STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155716	B. WING		02/05/2025
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	PROVIDER OR SUPPLIEF	R		BOEKE RD	
ENVIVE	OF EVANSVILLE			SVILLE, IN 47711	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg					
Ŭ	An Emergency Pre	paredness Survey was	E 0000	Preparation or execution of th	is
		diana Department of Health in		plan of correction does not	
	accordance with 42	-		constitute admission or agree	ment
				of provider of the truth of the f	
	Survey Dates: 02/05/25			alleged or conclusions set for the Statement of Deficiencies	th on
	Facility Number: 0	000439		Plan of Correction is prepared	
	Provider Number:			executed solely because it is	
	AIM Number: 100			required by the position of Fe	deral
	1111111110111001111100	2,00,0		and State Law. The Plan of	20101
	At this Emergency	Preparedness survey, Envive		Correction is submitted to res	pond
	of Evansville was found in compliance with			to the allegation of noncompli	•
		edness Requirements for		citedduring the Life Safety Code	
		caid Participating Providers		and Emergency Preparednes	
	and Suppliers, 42 C			Survey conducted February 5	
	and supplies, 12 c	110 1001/101		2025.	,
	The facility has a ca	apacity of 200 certified beds		Please accept this Plan of	
	-	129 at the time of this survey.		Correction as the provider's	
		125 00 012 01110 01 0110 001 001		credible allegation of complian	nce
	Ouality Review cor	mpleted on 02/07/25		as of February 26, 2025. The	
	(provider respectfully requests	desk
				review with paper compliance	
				be considered in establishing	
				the provider is in substantial	
				compliance.	
K 0000					
Bldg. 01					
	A Life Safety Code	Recertification and State	K 0000	Preparation or execution of th	is
	•	vas conducted by the Indiana	12 0000	plan of correction does not	
		Ith in accordance with 42 CFR		constitute admission or agree	ment
	483.90(a).			of provider of the truth of the f	
	. ,			alleged or conclusions set for	
	Survey Dates: 02/0	05/25		the Statement of Deficiencies	
	•			Plan of Correction is prepared	l and
	Facility Number: 0	000439		executed solely because it is	
				<u> </u>	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

(X6) DATE

Tara Trevino **Executive Director** 02/21/2025

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/05/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR Provider Number: AIM Number: 1000 At this Life Safety of Evansville was four Requirements for Pomedicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I. Health Care Occupate This one story facility basements was detected to the construction and was facility has a fire also smoke detectors in the corridors, both the sleeping rooms. The certified beds and hof this survey. All areas where resist were sprinklered an services were sprinklered and	Code survey, Envive of and not in compliance with articipation in 42 CFR Subpart 483.90(a), and the 2012 edition of the etion Association (NFPA) 101, and articipation (NFPA) 101, and articipation (NFPA) 101, and articipation and 410 IAC 16.2. The arm system with hard wired the corridors, spaces open to passements, and all resident are facility has a capacity of 200 and a census of 129 at the time are specified at the corridors, spaces open to be assembly and an are specified at the time.	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) required by the position of and State Law. The Plan of Correction is submitted to reto the allegation of noncomplete cited during the Life Safety and Emergency Prepared and Survey conducted Februar 2025. Please accept this Plan of Correction as the provider's credible allegation of complete as of February 26, 2025. The provider respectfully requein review with paper compliar be considered in establishing the provider is in substantial compliance.	Federal of respond inpliance Code iness beliance the sets desk ince to ing that	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation failed to ensure exit 3 exits from the bas 7.10. LSC 7.10.1.2 exit doors that obvious identifiable as exits	on and interview, the facility signage was provided for 1 of ement in accordance with LSC. I exits, other than main exterior ously and clearly are, shall be marked by an s readily visible from any	K 0293	K293 What corrective action wi accomplished for those residents found to have b affected by the deficient practice: There are no residents affe	peen	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155716	B. WI	NG		02/05/2	2025	
	PROVIDER OR SUPPLIED OF EVANSVILLE SUMMARY	STATEMENT OF DEFICIENCIE		601 N E	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE	
	horizontal componer an exit enclosure short directional exit so the egress path is not practice could affect in the breezeway rample the breezeway rample emergency.	cess. LSC 7.10.1.2.2 states ents of the egress path within hall be marked by approved exit eigns where the continuation of ot obvious. This deficient et staff while in the basement. cons on 02/05/25 between 2:15 during a tour of the facility with irector, there was no ign located in the back of the basement to lead staff to pexit. Based on interview at tion, the Maintenance Director I be an illuminated EXIT sign st corridor to help lead staff to pexit in the event of an eviewed with the Executive enance Director during the exit			the missing exit sign in the basement. An illuminated EXI 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 at therefore, no residents have the potential to be affected by the missing exit sign in the basement. An illuminated EXI 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 exisignage is needed. There were additional EXIT signs missing. What measures will be put in 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 exisignage. A walkthrough of the facility has been conducted to determine if any additional exisignage is needed. An audit we created to monitor that exit signage remains in place. How the corrective action will be monitored to ensure the	the ne		

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

PRINTED: 02/25/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155716	A. BUILDING B. WING	01	COMPLETED 02/05/2025		
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
14.0004				deficient practice will not recur, i.e., what quality assurance program will be p into place: Maintenance or designee will one section of facility per wee six months to determine if exit signage remains in place. Results of the audit will be reviewed by QA team during 0 meetings. POC may be revisu updated, based on QA review needed to achieve, and maint compliance. Audits may be discontinued after six months at least two consecutive mont 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	audit k for t QAPI ed or r, as ain with hs of		
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure on and interview, the facility	K 0321	K321	02/26/2025		
	failed to ensure 1 or such as a Central St provided with a self-practice could at lease. Findings include: Based on observation p.m. and 5:15 p.m. the Maintenance Distorage room corridit was not provided	f over 20 hazardous area doors, apply storage room door, was f closing device. This deficient ast 20 residents and staff. Ons on 02/05/25 between 2:15 during a tour of the facility with rector, the Central Supply for door was locked, however, with a self closing device.	K 0321	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 device has been add	n loor. the ne be		
	The room was over	with a self closing device. 50 square feet in size and dboard boxes full of supplies		same deficient practice will lidentified and what correctivaction will be taken:			

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

PRINTED: 02/25/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	e survey pleted 5/2025
	PROVIDER OR SUPPLIEI	R	601 N	ADDRESS, CITY, STATE, ZIP C BOEKE RD SVILLE, IN 47711	COD	
ENVIVE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF and several shelves such as paper, plast Based on interview Maintenance Direct Supply storage roof closing device. This finding was re-	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION with other combustible items, tic, and cardboard boxes. That the time of observation, the tor acknowledged the Central m was not provided with a self eviewed with the Executive tenance Director during the exit			e put into mic to ent ur: n educated or which ing devices. ction will re the not cy vill be put nee will audit ity per week ence of ll be during QAPI ne revised or a review, as d maintain ay be months with we months of ieved. iemic	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities	3		February 26, 2025		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL			ETED
		155716	B. W	ING		02/05/2	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			BOEKE RD		
FNVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711				
	C. LV/IIIOVILLL			LVANC	· · · · · · · · · · · · · · · · · · ·		
(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 APPROPRIATE		TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ation and interview, the	K 0	324	K 324		02/26/2025
		sure staff were instructed in the			What corrective action will b	е	
		L 300 hood fire suppression			accomplished for those		
	-	chen. NFPA 96, Standard for			residents found to have been	n	
		and Fire Protection of			affected:		
		ng Operations, Section 10.5.7			Dietary staff were educated or	n the	
		all be provided to employees			activation of the UL 300 hood		
		r use of portable fire			system.		
	-	ne manual activation of			Maintenance will install marks	on	
		quipment. Section 11.1.4 states			the floor of the kitchens to		
		nually operating the fire			designate where kitchen		
	extinguishing system shall be posted				equipment should be placed to		
	conspicuously in the kitchen and shall be				ensure it remains appropriatel	ly	
	reviewed with employees by management. This				placed withing the		
	deficient practice co	ould affect mostly kitchen staff.			fire-extinguishing system.		
	Findings include:				How other residents having	the	
	i mamga maraati				potential to be affected by th		
	Based on observation	ons on 02/05/25 between 2:15			same deficient practice will I		
		during a tour of the facility with			identified and what corrective	1	
		rector, the main kitchen was			action will be taken:		
		300 hood system. Based on			Dietary staff were educated or	n the	
	-	kitchen staff, when asked what			activation of the UL 300 hood		
		if there was a fire underneath			system.		
	-	the range hood suppression			Maintenance will install marks	on	
	-	omatically activated, one staff			the floor of the kitchens to		
	-	not know, the second staff			designate where kitchen		
	-	ıld cover the fire with a pan			equipment should be placed to	o	
	-	things off. When asked, she			ensure it remains appropriatel		
	also said she had we	orked in the kitchen for 12			placed within the fire-extinguis	-	
	years. Neither kitch	nen staff person mentioned			system.		
	activating the pull s	tation for the hood					
	suppression system	. This was acknowledged by			What measures will be put ir	nto	
		rector at the time of			place and what systemic		
		erview with the two kitchen			changes will be made to		
	staff people.				ensure that the deficient		
					practice does not recur:		
	_	viewed with the Executive			Dietary staff were educated or	n the	
	Director and Mainte	enance Director during the exit			activation of the UL 300 hood		
	conference.				system. All new dietary staff v	will	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLE	ETED
		155716	B. W	ING		02/05/2	2025
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			BOEKE RD		
ENVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					be educated on the activation		
	3.1-19(b)				the UL 300 hood system as p	art of	
	2. Based on observation and interview, the				their job specific orientation.		
					Dietary and Maintenance staf		
		ovide an approved method for			were educated on the placem		
		appliances to where they were			of kitchen equipment and hov		
		ood extinguishing equipment			determine where they need to		
	_	nstalled for 3 of 3 kitchen hood			placed if moved for service or	·	
		ms. NFPA 96, Standard for			cleaning.		
		and Fire Protection of			How the corrective action w	ill	
		ng Operations Section 2011			be monitored to ensure the		
	Edition Section 12.1.2.2, states cooking appliances				deficient practice will not		
		n shall not be moved, modified,			recur, i.e., what quality		
	_	out prior re-evaluation of the			assurance program will be p	out	
		system by the system installer			into place:		
		unless otherwise allowed by			The Maintenance Director or		
	_	e extinguishing system.			designee will interview two die	etary	
		ates the fire-extinguishing			staff members per week to		
		quire reevaluation where the			determine if they know how to		
		are moved for the purposes of			activate the UL 300 hood sys		
		eaning, provided the			and if they know how to deter		
		rned to approved design			where the equipment should		
	•	oking operations, and any			placed and reeducate them if	,	
		xtinguishing system nozzles			are unable to correctly respor	nd to	
		iances are reconnected in			the questions.		
		e manufacturer's listed design			Dietary manager or designee		
		.1.2.3.1 states an approved			audit the kitchen floors weekly		
	_	ovided that will ensure that the			determine if the marks remain	I	
		ed to an approved design			place and determine if the kite		
		eient practice could affect			equipment is placed within the	e fire	
	mostly kitchen staff	t.			extinguishing system.		
					Results of the audit will be		
	Findings include:				reviewed by QA team during		
		00/05/05/			meetings. POC may be revis		
		ons on 02/05/25 between 2:15			updated, based on QA review		
	_	during the tour of the facility			needed to achieve, and main	tain	
		ce Director, the gas stoves,			compliance. Audits may be		
		t grill located under the hood			discontinued after six months		
		kitchens were not provided			at least two consecutive mon	ths of	
	I with an approved m	nethod that would ensure that	1		100% compliance achieved		

CENTERS FOR	R MEDICARE & MEDIC		OM	B NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL		
		155716	B. W.	ING		02/05/	/2025	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0345	design location after maintenance and/or at the time of obser Director was not aw to be provided to er returned to an appromaintenance or clear ensure it was composed. This finding was not administrator and lexit conference. 3.1-19(b) NFPA 101	returned to an approved r they had been moved for cleaning. Based on interview vations, the Maintenance vare an approved method had asure that the appliances were oved design location after uning, but said he would leted as soon as possible. of reviewed with the Maintenance Director at the			By what date the systemic changes for each deficiency will be completed: February 26, 2025			
SS=F Bldg. 01	failed to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual inspe accordance with the more often if requir jurisdiction. Table must be visually insa. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op	view and interview, the facility of 1 fire alarm system in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ections shall be performed in eschedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors (e.g. duct detectors, manual eat detectors, smoke detectors, siances	K 0	345	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 device connected to the fire alarm system was completed. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken: A visual inspection of all device connected to the fire alarm system was completed.	n ces the ne be ve	02/26/2025	

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Findings include:

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What measures will be put into

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE C A. BUILDING B. WING	01	DATE SURVEY COMPLETED 02/05/2025	
	PROVIDER OR SUPPLIER		601 N	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	a.m. and 2:15 p.m. Maintenance Direct documentation proval alarm system inspectacility's fire alarm included a visual arall devices connected. There was no semimonths prior to the review. Based on it review, the Mainter 08/08/24 annual fire report was the only month period.	view on 02/05/25 between 9:45 with the Executive Director and for present, there was vided regarding an annual fire etion dated 08/08/24 by the inspection vendor, which ad functional test/inspection of ed to the fire alarm system. annual visual inspection available for interview at the time of recordinance Director confirmed the e alarm system inspection report available for the past 12 viewed with the Executive enance Director during the exit		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 QAF meetings. POC may be revised of 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.	P] or	
K 0353 SS=E Bldg. 01		- Maintenance and Testing ation and interview, the	K 0353	K353	07/30/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMI			ETED
		155716	B. WI	NG		02/05/	2025
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					BOEKE RD		
EINVIVE	OF EVANSVILLE			EVANS	SVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN 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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility failed to ens	sure sprinkler heads in 2 of 18			What corrective action will b	е	
		ats covered with corrosion were			accomplished for those		
	_	5, 2011 edition, at 5.2.1.1.1			residents found to have been	n I	
	_	show signs of leakage; shall			affected by the deficient		
		, foreign materials, paint, and			practice:		
		nd shall be installed in the			The sprinkler head in the Furr	nace	
		(e.g., up-right, pendent, or			Room within the main kitchen		
		nore, at 5.2.1.1.2 any sprinkler			the #3 walk-in cooler, the four		
	· · · · · · · · · · · · · · · · · · ·	any of the following shall be			sprinklers in the corridor outsi		
		age (2) Corrosion (3) Physical			the Pathways-1 kitchen, and t		
		f fluid in the glass bulb heat			five sprinklers in the Pathways		
	• • • •	(5) Loading (6) Painting			kitchen will be replaced.		
	unless painted by the sprinkler manufacturer.				A temporary waiver has been		
	This deficient practice could affect kitchen staff				requested to allow time for the		
	_	lent, as well as staff and			sprinkler parts to arrive and be		
	visitors.	,			installed by Koorsen. A quote		
					been obtained and approved.		
	Findings include:				Достинатов ста арристов		
					How other residents having	the	
	Based on observation	ons on 02/05/25 between 2:15			potential to be affected by the		
		during a tour of the facility with			same deficient practice will I		
		irector, the following was			identified and what corrective		
	noted:	,			action will be taken:		
		prinkler head in the Furnace			Any additional sprinklers with		
		ain kitchen that was covered			corrosion were identified and will		
	with corrosion.			be replaced.			
	b. There was one s	prinkler head in the #3 walk-in			'		
	cooler covered with	•			What measures will be put in	nto	
		sprinkler heads in the corridor			place and what systemic		
		ys #1 kitchen covered with			changes will be made to		
	corrosion.	•			ensure that the deficient		
	d. There were five	sprinkler heads in the			practice does not recur:		
		en covered with corrosion.			Maintenance visually inspecte	ed all	
	1	at the time of observations,			sprinkler heads in the facility a		
		irector agreed the previously			identified additional areas of		
		r heads were covered with			corrosion. Quotes have been		
	corrosion.				obtained for replacement of th		
					identified sprinkler heads.	-	
	This finding was re	viewed with the Executive			Maintenance has been educa	ted	
	_	enance Director during the exit			on the regulations governing		
	1				1 alo logaladono govorning		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	COMPLETED	
		155716	B. W	ING		02/05/	/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R			BOEKE RD			
FN\/I\/F	OF EVANSVILLE				SVILLE, IN 47711			
	OI EVANOVILLE			LV/IIIO	, , , , , , , , , , , , , , , , , , ,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		.TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	conference.				sprinkler heads and how to ide	-		
					those in need of replacement.			
	3.1-19(b)							
					How the corrective action wi	II		
		ration and interview, the			be monitored to ensure the			
	1	sure the ceiling in 1 of 18			deficient practice will not			
		compartments was maintained			recur, i.e., what quality			
	•	eads to function to their full			assurance program will be p	ut		
		ficient practice could affect			into place:			
	mostly kitchen staff	f.			The Maintenance Director, or			
					designee will audit one area o	f the		
	Findings include:				facility each week to visually			
					check sprinkler heads to ident	ify		
	Based on observations on 02/05/25 between 2:15				any in need of replacement.			
	1	during a tour of the facility with			Results of the audit will be			
		irector, there were two ceiling			reviewed by QA team during QAPI			
		partly missing leaving			meetings. POC may be revise			
		nch holes within the Furnace			updated, based on QA review			
		tchen. Based on interview at			needed to achieve, and maint	ain		
		tion, the Maintenance Director			compliance. Audits may be			
	_	damaged and partly missing			discontinued after six months			
	I -	the Furnace Room within the			at least two consecutive mont	ns of		
	kitchen.				100% compliance achieved.			
					By what date the systemic			
	_	viewed with the Executive			changes for each deficiency			
		enance Director during the exit			will be completed:			
	conference.				July 30, 2025			
	3.1-19(b)							
K 0511	NEDA 404							
	NFPA 101							
SS=D	Utilities - Gas and	Electric						
Bldg. 01	Deceded 1 C		1	-11			02/26/2025	
		on and interview, the facility	K 0	511	K 511	_	02/26/2025	
		f over 20 wet locations was			What corrective action will b	е		
	1 -	nd fault circuit interrupter			accomplished for those	_		
		against electric shock. NFPA			residents found to have been	1		
	· ·	ion at 210.8 Ground-Fault			affected by the deficient			
	1	Protection for Personnel,			practice: The two GECI recentacles have	10		
	L STATES, STOUDG-TAILIT	CHCHI-IIICH UDUOH TOF	1		L THE IWO GELT (ECEDIACIES NAV	.,⊢		

	MEDICARE & MEDIC		I		ONIB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155716	B. WING		02/05/2025	
NAME OF P	ROVIDER OR SUPPLIER	• }		ADDRESS, CITY, STATE, ZIP COD	-	
				BOEKE RD		
ENVIVE	OF EVANSVILLE		EVANS	SVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	personnel shall be p	provided as required in		been installed in the West Me	ed	
	210.8(A) through (0	C). The ground-fault		room.		
	circuit-interrupter sl	hall be installed in a readily				
	accessible location.					
	Informational Note:	: See 215.9 for ground-fault		How other residents having	the	
	circuit interrupter p	rotection for personnel on		potential to be affected by the		
	feeders.	•		same deficient practice will		
		relling Units. All 125-volt,		identified and what corrective		
	1 1	nd 20-ampere receptacles		action will be taken:		
		tions specified in 210.8(B)(1)		Other wet areas of the facility	have	
through (8) shall have ground-fault			been reviewed and no addition			
circuit-interrupter protection for personnel.			missing GFCI receptacles ha			
			been identified.	ve		
	(1) Bathrooms			been identified.		
	(2) Kitchens			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4	
	(3) Rooftops			What measures will be put i	nto	
	(4) Outdoors	(2) 1(A) D 1 . 1 .		place and what systemic		
	-	(3) and (4): Receptacles that are		changes will be made to		
	-	ole and are supplied by a		ensure that the deficient		
		cated to electric snow-melting,		practice does not recur:		
		and vessel heating equipment		Maintenance Staff have been		
	-	o be installed in accordance		educated on the requirement	for	
	with 426.28 or 427.			GFCI receptacles.		
	-	(4): In industrial establishments				
	only, where the con	ditions of maintenance and		How the corrective action w	ill	
	_	that only qualified personnel		be monitored to ensure the		
		sured equipment grounding		deficient practice will not		
	conductor program	as specified in 590.6(B)(2)		recur, i.e., what quality		
	shall be permitted for	or only those receptacle		assurance program will be p	out	
	outlets used to supp	ly equipment that would		into place:		
		ard if power is interrupted or		Maintenance Director or design	gnee	
		t is not compatible with GFCI		will monitor one area of the fa	-	
	protection.	-		per week to ensure that GFC	-	
	*	eceptacles are installed within		receptacles are in place per		
		outside edge of the sink.		regulations.		
		(5): In industrial laboratories,		Results of the audit will be		
	•	supply equipment where		reviewed by QA team during	_{OAPI}	
	_	yould introduce a greater		meetings. POC may be revis		
	_	nitted to be installed without		updated, based on QA review		
	GFCI protection.	miles to be instance without		needed to achieve, and main		
	_	(5): For recentuales located in			lalli	
	Exception No. 2 to	(5): For receptacles located in	1	compliance. Audits may be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/05/2025					
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N E	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE			
IAG	patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet locat (7) Locker rooms we facilities (8) Garages, service electrical diagnostic tools. NFPA 70, 517-20 Wereceptacles and fixes the wet location to be interrupter (GFCI) preduce the contact relectrical insulation. This deficient pract staff. Findings include: Based on observation p.m. and 5:15 p.m. the Maintenance Direct with a receptacles within for Med Room not provided with a receptacles did not be a seed on interview. Maintenance Direct the west Med Room protected. This finding was receptacles.	s of general care or critical care facilities other than those protection shall not be required.	IAG	discontinued after six months at least two consecutive mont 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	with hs of	DATE			
	3.1-19(b)								

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 02/05/2025	
	PROVIDER OR SUPPLIEF	8	601	EET ADDRESS, CITY, STATE, ZIP COE N BOEKE RD ANSVILLE, IN 47711)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APP	CTION (X5) JUD BE COMPLETION ROPRIATE DATE
K 0711 SS=F Bldg. 01	failed to provide a comparison of the following: (1) Use of alarms (2) Transmission of (3) Emergency pho (4) Response to alar (5) Isolation of fire (6) Evacuation of fire (6) Evacuation of some (8) Preparation of (8) Preparation of the evacuation (9) Extinguishment Section 19.2.3.4(4) corridor shall not be width where serving patient sleeping room required width shall equipment provided equipment during a addressed in the writaining program for equipment is limite i. Equipment in use ii. Medical emerger	view and interview, the facility complete facility specific clan for the protection of all ely address all life safety tem addressing all items 101, 2012 edition, Section 2.2.2 requires a written health care ty plan that shall provide for a call to fire department the call to fire department the call to fire department the compartment cloors and building for the states that any required aisle or the less than 48 inches in clear gray as means of egress from the libe permitted for wheeled the relocation of wheeled the relocation of wheeled the fire or similar emergency is sitten fire safety plan and the racility. The wheeled the carts in use they equipment not in use	K 0711	K 711 What corrective action of accomplished for those residents found to have affected by the deficient practice: A color-coded facility made been created to easily idelocation of smoke barrier identify where the next compartment is located. An explanation of the use class extinguisher in relate to the use of the kitchent extinguishing system was to the fire plan. How other residents have potential to be affected same deficient practice identified and what correction will be taken: A color-coded facility made been created to easily idelocation of smoke barrier identify where the next compartment is located. An explanation of the use class extinguisher in relate to the use of the kitchent extinguishing system was	p has entify the s to e of the K tionship overhead s added ving the by the will be rective p has entify the s to e of the K tionship overhead
		ransport equipment ice could affect all occupants mergency.		to the fire plan. What measures will be place and what systemi	c

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ensure that the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDIN	IG <u>01</u>	COMPLETED	
155716		B. WING		02/05/2025		
			CALL CALL	EET ADDRESS CITY CTATE TID COD		
NAME OF I	PROVIDER OR SUPPLIE	3		EET ADDRESS, CITY, STATE, ZIP COD		
				I N BOEKE RD		
ENVIVE	OF EVANSVILLE		EV/	ANSVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTIO	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE COMPLETION	
TAG	· ·		TAG	DEFICIENCY)	DATE	
	Based on a review	of the facility's Fire Plan on		practice does not recur:		
	02/05/25 between 9	2:45 a.m. and 2:15 p.m. with the		Staff were educated on how	v to	
		and Maintenance Director		identify the smoke compart		
		d not address the following:		based on the color-coded n	l l	
		dress evacuation of the smoke				
	_	ever, the plan did not identify		Dietary staff were educated use of the K class extinguis		
	_	arriers were located in the		relationship to the use of th	l l	
	facility and evacua			kitchen overhead extinguisl		
	-	L-class fire extinguisher in the		system.	9	
		hip with the use of the kitchen		System.		
	overhead extinguis	-		How the corrective action	will	
		at the time of record review,		be monitored to ensure th		
		etor and Maintenance Director		deficient practice will not		
	acknowledged the Fire Plan did not include the			recur, i.e., what quality		
previously mentioned items.			assurance program will be	nut		
	previously mention	od nems.		into place:	, put	
This finding was reviewed with the Executive			An audit will be completed	weekly		
Director and Maintenance Director during the exit conference.			by Maintenance Director or	-		
			designee to ensure that the			
	conference.			color-coded maps remain in		
	3.1-19(b)			An audit will be completed	•	
	3.1 15(0)			Maintenance Director or de	•	
				on two dietary employees p	_	
				week to ensure that they		
				understand the use of the k	Colass	
				extinguisher in relationship		
				use of the kitchen overhead		
				extinguishing system.	·	
				Results of the audit will be		
				reviewed by QA team durin	a OARI	
				meetings. POC may be rev	-	
				updated, based on QA revi		
				needed to achieve, and ma	l l	
				compliance. Audits may be		
				discontinued after six mont		
				at least two consecutive mo		
				100% compliance achieved		
				By what date the systemic		
				changes for each deficien	СУ	
1				will be completed:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155716 B. WING 02/05/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE. IN 47711** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE February 26, 2025 K 0920 **NFPA 101** SS=E Electrical Equipment - Power Cords and Bldg. 01 Extens Based on observation and interview, the facility K 0920 K 920 02/26/2025 failed to ensure power strips were not used as a What corrective action will be substitute for fixed wiring in two staff only rooms. accomplished for those LSC 19.5.1 requires utilities to comply with Section residents found to have been 9.1. LSC 9.1.2 requires electrical wiring and affected by the deficient equipment to comply with NFPA 70, National practice: Electrical Code, 2011 Edition. NFPA 70, Article No residents were affected by 400.8 requires that, unless specifically permitted, using the power strips in the flexible cords and cables shall not be used as a Nursing Scheduler Office and in substitute for fixed wiring of a structure. This the Pathways-1 Employee deficient practice could affect staff only. Breakroom. The power strips have been removed. Findings include: How other residents having the Based on observations on 02/05/25 between 2:15 potential to be affected by the p.m. and 5:15 p.m. during a tour of the facility with same deficient practice will be the facility Maintenance Director, the following identified and what corrective was noted: action will be taken: a. The Nursing Scheduler Office had a microwave Any other area with a power strip oven plugged into a power strip. in use has the potential to be b. The Pathways #1 employee breakroom had a affected. Power strips will be microwave oven and toaster plugged into a power removed from other areas of the strip. facility when being used as a This was acknowledged by the Maintenance substitute for fixed wiring of a Director at the time of each observation. structure. This finding was reviewed with the Executive What measures will be put into Director and Maintenance Director during the exit place and what systemic conference. changes will be made to ensure that the deficient 3.1-19(b) practice does not recur: Staff have been educated that power strips may not be used as a substitute for fixed wiring in a structure.

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		A. BUILDING 01 B. WING		COMPLETED 02/05/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
				How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Maintenance will audit one are the facility per week for the presence of power strips. Powstrips used in place of fixed will be removed. Results of the audit will be reviewed by QA team during meetings. POC may be revisupdated, based on QA review needed to achieve, and maint compliance. Audits may be discontinued after six months at least two consecutive mont 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	ea of ver iring QAPI ed or r, as rain with ths of		
K 0921 SS=F Bldg. 01	interview; the facili required maintenant documentation of it Related Electrical F 2012 edition, section physical integrity, it touch current tests is performed as require established with	ent - Testing and view, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care Equipment (PCREE). NFPA 99 ans 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE uired in 10.3. Testing intervals a policies and protocols. All ient 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 PCRE related inspections for all fixed portable patient-care related electrical equipment.	n E		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2025				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PEGLIL ATORY OR LSC IDENTIFYING DIFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
TAG	accordance with 10. into service and after Any system consists appliances demonst 99 as a complete system constructions, and promanufacturer include 10.5.3.1.1 and are confused a program for electrical equipment manuals are readily and condensed oper appliance are legible equipment tests, repmaintained for a per compliance in accordance in accordance and us	3.5.4 or 10.3.6 before being put er any repair or modification. Ing of several electrical rates compliance with NFPA stem. Service manuals, occdures provided by the le information as required by considered in the development extrical equipment maintenance available, and safety labels ating instructions on the le. A record of electrical eairs, and modifications is riod of time to demonstrate redance with the facility's esponsible for the testing, et of electrical appliances training. This deficient	TAG	How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken: All residents have the potential be affected. The facility will perform PCREE related inspections for all fixed and portable patient-care related electrical equipment. What measures will be put in 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 establitesting policy. Pertinent staff	the ne be //e al to d sh a will			
	a.m. and 2:15 p.m. v. Maintenance Direct documentation for t electric beds, nebuli pumps for air mattre other electrical med interview at the time Executive Director at the facility has not t PCREE items as of between 2:15 p.m. t facility with the Marevealed the facility electric beds, oxyge	riew on 02/05/25 between 9:45 with the Executive Director and or present, there was no he testing of PCREE, such as izers, oxygen concentrators, air esses, vital sign monitors, and ical equipment. Based on e of record review, the and Maintenance Director said ested and documented the yet. Based on observation of 5:30 p.m. during a tour of the intenance Director, it was provided PCREE such as n concentrators, air pumps for other electrical medical ent in the facility.		be trained on the policy and in how to complete the testing a record the results. All PCREF both fixed and portable will have an initial testing completed. A new PCREE obtained with has the PCREE testing completed documented prior to being play into use. A temporary waiver has been requested to allow time for obtaining the equipment, creat policies, and necessary staff training. How the corrective action where the deficient practice will not recur, i.e., what quality assurance program will be printo place:	nd E ave Any ave d and aced ating			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/25/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES OND NO. 0936-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
155716		B. WING	ì		02/05/2025		
				TDEET A	DDDECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD				
	OF EVANSVILLE						
EINVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	PREFIX (EACH CORRECTIVE ACTI CROSS-REFERENCED TO		HOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
					Upon completion of the initial		
	This finding was reviewed with the Executive Director and Maintenance Director during the exit				testing, maintenance will comp	ing, maintenance will complete	
					a weekly audit on one area of the		
	conference.				facility per week to ensure that		
					any equipment in place has be	een	
	3.1-19(b)				tested and has documentation	١.	
					Results of the audit will be		
					reviewed by QA team during (QAPI	
					meetings. POC may be revise	ed or	
					updated, based on QA review	, as	
					needed to achieve, and mainta	ain	
					compliance. Audits may be		
					discontinued after six months	with	
					at least two consecutive month	hs of	
					100% compliance achieved.		
					By what date the systemic		
					changes for each deficiency		
					will be completed:		
					July 30, 2025		
					,,		l

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