Testing**.** **(1)** Sprinkler systems are required to be tested timely. *This task has been added to the Tels building system for quarterly testing as required. This task will auto populate quarterly and require documentation upload before task can be signed off. (2) The Sprinkler gauge and control valve inspections should be done per CMS requirements. This task has been added to the Tels building system for weekly testing as required. This task will auto populate quarterly and require documentation upload before task can be signed off* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** This Tels task will be reviewed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection records on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the facility Maintenance Director and Maintenance Director from a sister facility present, the following was noted: a. There were no sprinkler gauge inspection records available to review prior to 09/30/24 for the past 12 month period. b. There was no control valve inspection documentation available to review for the past 12 month period. Based on interview at the time of record review, the facility Maintenance Director said he has been at the facility for only two months and was unable to find sprinkler system gauge and control valve inspection documentation prior to him being at the facility. Based on observations during a tour of the facility with both Maintenance Director's there were two sprinkler gauges and one main control valve on the wet sprinkler system riser. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *11/8/2024*	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors	K 0374	Please accept this Plan of Correction as the provider's	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	would close and latch to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 10/29/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the facility Maintenance Director and Maintenance Director from a sister facility, the set of 90 minute rated smoke barrier/fire barrier doors between the 100 Unit and the north Nurse's Station area did not close completely and latch when tested several times. These doors were equipped with latching hardware. There remained a one half inch gap between the doors when closed to their fullest. This was acknowledged by both Maintenance Director's at the time of observation. The facility Maintenance Director further said he has worked on this set of smoke/fire doors several times but has been unable to fix them permanently. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		credible allegation of compliance as of November 8, 2024. the provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual Survey conducted October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director has repaired the doors in question. They now shut and latch on their own power. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			At least 20 residents had potential to be affected by this alleged deficient practice. The Campus has repaired the doors in question. They now shut and latch on their own power. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K374 Subdivision of Building Spaces - Smoke Barrier Doors. A door latch task has been added to the TELS building system for monthly testing as required. This task will auto populate monthly and is required to be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI Committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			5.) Date of Completion: November 8, 2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 3 of over 20 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (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 Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2)	K 0511	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual Survey conducted October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director has replaced the GFCI's in question.	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (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 ground-fault circuit interrupter (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 mostly staff. Findings include: Based on observations on 10/29/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with both Maintenance Director's, the following was noted: a. There were two electric receptacles within five feet of the sink in the basement employee breakroom not provided with GFCI protection.		2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All staff had potential to be affected by this alleged deficient practice. The Maintenance Director has replaced the GFCI's in question. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K511 Utilities - Gas and Electric. GFCI check task has been added to the TELS building system for monthly testing. This task will auto populate monthly and is required to be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI Committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	When tested with a GFCI testing device the receptacles did not break the electrical circuit. b. The electric receptacle within two feet to the sink in the 200 Hall Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. c. The electric receptacle within two feet to the sink in the 200 Hall Soiled Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of each observation, both Maintenance Director's agreed the receptacles in question were not properly GFCI protected. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all	K 0918	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	residents, staff and visitors. Findings include: Based on record review on 10/29/24 between 9:30 a.m. and 1:15 p.m. with the Administrator, facility Maintenance Director, and Maintenance Director from a sister facility present, there was no documentation on the generator monthly load test log for percentage of load for the past 12 month period. Based on interview at the time of record review, the facility Maintenance Director confirmed there was no percentage of load on the monthly generator log for the past 12 month period. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual Survey conducted October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director is now documenting the load monthly. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had potential to be affected by this alleged deficient practice. Load is now documented monthly. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			Director on K918 Electrical Systems - Essential Electric System Mtn and Testing. Load documentation task has been added to the TELS building system for monthly load testing. This task will auto populate monthly and is required to be signed off. Paper documentation will also be kept. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI Committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8, 2024	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in one staff only room. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article	K 0920	Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 8, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
	400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect Physical Therapy staff only. Findings include: Based on observations on 10/29/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the facility Maintenance Director and Maintenance Director from a sister facility, the Physical Therapy staff office had a refrigerator and coffee machine plugged into a power strip. This was acknowledged by both Maintenance Director's at the time of observation. This finding was reviewed with the Administrator and both Maintenance Director's during the exit conference. 3.1-19(b)		the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Annual Survey conducted October 29, 2024. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director has removed all unapproved items from surge protectors and done a full building audit. 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Physical Therapy Staff had potential to be affected by this alleged deficient practice. The Maintenance Director has removed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 01 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

(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
			all unapproved items from surge protectors and completed a full building audit. 3.) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? The Director of Maintenance was educated by the Executive Director on K920-Electrical Equipment - Power Cords. High amperage equipment needs plugged in directly to the wall. UL rated is required in resident care areas. This task was added to the TELS building system and will auto populate monthly and is required to be signed off. 4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be reviewed by the Safety/QAPI Committee, led by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 5.) Date of Completion: November 8,2024	