| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|---|----------------------------------|----------------------|--|--|--|--|
| | | | A. BUILDING | or, or the critical control of | · ' | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | COMPLETED | | |
| | | 155520 | B. WING | | 10/29/2024 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| 5. 0. 0. 6 | 05 DI (5D 017) (| | | ORTH FIRST AVE | | | |
| ENVIVE (| OF RIVER CITY | | EVANSVILLE, IN 47710 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | | |
| E 0000 | | | | | | | |
| | | | | | | | |
| Bldg | | _ | | | | | |
| | | paredness Survey was | E 0000 | Preparation and/or execution | | | |
| | - | diana Department of Health in | | this plan of correction does no | | | |
| | accordance with 42 | CFR 483.73. | | constitute admission or agree | | | |
| | G B: 10/20 |)/2.4 | | by the provider of the truth of | | | |
| | Survey Date: 10/29 | 9/24 | | facts alleged or conclusions s | et | | |
| | TELLINA NO. 1 O | 000427 | | forth in the Statement of | | | |
| | Facility Number: 0 | | | Deficiencies. The Plan of | | | |
| | Provider Number: | | | Correction is prepared and/or | | | |
| | AIM Number: 100273770 | | | executed solely because it is | | | |
| | At this Emergency Preparedness survey, Envive | | | required by the provisions of | an of | | |
| | | ound not in compliance with | | Federal and State law. The Pl | | | |
| | - | dness Requirements for | | Correction is submitted to res | • | | |
| | | caid Participating Providers | | to the allegation of noncompli | | | |
| | and Suppliers, 42 C | | | cited during the Life Safety vis October 29, 2024. | SIL OI | | |
| | and Suppliers, 42 C | TK 403.73 | | Please accept this Plan of | | | |
| | The facility has 71 | certified beds. At the time of | | Correction as the provider's | | | |
| | the survey, the cens | | | credible allegation of complian | 200 | | |
| | the survey, the cens | was 71. | | as of November 8, 2024. The | | | |
| | Onality Review cor | mpleted on 10/31/24 | | provider respectfully requests | desk | | |
| | Quality Teeview con | mpreced on 10/31/21 | | review with paper compliance | | | |
| | The requirement at | 42 CFR, Subpart 483.73 is NOT | | be considered in establishing | | | |
| | MET as evidenced | | | the provider is in substantial | that the transfer of the trans | | |
| | | | | compliance. | | | |
| | | | | | | | |
| | | | | | | | |
| E 0004 | 403.748(a), 416.5 | 4(a), 418.113(a), 441.1 | | | | | |
| SS=F | Develop EP Plan, | Review and Update | | | | | |
| Bldg | Annually | | | | | | |
| | | view and interview, the facility | E 0004 | Please accept this Plan of | 11/08/2024 | | |
| | _ | d maintain an emergency | | Correction as the provider's | | | |
| | | hat was completely reviewed | | credible allegation of complian | nce | | |
| | • | t annually in accordance with | | as of November 8, 2024. The | | | |
| | | This deficient practice could | | provider respectfully requests | | | |
| | affect all residents i | in the facility. | | review with paper compliance | | | |
| | To 1' ' ' 1 | | | be considered in establishing | that | | |
| | Findings include: | | | the provider is in substantial | | | |

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

TITLE

(X6) DATE

Brandon Levi Back VP of Clinical Services 11/20/2024

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

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PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | ì í | UILDING | NSTRUCTION | (X3) DATE : COMPL 10/29/ | ETED | |
|--|--|--|---|---------------------|--|--|----------------------------|
| NAME OF PROVIDER OF | | 1 | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| PREFIX (EACH | I DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| Plan on 10 with the A Director, facility premergence date of 09 provided comments required. changed I however, Nursing I manual aremergence of Envive time of rename of the review on manual, at the facility prepared said she he facility for who performs the said she he facility for the said she he said she he facility for the said she he said she said she he said she he said she he said she said she he said she said she sai | o/29/24 be administration of A | the Emergency Preparedness etween 9:30 a.m. and 1:15 p.m. ator, facility Maintenance tenance Director from a sister facility did provide an dness manual with a review of the did the review, and in the traid no updates were ore, the name of the facility, 2024, to Envive of River City, or name of the facility, Braun's anamed on the cover of the ned throughout the entire dness manual with no mention City. Based on interview at the Administrator confirmed the or persons that performed the was not included in the confirmed the current name of the entitioned in the emergency al. The Administrator at the anamonth and was not sure review. Viewed with the Administrator are Director's during the exit | | | Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions soforth 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 responsible to the allegation of noncomplicated during the Life Safety And visit of October 29, 2024. 1.) What corrective action(s) who is accomplished for those residents found to have been affected by the deficient practice. The Emergency Plans Policiand Procedures were reviewed updated. A new cover sheet who is 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 be affected by this alleged deficient practice. The Emergency Plans Policies and Procedures were reviewed and updated. A second procedures were reviewed and updated. | t ment the et an of cond ance nual vill ce? es d and vith the ency s | |

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Event ID:

J7X021 Fac

Facility ID: 000437

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/29/2024 | | | |
|--|----------------------|---|---|---|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | cover sheet with signatures of reviewers was added. 3.) What measures will be put place or what systemic change will be made to ensure that the deficient practice does not occagain? The Director of Maintenance was educated by the Executiv Director on E004-Emergency review and update. An annual review of the Emergency Plan added to the task section of the TELS building system. This ta will auto populate annually, as for a review and required documentation upload before can be signed off. 4.) How the corrective action who 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. results will be reviewed for patterns, trends, and continue recommendations for process monitoring and improvement to | in es e cur es e Plan was e sk king task will e common es e common | | |
| | | | | 100% compliance is achieved5.) Date of Completion:November 8, 2024 | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|--|--|---|---|---------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER OF RIVER CITY | 2 | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| E 0013 SS=F Bldg | 1 ' ' | 4(b), 418.113(b), 441.1 P Policies and Procedures | | | | | |
| | failed to develop an preparedness policies and proced updated at least ann CFR 483.73(b). The all residents in the fall residents in | the Emergency Preparedness etween 9:30 a.m. and 1:15 p.m. ator, facility Maintenance tenance Director from a sister facility did provide an dness manual, which included and procedures, with a review owever, there was no name(s) tho did the review, and in the tail said no updates were ore, the name of the facility, 2024, to Envive of River City, or name of the facility, Braun's anamed on the cover of the need throughout the entire dness manual with no mention City. Based on interview at the Administrator confirmed the or persons that performed the was not included in the confirmed the current name of the entire dness manual with no mention City. Based on interview at the Administrator confirmed the current name of the entire dness manual with no mention City. Based on interview at the Administrator also the Administrator also the Administrator at the talk a month and was not sure | E 0 | 013 | Please accept this Plan of Correction as the provider's credible allegation of compliant as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed 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 Place Correction is submitted to respect to the allegation of noncomplicated during the Life Safety And visit on October 29, 2024. 1.) What corrective action(s) we be accomplished for those residents found to have been affected by the deficient praction. The Emergency Plans Policiand Procedures were reviewed updated. A new cover sheet we signatures of reviewers was added. | desk to that of t ment he et an of cond ance nual vill ce? | 11/08/2024 |

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PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING | | COMPL | (X3) DATE SURVEY COMPLETED 10/29/2024 | | |
|--|---------------------|---|---|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIE | R | • | 909 NO | ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE OVILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | This finding was re | eviewed with the Administrator nee Director's during the exit | | | 2.) How other residents have potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents had potential to affected by this alleged deficie practice. The Emergency Plan was reviewed and updated. A cover sheet with signatures or reviewers was added. 3.) What measures will be put place or what systemic chang will be made to ensure that the deficient practice does not occagain? The Director of Maintenance was educated by the Executive Director on E013 - Emergence Plan review and update. An a review of the Emergency Plan added to the Task section of the TELS building system. This take will auto populate annually, as for a review and required documentation upload before can be signed off. 4.) How the corrective action be monitored to ensure the deficient practice will not reur what quality assurance prograwill be put into place? This TELS task will be reviet by the Safety/QAPI committeed. | o be ent n n new f t into ges ie cur e ve yy annual n was the ask sking task will i.e., am | |

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Event ID:

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Facility ID: 000437

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. BUILDING B. WING | | COMPLETED 10/29/2024 | | |
|--|---|--|---|--|------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| E 0029 SS=F Bldg | Development of Construction Based on record rev | 4(c), 418.113(c), 441.1 ommunication Plan iew and interview, the facility d maintain an emergency | E 0029 | led by the the Executive Direct and/or Maintenance Director. results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved 5.) Date of Completion: Nove 8, 2024 Please accept this Plan of Correction as the provider's | The duntil | |
| | with Federal, State, and updated at least | unication plan that complies and local laws was reviewed annually in accordance with This deficient practice could | | credible allegation of compliar as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance. | desk to | |
| | Plan on 10/29/24 be with the Administra Director, and Maint facility present, the emergency prepared a plan to develop an preparedness comm with Federal, State, date of 09/26/24, ho provided to show with comments section it | the Emergency Preparedness tween 9:30 a.m. and 1:15 p.m. tor, facility Maintenance enance Director from a sister facility did provide an lness manual that did include d maintain an emergency unication plan that complies and local laws with a review tweer, there was no name(s) the did the review, and in the said no updates were ore, the name of the facility | | Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth 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 Correction is submitted to respect to the allegation of noncompliant. | an of | |

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Event ID:

J7X021

Facility ID: 000437

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PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | | | JILDING | ONSTRUCTION | (X3) DATE : COMPL 10/29/ | ETED |
|--------------------------|---|--|--|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | <u> </u> | | 909 NO | ADDRESS, CITY, STATE, ZIP COD RTH FIRST AVE VILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | however, the forme Nursing Home, was manual and mention | , 2024, to Envive of River City, r name of the facility, Braun's named on the cover of the ned throughout the entire | | | cited during the Life Safety Su visit conducted October 29, 20 1.) What corrective action(s) w |)24. | |
| | of Envive of River time of review, the | Iness manual with no mention City. Based on interview at the Administrator confirmed the or persons that performed the | | | be accomplished for those residents found to have been affected by the deficient practi | ce? | |
| | manual, and further the facility is not m preparedness manual said she has only be | was not included in the confirmed the current name of entioned in the emergency al. The Administrator also een the Administrator at the a month and was not sure | | | The Emergency Plans Communication Plans were reviewed and updated. A new cover sheet with signatures of reviewers was added. | | |
| | who performed the This finding was re | | | | 2.) How other residents have t potential to be affected by the same deficient practice will be identified and what corrective action will be taken? | | |
| | | | | | All residents had potential to affected by this alleged deficie practice. The Emergency Plan Communication Plan was reviand updated. A new cover she with signatures of reviewers wadded. | ent is ewed eet | |
| | | | | | 3.) What measures will be put place or what systemic change will be made to ensure that the deficient practice does not occagain? | es e | |
| | | | | | The Director of Maintenance was educated by the Executiv Director on E029 - Emergency Plan review and update. An arreview of the Emergency Plan added to the Task section of the Company of the Emergency Plan added to the Task section of the Emergency Plan added to the Emergency Plan added to the Task section of the Emergency Plan added to the Emergency Plan added t | e nnual was | |

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PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. BUILDING B. WING | | COMPLETED 10/29/2024 | | |
|--|--|--|---|--|------------------------|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | TELS building system. This ta will auto populate annually, as for a review and requires documentation upload before can be signed off. 4.) How the corrective action where the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be review 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 to 100% compliance is achieved. | king task vill wed The | |
| E 0036 SS=F Bldg | EP Training and T Based on record rev | iew and interview, the facility | E 0036 | 8, 2024 Please accept this Plan of | 11/08/2024 | |
| | preparedness trainin was reviewed and u accordance with 42 practice could affect Findings include: | | | Correction as the provider's credible allegation of complian as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance. | desk to | |
| | Plan on 10/29/24 be | the Emergency Preparedness tween 9:30 a.m. and 1:15 p.m. tor, facility Maintenance | | Preparation and/or execution of this plan of correction does no | | |

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

Event ID:

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Facility ID: 000437

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. BUILDING B. WING | | COMPLETED 10/29/2024 | |
|--|---|--|--------|--|---|
| | PROVIDER OR SUPPLIER | | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| | SUMMARY S (EACH DEFICIENCE REGULATORY OR Director, and Maint facility present, the emergency prepared training and testing 09/26/24, however, to show who did the section it said no up Furthermore, the nat February 1, 2024, to however, the former Nursing Home, was manual and mention emergency prepared of Envive of River of time of review, the name of the person review on 09/26/24 manual, and further the facility is not may preparedness manual said she has only be facility for less than who performed the total straining was review. | ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION enance Director from a sister facility did provide an lness manual that included a program with a review date of there was no name(s) provided e review, and in the comments dates were required. me of the facility changed be Envive of River City, rename of the facility, Braun's named on the cover of the need throughout the entire lness manual with no mention City. Based on interview at the Administrator confirmed the or persons that performed the was not included in the confirmed the current name of entioned in the emergency al. The Administrator at the a month and was not sure | 909 NC | | mate (X5) COMPLETION DATE ement if the set r Plan of spond he sucted will tice? ning nd with the se e |
| | | | | Training and Testing was reviewed and updated. A new cover sheet with signatures or reviewers was added. 3.) What measures will be puplace or what systemic chang will be made to ensure that the | of ut into ges |

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J7X021

Facility ID: 000437

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION C | completed 10/29/2024 |
|--------------------------|---------------------------------------|---|-------------------------------------|---|--------------------------------|
| | PROVIDER OR SUPPLIED OF RIVER CITY | ? | 909 NO | ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | The Director of Maintenance was educated by the Executive Director on E036-Emergency Preview and update. An annual review of the Emergency Plan wadded to the Task section of the TELS building system. This task will auto populate annually, ask for a review and requiring documentation upload before to can be signed off. 4.) How the corrective action with the deficient practice will not recur i.e., what quality assurance program will be put into place? This TELS task will be review by the Safety/QAPI committee, led by the Executive Director and/or Maintenance Director. Tresults will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement ur 100% compliance is achieved. 5.) Date of Completion: Novem 8, 2024 | lan vas e K ing ask II ed he |
| E 0039 SS=F Bldg | EP Testing Requi | | | | |
| | Based on record re | view and interview, the facility | E 0039 | Please accept this Plan of | 11/15/2024 |

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Event ID:

J7X021

Facility ID: 000437

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. B | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/29/2024 | | |
|--|---|--|--|--|---|-------|--------------------|
| NAME OF I | PROVIDER OR SUPPLIE | R | • | | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE | • | |
| ENVIVE | OF RIVER CITY | | | EVANS | SVILLE, IN 47710 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | TE | COMPLETION DATE |
| TAG | | xercises to test the emergency | | IAU | Correction as the provider's | | DATE |
| | plan at least twice p | | | | credible allegation of compliar | nce | |
| | | drills using the emergency | | | as of November 8, 2024. The | | |
| | procedures. The LT | TC facility must do the | | | provider respectfully requests | desk | |
| | following: | | | | review with paper compliance | to | |
| | | annual full-scale exercise that | | | be considered in establishing | that | |
| | is community-base | | | | the provider is in substantial | | |
| | | ity-based exercise is not an annual individual, | | | compliance. | | |
| | facility-based funct | | | | Preparation and/or execution | of | |
| b. If the LTC facility experiences an actual natural | | | | this plan of correction does no | ot | | |
| or man-made emergency that requires activation | | | | constitute admission or agree | | | |
| of the emergency plan, the LTC facility is exempt | | | | by the provider of the truth of | | | |
| from engaging its next required full-scale in a | | | | facts alleged or conclusions s | et | | |
| | community-based or individual, facility-based | | | | forth in the Statement of | | |
| | | l exercise for 1 year following | | | Deficiencies. The Plan of | | |
| | the onset of the act | | | | Correction is prepared and/or | | |
| | | litional exercise that may | | | executed solely because it is | | |
| | a. A second full-sca | imited to the following: | | | required by the provisions of | on of | |
| | | or an individual, facility-based | | | Federal and State law. The Pl Correction is submitted to res | | |
| | functional exercise | | | | to the allegation of noncomplia | | |
| | b. A mock disaster | | | | cited during the Life Safety Ar | | |
| | | ise or workshop that is led by a | | | visit conducted on October 29 | | |
| | • | ides a group discussion, using | | 2024. | | | |
| | | y-relevant emergency scenario, | | | | | |
| | · · | n statements, directed | | | 1.) What corrective action(s) v | vill | |
| | messages, or prepar | red questions designed to | | | be accomplished for those | | |
| | challenge an emerg | gency plan. | | | residents found to have been | | |
| | (iii) Analyze the LT | ΓC facility's response to and | | | affected by the deficient practi | ce? | |
| | maintain document | ation of all drills, tabletop | | | | | |
| | | rgency events, and revise the | | | The campus has had an | | |
| | _ | gency plan, as needed in | | | unannounced elopement drill | | |
| | | CFR 483.73(d)(2). | | | which staff implemented the | | |
| | • | tice could affect all occupants | | | Emergency Plan. | | |
| | in the facility. | | | | | | |
| | Diadian 1 1 1 | | | | 2.) How other residents have | | |
| | Findings include: | | | | potential to be affected by the | | |
| | Događ or marijara - 4 | Etha Emarganay Dramaradusas | | | same deficient practice will be | | |
| | based on review of | the Emergency Preparedness | I | | identified and what corrective | | İ |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | A. BUILDING B. WING | UN51 RUCTION | COMPLETED 10/29/2024 | |
|--|--|---|---------------------|---|--|
| | PROVIDER OR SUPPLIER | | 909 NG | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| TAG | Plan on 10/29/24 be with the Administra Director, and Maint facility present, the documentation of at that created a power 09/04/24, however, a second exercise course the past 12 month p the Administrator at This finding was rev | tween 9:30 a.m. and 1:15 p.m. tor, facility Maintenance enance Director from a sister facility was able to provide a actual event (near by fire routage) that happened on there was no documentation of onducted by the facility during eriod. This was confirmed by the time of record review. Viewed with the Administrator, ce Director's during the exit | TAG | action will be taken? All residents had potential to affected by this alleged deficie practice. The campus has had unannounced elopement drill which staff implemented the Emergency Plan. 3.) What measures will be purplace or what systemic chang will be made to ensure that the deficient practice does not occome the compact of the Director of Maintenance was educated by the Executive Director on E039-Emergncy testing requirements. An annuemergency/disaster drill were added to the Task section of the TeLS building system. This take will auto populate annually an require documentation uploaded before task can be signed off. 4.) How the corrective action to be monitored to ensure the deficient practice will not recurred i.e., what quality assurance program will be put into place. This TELS task will be reviewed for patterns, trends and continue recommendations for process monitoring and improvement 100% compliance is achieved. | be ent dan |

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE (A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 10/29/2024 | | |
|--------------------------|--|--|---|---|--|--|--|
| | PROVIDER OR SUPPLIER OF RIVER CITY | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | | |
| | | | | 5.) Date of Completion: Nover 15, 2024 | nber | | |
| E 0041 SS=C Bldg | Based on record reversal failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). Based on record reversal failed to maintain a monthly generator I during 12 of the past 6.4.4.1.1.4(a) of 20 testing of the general electrical system to 110, the Standard for Powers Systems, Clay NFPA 99 requires a performance, exercing generator to be regurated for inspection by the jurisdiction. This difference is a mean of the safe | eficient practice could affect all | E 0041 | Please accept this Plan of Correction as the provider's credible allegation of complian as of November 8, 2024. The provider respectfully requests of review with paper compliance of be considered in establishing to the provider is in substantial compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions see 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 Plat Correction is submitted to resp to the allegations of noncompliance cited during the Life Safety Annual visit conduct on October 29, 2024. 1.) What corrective action(s) w be accomplished for those | desk to hat of the nent ne of the | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|--|---|---|--------------|--|--|
| | ROVIDER OR SUPPLIER | | 909 N | ORTH FIRST AVE SVILLE, IN 47710 | • |
| | SUMMARY (EACH DEFICIEN REGULATORY OR documentation on the log for percentage of period. Based on in review, the facility confirmed there was monthly generator liperiod. This finding was recommended. | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ne generator monthly load test of load for the past 12 month atterview at the time of record Maintenance Director s no percentage of load on the og for the past 12 month wiewed with the Administrator ace Director's during the exit | 909 N | ORTH FIRST AVE SVILLE, IN 47710 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) residents found to have been affected by the deficient practic. The Maintenance Director in documents load bank monthly. 2.) How other residents have 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 affected by this alleged deficipractice. The Maintenance Director now documents load monthly. 3.) What measures will be purplace or what systemic change will be made to ensure that the deficient practice does not occur. The Director of Maintenance was educated by the Executive. | tice? ow y. the e b bank t into ges ge cur? e ye |
| | | | | Director on E041- Hospital Coand LTC Emergency Power. annual tasks have been added the TELS building system. The tasks will auto populate montand requires documentation upload before task can be signoff. 4.) How the corrective action be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place | AH Two ed to lesse hly lined will |

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | | JILDING | NSTRUCTION | (X3) DATE : COMPL 10/29/ | ETED |
|--------------------------|--|--|-----|---------------------|--|---|----------------------------|
| | ROVIDER OR SUPPLIER OF RIVER CITY | | | 909 NO | ADDRESS, CITY, STATE, ZIP COD RTH FIRST AVE VILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | | | | | This TELS task will be review 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 up 100% compliance is achieved. 5.) Date of Completion: Novem 8, 2024 | , Γhe ntil | |
| K 0000 | | | | | | | |
| Bldg. 01 | Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/29 Facility Number: 0 Provider Number: 1000 At this Life Safety 0 City was found not Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation) This one story facility basements was dete | 00437 155520 273770 Code survey, Envive of River in compliance with | K 0 | 000 | Preparation and/or execution of this plan of correction does not constitute admission or agreed 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 Plate Correction is submitted to respect to the allegation of noncompliacited during the Life Safety vistoctober 29, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliant as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial | t nent he et an of cond ince it of ce desk to | |

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MUL' A. BUIL B. WINC | DING | nstruction 01 | (X3) DATE COMPL 10/29/ | ETED |
|----------------------------|--|---|---------------------------------|-------------------|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | 9 | 909 NO | NDDRESS, CITY, STATE, ZIP COD RTH FIRST AVE VILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | PR | ID EFIX ΓAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| K 0291 SS=F Bldg. 01 | smoke detectors in the corridors and be operated smoke alar rooms. The facility census of 31 at the table of the consus of 31 at the table of the census of 31 at the table of 31 at table of 3 | dents have customary access d all areas providing facility klered, except one detached lity storage. Impleted on 10/31/24 Ing Priew, observation, and ty failed to ensure there was he testing of 8 of 8 battery were tested annually for 90 past 12 months to ensure the e lighting during periods of C 19.2.9.1 requires emergency ovided in accordance with in 7.9.3.1.1 (1) requires mall be conducted monthly, 3 weeks and a maximum of 5 s, for not less than 30 onal testing shall be for a minimum of 1 1/2 hours ghting system is battery ritten records of visual s shall be kept by the owner | K 029 | 1 | Please accept this Plan of Correction as the provider's credible allegation of complia as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of the facts of the provider of the truth of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Proposition of the allegations of the allegations of the statement of the statement of the allegations of the statement of the s | es desk e to that of ot ement the set | 11/08/2024 |
| | Findings include: | | | | to the allegations of | | |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|--|--|--|---------------------|--|----------------------|
| | PROVIDER OR SUPPLIER | | 909 N | CADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | a.m. and 1:15 p.m. | view on 10/29/24 between 9:30 with the facility Maintenance enance Director from a sister | | noncompliance cited during the Life Safety Annual visit conduction on October 29, 2024. | |
| | eight battery power throughout the facil | nance (PM) report that the ed emergency lights ity were tested monthly for 30 | | What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice. | |
| | However, there was to show the eight ba light was tested ann | past 12 month period. no documentation available attery powered emergency ually for 90 minutes during arrived. The most recent 90 | | The campus has tested and documented the 90-minute te the emergency lights. | |
| | 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 | | | 2.) How other residents have potential to be affected by the same deficient practice will be | 2 |
| | Maintenance Direct p.m., the facility wa emergency battery | or's between 1:15 p.m. and 3:15 as equipped with eight powered light units located | | identified and what corrective action will be taken? All residents had potential to | o be |
| | This finding was no conference. | ity. | | affected by this alleged deficiency practice. The campus has test and documented the 90-minutest on the emergency lights. | ted |
| | 3.1-19(b) | | | 3.) What measures will be put place or what systemic chang will be made to ensure that the deficient practice does not oc | es e |
| | | | | The Director of Maintenance | e ve |
| | | | | Director on K291- Emergency Lighting. These tasks have be added to the TELS building system. These tasks will auto | een |
| | | | | populate monthly for a 30 sec and annually for a 90-minute and requires documentation upload before task can be sig | test |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 10/29/2024 |
|----------------------------|--|--|--|---|---|
| | ROVIDER OR SUPPLIER | | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| K 0300 | NEDA 404 | | | off. 4.) How the corrective action be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place This TELS task will be revie by the Safety/QAPI committed led by the Executive Director and/or Maintenance Director. results will be reviewed for patterns, trends and continue recommendations for process monitoring and improvement 100% compliance is achieved 5.) Date of Completion: Nove 8, 2024 | ewed e, The d s until |
| K 0300 SS=F Bldg. 01 | failed to ensure doc preventative mainte smoke alarms in all complete. NFPA 7: operations integrity inspection, testing, NFPA 72 29.10 stat be maintained and t manufacturer's publ requirements of Cha | view and interview, the facility | K 0300 | Please accept this Plan of Correction as the provider's credible allegation of complia as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance (this date of compliance is to be determine the future since we have order the item and waiting delivery) | e desk e to that ed in ered |

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| CROSS-REFERENCED TO THE APPROPRIATE | |
|--|--------------------------|
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG Preparation and/or execution of this plan of correction does not constitute admission or agreement | |
| Findings include: this plan of correction does not constitute admission or agreement | (X5) IPLETION DATE |
| 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) The Campus has ordered all new battery-operated smoke detectors to be replaced upon delivery immediately. 2.) How other residents have the potential by 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. The Campus has ordered and will replace all battery-operated smoke detectors immediately upon delivery. 3.) What measures will be put into | AIE |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|------------------------------|---|--------|--|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | COMPL | |
| | | 155520 | B. W | ING | 10/29/2024 | | 2024 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | 1 | ID | | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| TAG | REGULATORY OR | ALSC IDENTIFYING INFORMATION | | TAG | place or what systemic change will be made to ensure that the deficient practice does not occome. The Director of Maintenance was educated by the Executiv Director on K300-Protection of Smoke detectors need weekly testing along with annual batter change. The task have been added to the TELS building system for annual battery change will be kept by the maintenance director. This task will auto populate Annual Batter change and require document upload before task can be sign off. 4.) How the corrective action who 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 Executive Director and/or Maintenance Director. The safety/QAPI committee led by the Executive Director and/or Maintenance Director. The safety will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved. 5.) Date of Completion: Week Battery testing - November 8, 2024 New | e cur? e e ther. ery nge. sk ery ation ned will re ? wed e, The | DATE |

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|----------------------------|--|--|-------------------------------------|--|---------------------------------------|--|
| NAME OF F | PROVIDER OR SUPPLIER | <u> </u> | | ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE | | |
| ENVIVE | OF RIVER CITY | | | SVILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | Battery-Operated Smoke Detectors - Upon arrival from vendor | | |
| K 0353 SS=F Bldg. 01 | 1. Based on record facility failed to proof other evidence the shad been inspected of 2 of 4 quarters for 4.6.12.1 requires an required for complimaintained in according requirements. Spring maintained in according for the Inspection, Twater-Based Fire Parameters of the Inspections, tests, and components and shad authority having jurged requires that recording performed (e.g., instead the organization that results, and the date waterflow alarm dequarterly to verify the damage. NFPA 25, waterflow alarm deto, water motor gon 5.3.3.2 requires van switch-type waterflottested semiannually | review and interview, the wide written documentation or sprinkler system components and tested for the equivalent or 1 of 1 sprinkler system. LSC y device, equipment or system ance with this Code be dance with applicable NFPA ankler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 s shall indicate the procedure pection, test, or maintenance), at performed the work, the services shall be inspected they are free of physical 5.3.3.1 requires the mechanical vices including, but not limited gs, shall be tested quarterly. e-type and pressure ow alarm devices shall be to the staff, and visitors in the | K 0353 | K353 Sprinkler System - Mtn and Testing 1 What corrective action(s) Whe accomplished for those Residents found to have been affected by the deficient practice? (1) The Campus has contract Koorsen Fire and security to inspect our systems on as required (2) Sprinkler gauge and contivative inspections are now don weekly. The documentation is kept on a clipboard next to the riser. 2. How other residents have to 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. | ted rol e the | |

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| STATEMEN | TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------|---|----------------------------------|--------|------------|--|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPLETED | |
| | | 155520 | B. W | ING | | 10/29/2024 | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | 1 | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | RTH FIRST AVE | | |
| ENVIVE | OF RIVER CITY | | | | VILLE, IN 47710 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE | |
| | facility. | | | | Sprinkler gauge and control v | | |
| | | | | | inspections are now done we | | |
| | Findings include: | | | | The documentation is kept on | а | |
| | | | | | clipboard next to the riser. | | |
| | | f the quarterly sprinkler system | | | 3. What measures will be | | |
| | _ | on 10/29/24 between 9:30 a.m. | | | putting place or what system | nic | |
| | _ | the facility Maintenance | | | changes will be made to | | |
| | | tenance Director from a sister | | | ensure that the deficient | | |
| | | ere were no quarterly sprinkler | | | practice does not occur? | | |
| | | reports available between | | | <u> </u> | | |
| | | 1/24. Based on interview at the | | | The Director of Maintenance | was | |
| | | ew, the facility Maintenance | | | educated by the Executive | | |
| | | the lack of quarterly sprinkler | | | Director on K353 Sprinkler | | |
| | | reports between 01/05/24 and | | | System - Mtn and Testing. | . , | |
| | 09/04/24. | | | | (1) Sprinkler systems are requ | | |
| | TT1 : C' 1: | | | | to be tested timely. This task | | |
| | _ | eviewed with the Administrator | | | been added to the Tels building | - | |
| | | nce Director's during the exit | | | system for quarterly testing as | S | |
| | conference. | | | | required. This task will auto | | |
| | 2.1.10(%) | | | | populate quarterly and require | | |
| | 3.1-19(b) | | | | documentation upload before | lask | |
| | 2 Rosed on record | l review, observation, and | | | can be signed off. (2) The | anh an | |
| | | ity failed to document sprinkler | | | Sprinkler gauge and control v inspections should be done p | | |
| | | in accordance with NFPA 25 | | | CMS requirements. This task | | |
| | | systems. NFPA 25, Standard | | | been added to the Tels buildi | | |
| | | Testing, and Maintenance of | | | system for weekly testing as | '9 | |
| | _ | Protection Systems, 2011 | | | required. This task will auto | | |
| | | 2.4.1 states gauges on wet pipe | | | populate quarterly and require | e | |
| | | hall be inspected monthly to | | | documentation upload before | | |
| | | e in good condition and the | | | can be signed off | | |
| | | ure is being maintained. | | |] | | |
| | ^ | s valves and fire department | | | | | |
| | | be inspected, tested, and | | | 4. How the corrective action | | |
| | | rdance with Chapter 13. | | | will be monitored to ensure | | |
| | | ates Table 13.1.1.2 shall be | | | deficient practice will not re- | | |
| | utilized for inspect | ion, testing and maintenance of | | | i.e., what quality assurance | | |
| | | ponents and trim. Section 4.3.1 | | | program will be put into place | ce? | |
| | _ | be made for all inspections, | | | | | |
| | tests, and maintena | nce of the system and its | | | This Tels task will be reviewe | d by | |

J7X021

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|--|--|--|---------------------|--|-----------------------|
| | ROVIDER OR SUPPLIED OF RIVER CITY | R | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| K 0374 | components and shauthority having judeficient practice of and visitors in the first state of the findings include: Based on review of inspection records and 1:15 p.m. with Director and Maint facility present, the a. There were no serecords available to the past 12 month plants. There was no condocumentation available to the facility Mainter at the facility Mainter at the facility Mainter at the facility. Based on observation with both Maintenas sprinkler gauges are the wet sprinkler sy | all be made available to the risdiction upon request. This ould affect all residents, staff, facility. The sprinkler system on 10/29/24 between 9:30 a.m. the facility Maintenance enance Director from a sister of following was noted: prinkler gauge inspection or review prior to 09/30/24 for period. Ontrol valve inspection ilable to review for the past 12 at the time of record review, nance Director said he has been ally two months and was unable stem gauge and control valve intation prior to him being at one during a tour of the facility ance Director's there were two ad one main control valve on | IAG | 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 to 100% compliance is achieved 5. Date of Completion: 11/8/2024 | r or d Jntil |
| SS=E Bldg. 01 | Barrie Based on observati | on and interview, the facility f 7 sets of smoke barrier doors | K 0374 | Please accept this Plan of Correction as the provider's | 11/08/2024 |

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Event ID:

J7X021

Facility ID: 000437

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| STATEMEN | IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|---|-------------------------------------|------------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> COMPLE | | | ETED | |
| | | 155520 | B. W | ING | | 10/29/ | 2024 |
| | | | | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | RTH FIRST AVE | | |
| ENI\/I\/E | OF RIVER CITY | | | | VILLE, IN 47710 | | |
| CINVIVE | OF RIVER CITT | | | EVANS | VILLE, IN 477 TO | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | . – | DATE |
| | would close and lat | ch to form a smoke resistant | | | credible allegation of complian | ice | |
| | barrier. LSC, Secti | on 19.3.7.8 requires that doors | | | as of November 8, 2024. the | | |
| | in smoke barriers sl | nall comply with LSC, Section | | | provider respectfully requests | desk | |
| | 8.5.4. LSC, Section | n 8.5.4.1 requires doors in smoke | | | review with paper compliance | to | |
| | barriers to close the | opening leaving only the | | | be considered in establishing t | that | |
| | minimum clearance | necessary for proper operation | | | the provider is in substantial | | |
| | which is defined as | 1/8 inch to restrict the | | | compliance. | | |
| | movement of smok | e. This deficient practice could | | | | | |
| | affect at least 20 res | sidents, as well as staff and | | | Preparation and/or execution o | of | |
| | visitors. | | | | this plan of correction does no | | |
| | | | | | constitute admission or agreer | | |
| | Findings include: | | | | by the provider of the truth of t | | |
| | | | | | facts alleged or conclusions se | | |
| | Based on observations on 10/29/24 between 1:15 | | | | forth in the Statement of | | |
| | p.m. and 3:15 p.m. | during a tour of the facility with | | | Deficiencies. The Plan of | | |
| | the facility Mainten | _ | | | Correction is prepared and/or | | |
| | | tor from a sister facility, the set | | | executed solely because it is | | |
| | | smoke barrier/fire barrier doors | | | required by the provisions of | | |
| | between the 100 Ur | nit and the north Nurse's | | | Federal and State law. The Pla | an of | |
| | | close completely and latch | | | Correction is submitted to resp | | |
| | | times. These doors were | | | to the allegation of noncomplia | | |
| | | ing hardware. There remained | | | cited during the Life Safety An | | |
| | | between the doors when | | | Survey conducted October 29 | | |
| | | st. This was acknowledged by | | | 2024. | | |
| | both Maintenance I | Director's at the time of | | | | | |
| | observation. The fa | acility Maintenance Director | | | 1.) What corrective action(s) w | /ill | |
| | | worked on this set of | | | be accomplished for those | | |
| | smoke/fire doors se | everal times but has been | | | residents found to have been | | |
| | unable to fix them | | | | affected by the deficient practi | ce? | |
| | _ | • | | | , | | |
| | This finding was re | viewed with the Administrator | | | The Maintenance Director ha | as I | |
| | | nce Director's during the exit | | | repaired the doors in question | | |
| | conference. | C | | | They now shut and latch on th | | |
| | | | | | own power. | | |
| | 3.1-19(b) | | | | ' | | |
| | | | | | 2.) How other residents have t | _{he} | |
| | | | | | potential to be affected by the | | |
| | | | | | same deficient practice will be | | |
| | | | | | identified and what corrective | | |
| | | | | | action will be taken? | | |

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Facility ID: 000437

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 10/29/2024 |
|--------------------------|-------------------------------------|---|--|---|---|
| | ROVIDER OR SUPPLIE DF RIVER CITY | R | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | At least 20 residents had potential to be affected by this alleged deficient practice. The Campus has repaired the doo question. They now shut and I on their own power. 3.) What measures will be put place or what systemic change will be made to ensure that the deficient practice does not occur. The Director of Maintenance was educated by the Executiv Director on K374 Subdivision Building Spaces - Smoke Barr Doors. A door latch task has be 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 who 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 review by the Safety/QAPI Committed led by the Executive Director and/or Maintenance Director. results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved | rs in atch in es e cur? e e of ier een red vill ? wed e, The |

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Event ID:

J7X021

Facility ID: 000437

If continuation sheet

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| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520 | | (X2) MULTIPLE (A. BUILDING B. WING | O1 | (X3) DATE SURVEY COMPLETED 10/29/2024 |
|--|---|-------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIE | ER | 909 N | r address, city, state, zip cod ORTH FIRST AVE SVILLE, IN 47710 | |
| PREFIX (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| | | | 5.) Date of Completion: Noven 8, 2024 | nber |
| K 0511 NFPA 101 SS=E Utilities - Gas an | d Electric | | | |
| Based on observarial failed to ensure 3 provided with gro (GFCI) protection 70, NEC 2011 Ed Circuit-Interruptes states, ground-fau personnel shall be 210.8(A) through circuit-interrupter accessible location Informational Not circuit interrupter feeders. (B) Other Than D single-phase, 15-installed in the location through (8) shall I circuit-interrupter (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily access branch circuit ded deicing, or pipelin shall be permitted with 426.28 or 42 Exception No. 2 to only, where the cosupervision ensurare involved, an a | welling Units. All 125-volt, and 20-ampere receptacles eations specified in 210.8(B)(1) | K 0511 | Please accept this Plan of Correction as the provider's credible allegation of complian as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreer by the provider of the truth of the facts alleged or conclusions seforth 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 Correction is submitted to resp to the allegation of noncompliative during the Life Safety An Survey conducted October 29 2024. 1.) What corrective action(s) where the service of the s | desk to that of t ment the et an of cond ance nual , vill ce? as |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------------------|--|---|--------|-----------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>01</u> | | COMPLETED | |
| | | 155520 | B. W | ING | | 10/29/ | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ORTH FIRST AVE | | |
| ENVIVE | OF RIVER CITY | | | | SVILLE, IN 47710 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRE | | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | _ | for only those receptacle | | | | | |
| | | ply equipment that would | | | 2.) How other residents have | | |
| | - | eard if power is interrupted or | | | potential to be affected by the | | |
| | | at is not compatible with GFCI | | | same deficient practice will be | | |
| | protection. | | | | identified and what corrective | | |
| | | eceptacles are installed within outside edge of the sink. | | | action will be taken? | | |
| | | (5): In industrial laboratories, | | | All staff had natartial to be | | |
| | _ | supply equipment where | | | All staff had potential to be | ont | |
| | _ | would introduce a greater | | | affected by this alleged deficiently practice. The Maintenance | ∵ ill | |
| | _ | - | | | Director has replaced the GF | ∩l'e | |
| | hazard shall be permitted to be installed without GFCI protection. | | | | in question. | 013 | |
| | Exception No. 2 to (5): For receptacles located in | | | | in question. | | |
| | patient bed locations of general care or critical | | | | 3.) What measures will be pu | t in | |
| | - | care facilities other than those | | | place or what systemic change | | |
| | covered under | | | | will be made to ensure that the | | |
| | 210.8(B)(1), GFCI | protection shall not be required. | | | deficient practice does not oc | | |
| | (6) Indoor wet loca | | | | · | | |
| | (7) Locker rooms v | vith associated showering | | | The Director of Maintenance | е | |
| | facilities | | | | was educated by the Executiv | /e | |
| | (8) Garages, servic | e bays, and similar areas where | | | Director on K511 Utilities - Ga | as | |
| | electrical | | | | and Electric. GFCI check task | c has | |
| | diagnostic equipme | ent, electrical hand tools. | | | been added to the TELS build | ding | |
| | | Wet Locations, requires all | | | system for monthly testing. TI | | |
| | _ | ed equipment within the area of | | | task will auto populate month | - | |
| | | have ground-fault circuit | | | and is required to be signed of | off. | |
| | | protection. Note: Moisture can | | | | | |
| | | resistance of the body, and | | | 4.) How the corrective action | will | |
| | | n is more subject to failure. | | | be monitored to ensure the | | |
| | This deficient prac | tice could affect mostly staff. | | | deficient practice will not recu | | |
| | Findings in the J | | | | what quality assurance progra | am | |
| | Findings include: | | | | will be put into place? | | |
| | Based on observati | ons on 10/29/24 between 1:15 | | | This TELS task will be revie | wed | |
| | | during a tour of the facility with | | | by the Safety/QAPI Committee | | |
| | | Director's, the following was | | | led by the Executive Director | Ο, | |
| | noted: | | | | and/or Maintenance Director. | The | |
| | | electric receptacles within five | | | results will be reviewed for | | |
| | | he basement employee | | | patterns, trends and continue | d | |
| | | vided with GFCI protection. | | | recommendations for process | | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|---|----------------------------------|--|---|-------------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>01</u> | | 01 | COMPLETED | |
| | | 155520 | B. WI | ING | | 10/29/2024 | |
| NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY | | | STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | .TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | GFCI testing device the | | | monitoring and improvement u | | |
| | - | break the electrical circuit. | | | 100% compliance is achieved. | | |
| | | eptacle within two feet to the | | | 5) Data of Commistions November | ember | |
| | | Clean Utility Room was not CI receptacle. When tested | | | 5.) Date of Completion: Novel | | |
| | - | device the receptacle did not | | | 8, 2024 | | |
| | break the electrical | - | | | | | |
| | | ptacle within two feet to the | | | | | |
| | | Soiled Utility Room was not | | | | | |
| | provided with a GF | CI receptacle. When tested | | | | | |
| | | device the receptacle did not | | | | | |
| | break the electrical | | | | | | |
| | Based on interview | | | | | | |
| | | faintenance Director's agreed uestion were not properly | | | | | |
| | GFCI protected. | destion were not property | | | | | |
| | Gr Cr protected. | | | | | | |
| | This finding was re | viewed with the Administrator | | | | | |
| | - | ace Director's during the exit | | | | | |
| | conference. | | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |
| K 0918 | NFPA 101 | | | | | | |
| SS=C | - | s - Essential Electric Syste | | | | | |
| Bldg. 01 | Liectrical Systems | s - Essertial Electric Syste | | | | | |
| 2.49.0. | Based on record rev | view and interview, the facility | K 0 | 918 | Please accept this Plan of | | 11/08/2024 |
| | | complete written record of | 11 0 | <i>)</i> 10 | Correction as the provider's | | 11/00/2021 |
| | monthly generator l | oad testing for 1 of 1 generator | | | credible allegation of compliar | ісе | |
| | during 12 of the pas | st 12 months. Chapter | | | as of November 8, 2024. The | | |
| | 1 1 | 12 NFPA 99 requires monthly | | | provider respectfully requests | | |
| | | ator serving the emergency | | | review with paper compliance | | |
| | | be in accordance with NFPA | | | be considered in establishing | that | |
| | | or Emergency and Standby | | | the provider is in substantial | | |
| | | hapter 8. Chapter 6.4.4.2 of written record of inspection, | | | compliance. | | |
| | - | ising period, and repairs for the | | | Preparation and/or execution of | of. | |
| | - | ularly maintained and available | | | this plan of correction does no | | |
| | for inspection by th | - | | | constitute admission or agreer | | |
| | | eficient practice could affect all | | | by the provider of the truth of t | | |
| | | | 1 | | | Į. | |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE C A. BUILDING B. WING | O1 | (X3) DATE SURVEY COMPLETED 10/29/2024 |
|-----------|---|---|-------------------------------------|---|--|
| NAME OF P | ROVIDER OR SUPPLIEI | ? | | ADDRESS, CITY, STATE, ZIP COD | |
| ENVIVE (| OF RIVER CITY | | | ORTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | * | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY) | BE COMPLETION |
| TAG | | | TAG | | Bitte |
| TAG | residents, staff and Findings include: Based on record reta.m. and 1:15 p.m. Maintenance Director from a sister facility documentation on the log for percentage of period. Based on in review, the facility confirmed there was monthly generator period. This finding was retained. | view on 10/29/24 between 9:30 with the Administrator, facility tor, and Maintenance Director y present, there was no he generator monthly load test of load for the past 12 month interview at the time of record Maintenance Director is no percentage of load on the log for the past 12 month interview with the Administrator ince Director's during the exit | TAG | facts alleged or conclusions forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it required by the provisions of Federal and State law. The Correction is submitted to reduce to the allegation of noncommented during the Life Safety Survey conducted October 2024. 1.) What corrective action(see accomplished for those residents found to have been affected by the deficient practice of the monthly. 2.) How other residents have potential to be affected by the same deficient practice will identified and what correcting action will be taken? All residents had potential affected by this alleged definition practice. Load is now documentally. 3.) What measures will be place or what systemic chanvill be made to ensure that deficient practice does not | /or is of Plan |
| | | | | The Director of Maintenance educated by the Executive | ce was |

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PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 155520 | A. BUILDING B. WING | 01 | COMPLETED 10/29/2024 |
|----------------------------|--|--|----------------------|---|------------------------------------|
| | ROVIDER OR SUPPLIER | | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| × 0030 | NEDA 404 | | | 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 testin This task will auto populate monthly and is required to be signed off. Paper documentati will also be kept. 4.) How the corrective action to 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 revie by the Safety/QAPI Committee led by the Executive Director and/or Maintenance Director. results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved 5.) Date of Completion: Nove 8, 2024 | g. ion will r ? wed e, The d until |
| K 0920 SS=E Bldg. 01 | Extens Based on observation failed to ensure a possubstitute for fixed vLSC 19.5.1 requires 9.1. LSC 9.1.2 requirequipment to complete | ent - Power Cords and on and interview, the facility ower strip was not used as a wiring in one staff only room. tutilities to comply with Section tires electrical wiring and y with NFPA 70, National 11 Edition. NFPA 70, Article | K 0920 | Please accept this Plan of Correction as the provider's credible allegation of compliar as of November 8, 2024. The provider respectfully requests review with paper compliance be considered in establishing | desk to |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|---------------------------|-----------------------|------------------------------------|----------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | a. Building <u>01</u> | | 01 | COMPLETED | |
| | | 155520 | B. WIN | G | | 10/29/ | 2024 |
| | | | \vdash | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | RTH FIRST AVE | | |
| FN\/I\/F | OF RIVER CITY | | | | VILLE, IN 47710 | | |
| | C. 13.7 LTC 011 1 | | 1 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | - | unless specifically permitted, | | | the provider is in substantial | | |
| | | ables shall not be used as a | | | compliance. | | |
| | | wiring of a structure. This | | | | | |
| | - | ould affect Physical Therapy | | | Preparation and/or execution of | | |
| | staff only. | | | | this plan of correction does no | | |
| | | | | | constitute admission or agreer | | |
| | Findings include: | | | | by the provider of the truth of t | | |
| | | | | | facts alleged or conclusions se | et | |
| | | ons on 10/29/24 between 1:15 | | | forth in the Statement of | | |
| | | during a tour of the facility with | | | Deficiencies. The Plan of | | |
| | the facility Mainten | | | | Correction is prepared and/or | | |
| | | or from a sister facility, the | | | executed solely because it is | | |
| | | aff office had a refrigerator | | | required by the provisions of | | |
| | | plugged into a power strip. | | | Federal and State law. The Pla | | |
| | | lged by both Maintenance | | | Correction is submitted to resp | | |
| | Director's at the tim | e of observation. | | | to the allegation of noncomplia | | |
| | 7F1 ' C' 1' | | | | cited during the Life Safety An | | |
| | _ | viewed with the Administrator | | | Survey conducted October 29 | , | |
| | | ice Director's during the exit | | | 2024. | | |
| | conference. | | | | 4 > \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 20 | |
| | 2 1 10(b) | | | | 1.) What corrective action(s) w | /111 | |
| | 3.1-19(b) | | | | be accomplished for those residents found to have been | | |
| | | | | | affected by the deficient practi | 002 | |
| | | | | | anected by the delicient practi | ∪ C : | |
| | | | | | The Maintenance Director h | 26 | |
| | | | | | removed all unapproved items | | |
| | | | | | surge protectors and done a fu | | |
| | | | | | building audit. | ali | |
| | | | | | Sanding addit. | | |
| | | | | | 2.) How other residents have t | he | |
| | | | | | 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 rem | | |
| | | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/29/2024 | |
|---|----------------|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY | | | 909 NC | ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | all unapproved items from sur protectors and completed a fur building audit. 3.) What measures will be put place or what systemic change will be made to ensure that the deficient practice does not occording to the Director of Maintenance we ducated by the Executive Director on K920-Electrical Equipment - Power Cords. High amperage equipment needs plugged in directly to the wall. rated is required in resident careas. This task was added to TELS building system and will auto populate monthly and is required to be signed off. 4.) How the corrective action who 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 review by the Safety/QAPI Committed led by the Executive Director and/or Maintenance Director. results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved. | ge II in es e cur? vas gh UL are the vill r ? wed e, The d until | |

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