STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING -- B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 Dates: 02/05/25 Facility Number: 000439 Provider Number: 155716 AIM Number: 100275070 At this Emergency Preparedness survey, Envive of Evansville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 200 certified beds and had a census of 129 at the time of this survey. Quality Review completed on 02/07/25	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Life Safety Code and Emergency Preparedness Survey conducted February 5, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 26, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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 Dates: 02/05/25 Facility Number: 000439	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Trevino	Executive Director	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	Provider Number: 155716 AIM Number: 100275070 At this Life Safety Code survey, Envive of Evansville 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, both basements, and all resident sleeping rooms. The facility has a capacity of 200 certified beds and had a census of 129 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds used for facility storage and one plastic shed used for bio hazard waste. Quality Review completed on 02/07/25		required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Life Safety Code and Emergency Preparedness Survey conducted February 5, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 26, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure exit signage was provided for 1 of 3 exits from the basement in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any	K 0293	**K293** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** There are no residents affected by	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff while in the basement. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, there was no illuminated EXIT sign located in the back southeast corridor of the basement to lead staff to the breezeway ramp exit. Based on interview at the time of observation, the Maintenance Director agreed there should be an illuminated EXIT sign in the back southeast corridor to help lead staff to the breezeway ramp exit in the event of an emergency. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		the missing exit sign in the basement. An illuminated EXIT sign has been installed in the back Southeast corridor in the basement. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The basement is a staff only area; therefore, no residents have the potential to be affected by the missing exit sign in the basement. An illuminated EXIT sign has been installed in the back Southeast corridor in the basement. A walkthrough of the facility has been conducted to determine if any additional exit signage is needed. There were no additional EXIT signs missing. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance has been educated on the regulation regarding exit signage. A walkthrough of the facility has been conducted to determine if any additional exit signage is needed. An audit will be created to monitor that exit signage remains in place. **How the corrective action will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 practice will not recur, i.e., what quality assurance program will be put into place: Maintenance or designee will audit one section of facility per week for six months to determine if exit signage remains in place. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous area doors, such as a Central Supply storage room door, was provided with a self closing device. This deficient practice could at least 20 residents and staff. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, the Central Supply storage room corridor door was locked, however, it was not provided with a self closing device. The room was over 50 square feet in size and stored over 100 cardboard boxes full of supplies	K 0321	**K321** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A self-closing device has been added to the Central Supply door. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	and several shelves with other combustible items, such as paper, plastic, and cardboard boxes. Based on interview at the time of observation, the Maintenance Director acknowledged the Central Supply storage room was not provided with a self closing device. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		There were no other hazardous areas without a self-closing device. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance has been educated on the requirements for which areas require self-closing devices. **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:** Maintenance or designee will audit one section of the facility per week for the continued presence of self-closing devices. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 3 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, the main kitchen was provided with a UL 300 hood system. Based on interview with two kitchen staff, when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, one staff person said he did not know, the second staff person said she would cover the fire with a pan and then try to turn things off. When asked, she also said she had worked in the kitchen for 12 years. Neither kitchen staff person mentioned activating the pull station for the hood suppression system. This was acknowledged by the Maintenance Director at the time of observation and interview with the two kitchen staff people. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.	K 0324	**K 324** **What corrective action will be accomplished for those residents found to have been affected:** Dietary staff were educated on the activation of the UL 300 hood system. Maintenance will install marks on the floor of the kitchens to designate where kitchen equipment should be placed to ensure it remains appropriately placed withing the fire-extinguishing system. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Dietary staff were educated on the activation of the UL 300 hood system. Maintenance will install marks on the floor of the kitchens to designate where kitchen equipment should be placed to ensure it remains appropriately placed within the fire-extinguishing system. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff were educated on the activation of the UL 300 hood system. All new dietary staff will	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	3.1-19(b) 2. Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 3 of 3 kitchen hood extinguishing systems. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during the tour of the facility with the Maintenance Director, the gas stoves, deep fryers, and flat grill located under the hood in each of the three kitchens were not provided with an approved method that would ensure that		be educated on the activation of the UL 300 hood system as part of their job specific orientation. Dietary and Maintenance staff were educated on the placement of kitchen equipment and how to determine where they need to be placed if moved for service or cleaning. **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:** The Maintenance Director or designee will interview two dietary staff members per week to determine if they know how to activate the UL 300 hood system and if they know how to determine where the equipment should be placed and reeducate them if they are unable to correctly respond to the questions. Dietary manager or designee will audit the kitchen floors weekly to determine if the marks remain in place and determine if the kitchen equipment is placed within the fire extinguishing system. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	the appliances were returned to an approved design location after they had been moved for maintenance and/or cleaning. Based on interview at the time of observations, the Maintenance Director was not aware an approved method had to be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning, but said he would ensure it was completed as soon as possible. This finding was not reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include:	K 0345	**K 345** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A visual inspection of all devices connected to the fire alarm system was completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A visual inspection of all devices connected to the fire alarm system was completed. **What measures will be put into**	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 02/05/25 between 9:45 a.m. and 2:15 p.m. with the Executive Director and Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 08/08/24 by the facility's fire alarm inspection vendor, which included a visual and functional test/inspection of all devices connected to the fire alarm system. There was no semi-annual visual inspection six months prior to the annual inspection available for review. Based on interview at the time of record review, the Maintenance Director confirmed the 08/08/24 annual fire alarm system inspection report was the only report available for the past 12 month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance was educated on the requirements for a semi-annual visual inspection of the fire alarm system. A task was placed in TELs to indicate when the semi-annual visual inspection is due. **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:** Executive Director audited task in TELs to determine completion. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after 12 months with at least two consecutive semi-annual visual inspections completed. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the	K 0353	**K353**	07/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 failed to ensure sprinkler heads in 2 of 18 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff and at least 20 resident, as well as staff and visitors. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was one sprinkler head in the Furnace Room within the main kitchen that was covered with corrosion. b. There was one sprinkler head in the #3 walk-in cooler covered with corrosion. c. There were four sprinkler heads in the corridor outside the Pathways #1 kitchen covered with corrosion. d. There were five sprinkler heads in the Pathways #1 kitchen covered with corrosion. Based on interview at the time of observations, the Maintenance Director agreed the previously mentioned sprinkler heads were covered with corrosion. This finding was reviewed with the Executive Director and Maintenance Director during the exit		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The sprinkler head in the Furnace Room within the main kitchen, in the #3 walk-in cooler, the four sprinklers in the corridor outside the Pathways-1 kitchen, and the five sprinklers in the Pathways-1 kitchen will be replaced. A temporary waiver has been requested to allow time for the sprinkler parts to arrive and be installed by Koorsen. A quote has been obtained and approved. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any additional sprinklers with corrosion were identified and will be replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance visually inspected all sprinkler heads in the facility and identified additional areas of corrosion. Quotes have been obtained for replacement of the identified sprinkler heads. Maintenance has been educated on the regulations governing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 18 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, there were two ceiling tiles damaged and partly missing leaving approximately 10 inch holes within the Furnace Room within the kitchen. Based on interview at the time of observation, the Maintenance Director acknowledged the damaged and partly missing ceiling tiles within the Furnace Room within the kitchen. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		sprinkler heads and how to identify those in need of replacement. **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:** The Maintenance Director, or designee will audit one area of the facility each week to visually check sprinkler heads to identify any in need of replacement. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** July 30, 2025	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 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	K 0511	**K 511** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The two GFCI receptacles have	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	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) 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		been installed in the West Med room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other wet areas of the facility have been reviewed and no additional missing GFCI receptacles have been identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff have been educated on the requirement for GFCI receptacles. **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:** Maintenance Director or designee will monitor one area of the facility per week to ensure that GFCI receptacles are in place per regulations. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	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 one or two staff. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the Maintenance Director, there were two electric receptacles within five feet of the sink in the west Med Room not provided with GFCI protection. When tested with a GFCI testing device the receptacles did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the receptacles in the west Med Room were not properly GFCI protected. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states that any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include:	K 0711	**K 711** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A color-coded facility map has been created to easily identify the location of smoke barriers to identify where the next compartment is located. An explanation of the use of the K class extinguisher in relationship to the use of the kitchen overhead extinguishing system was added to the fire plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A color-coded facility map has been created to easily identify the location of smoke barriers to identify where the next compartment is located. An explanation of the use of the K class extinguisher in relationship to the use of the kitchen overhead extinguishing system was added to the fire plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 a review of the facility's Fire Plan on 02/05/25 between 9:45 a.m. and 2:15 p.m. with the Executive Director and Maintenance Director present, the plan did not address the following: a. The plan did address evacuation of the smoke compartment; however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Executive Director and Maintenance Director acknowledged the Fire Plan did not include the previously mentioned items. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**practice does not recur:** Staff were educated on how to identify the smoke compartments based on the color-coded map. Dietary staff were educated on the use of the K class extinguisher in relationship to the use of the kitchen overhead extinguishing system. **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:** An audit will be completed weekly by Maintenance Director or designee to ensure that the color-coded maps remain in place. An audit will be completed by Maintenance Director or designee on two dietary employees per week to ensure that they understand the use of the K class extinguisher in relationship to the use of the kitchen overhead extinguishing system. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in two staff only rooms. 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 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 staff only. Findings include: Based on observations on 02/05/25 between 2:15 p.m. and 5:15 p.m. during a tour of the facility with the facility Maintenance Director, the following was noted: a. The Nursing Scheduler Office had a microwave oven plugged into a power strip. b. The Pathways #1 employee breakroom had a microwave oven and toaster plugged into a power strip. This was acknowledged by the Maintenance Director at the time of each observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0920	February 26, 2025 **K 920** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by using the power strips in the Nursing Scheduler Office and in the Pathways-1 Employee Breakroom. The power strips have been removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any other area with a power strip in use has the potential to be affected. Power strips will be removed from other areas of the facility when being used as a substitute for fixed wiring of a structure. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been educated that power strips may not be used as a substitute for fixed wiring in a structure.	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
			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: Maintenance will audit one area of the facility per week for the presence of power strips. Power strips used in place of fixed wiring will be removed. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in	K 0921	**K921** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The facility will perform PCREE related inspections for all fixed and portable patient-care related electrical equipment.	07/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 02/05/25 between 9:45 a.m. and 2:15 p.m. with the Executive Director and Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment. Based on interview at the time of record review, the Executive Director and Maintenance Director said the facility has not tested and documented the PCREE items as of yet. Based on observation between 2:15 p.m. to 5:30 p.m. during a tour of the facility with the Maintenance Director , it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. The facility will perform PCREE related inspections for all fixed and portable patient-care related electrical equipment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Facility will obtain the required testing equipment and establish a testing policy. Pertinent staff will be trained on the policy and in how to complete the testing and record the results. All PCREE both fixed and portable will have an initial testing completed. Any new PCREE obtained with have the PCREE testing completed and documented prior to being placed into use. A temporary waiver has been requested to allow time for obtaining the equipment, creating policies, and necessary staff training. **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
	155716	A. BUILDING 01 B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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 Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		Upon completion of the initial testing, maintenance will complete a weekly audit on one area of the facility per week to ensure that any equipment in place has been tested and has documentation. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** July 30, 2025	