PRINTED: 12/31/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		IDENTIFICATION NUMBER	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY  COMPLETED  12/05/2024	
NAME OF	DD OTABLE OF CLIDATE	rn.	STREE	Γ ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLI			MILL ST		
ENVIVE	OF HARTFORD C	CITY	HART	FORD CITY, IN 47348		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, and the second	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG E 0000	REGULATORY (	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
E 0000						
Bldg						
	An Emergency Pr	reparedness Survey was	E 0000	Preparation or execution of the	nis	
	conducted by the	Indiana Department of Health in		plan of correction does not		
	accordance with 4	42 CFR 483.73.		constitute admission or agree	ment	
				of provider of the truth of the		
	Survey Date: 12/	05/24		alleged or conclusions set for		
	F 111. N. 1	00000		the Statement of Deficiencies		
	Facility Number:			Plan of Correction is prepared	d and	
	Provider Number			executed solely because it is	danal	
	AIM Number: 10	03/99/0		required by the position of Fe and State Law. The Plan of	derai	
	At this Emergency	y Preparedness survey, Envive		Correction is submitted to res	enond	
		vas found in compliance with		to the allegation of noncompli	•	
	1	redness Requirements for		cited during the Annual Surve	<b> </b>	
		dicaid Participating Providers		conducted December 5, 2024	-	
		CFR 483.73. The facility has a		Seriadeted Becomper 6, 202		
		d had a census of 29 at the time				
	of this survey.					
	Quality Review co	ompleted on 12/10/24				
K 0000						
Bldg. 01						
	A Life Safety Coo	de Recertification and State	K 0000	Preparation or execution of the	nis	
	Licensure Survey	was conducted by the Indiana		plan of correction does not		
	Department of He	ealth in accordance with 42 CFR		constitute admission or agree	ment	
	483.90(a).			of provider of the truth of the	•	
				alleged or conclusions set for		
	Survey Date: 12/0	05/24		the Statement of Deficiencies		
	E W. M. 1	000200		Plan of Correction is prepared	and bns t	
	Facility Number:			executed solely because it is	danal	
	Provider Number:			required by the position of Fe	deral	
	AIM Number: 10	U3/77/U		and State Law. The Plan of	nond	
	At this I if Sofat	y Code survey, Envive of		Correction is submitted to res	·	
	1	s found not in compliance with		to the allegation of noncomplicited during the Annual Surve	•	
	Requirements for	-		conducted December 5. 2024	-	

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

TITLE (X6) DATE

Sarah Jackman **HFA** 12/21/2024

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

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155699	A. BUILDING <u>01</u> COMPLETE		(X3) DATE SURVEY COMPLETED 12/05/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of This one story facility Type V(111) constraints sprinklered. The fact with smoke detection to the corridors and wired to the fire alar rooms in the 200 Ha operated smoke deterooms in the 100 Ha of 78 and had a cent survey.  All areas where the	the and the 2012 edition of the ention Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2.  The was determined to be of encion and was fully evility has a fire alarm system on in the corridors, areas open has smoke detectors hard erm system in resident sleeping entil. The facility has battery entered in resident sleeping entil. The facility has a capacity sus of 29 at the time of this eresidents have customary ered. All areas providing					
K 0227	Quality Review con						
SS=E Bldg. 01	failed to ensure ram were in accordance 7.2.5. Table LSC 7 slope for existing ra shall be in accordan Handrails complyin provided along both rise greater than 6 in provided in LSC 7.2 could affect over 15	exits  on and interview, the facility ps in 2 of 6 exit discharges with the provisions of LSC 2.5.2 (b) states the maximum mps shall be 1 in 8. Landings ce with Section 7.2.5.3.2. g with LSC 7.2.2.4 shall be a sides of a ramp run with a nches, unless otherwise 2.5.4.4. This deficient practice residents, staff and visitors if acility exits by Room 102 and	K 0227	K227 Ramps and other Exits  1 What corrective action(s) to be accomplished for those Residents found to have be affected by the deficient practice?  A contractor will be obtained to or replace ramps to meet CM requirements.	<b>Vill</b> en do fix		

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CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 12/05/2024					
	PROVIDER OR SUPPLIER			715 N I	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
	Findings include:  Based on observation the Director of Nurse Maintenance and the Supervisor during a p.m. to 3:20 p.m. or noted:  a. the ramp in the expectation of the ramp in the expectation of the ramp in the expectation of the ramp. The ramp handrails.  Based on interview observations, the Director of Maintenance and a doministrator, the I Director of Maintenance and Maintena	ons with the Administrator, sing, the Director of e Field Maintenance tour of the facility from 1:20 in 12/05/24, the following was kit discharge outside the Room 102 measured 25.5 feet of seven inches over each the of the ramp. The ramp was andrails. Kit discharge outside the Room 121 measured 6.6 feet in Finine inches over the length of the was not provided with at the time of the irector of Maintenance and the Supervisor confirmed the agreed each of the the exit discharge ramps were not rails.			2. How other residents have potential to be affected by to same deficient practice will be identified and what corrective action will be taken?  This deficient practice could a up to 15 residents, A contractor will be obtained or replace ramps to meet CM requirements.  3. What measures will be putting place or what system changes will be made to ensure that the deficient practice does not occur?  The Director of Maintenance educated by the Executive Director on K227 Ramps and Exits. Once repaired a quart inspection will be added to the Tels system.	he  nd  pe  affect  to fix IS  mic  was  other erly ie			

will be monitored to ensure the

					PRINTED: 12/31/2024
	「OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155699	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  12/05/2024
	PROVIDER OR SUPPLIE OF HARTFORD CI		715 N	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm Syster Maintenance	m - Testing and		deficient practice will not reci.e., what quality assurance program will be put into place. This Tels task will be reviewed the Safety/QAPI committee. Lead by the Executive Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement of 100% compliance is achieved.  5. Date of Completion:  11-1-25  Waiver submitted	ce?  d by  or  or  d  s  Until
	Based on record re	view and interview, the facility	K 0345	K345 Fire Alarm - Maintenan	oce 01/29/2025

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failed to ensure all fire alarm system initiating

Section 19.3.4.1 states a manual fire alarm system

shall be provided in accordance with Section 9.6.

LSC Section 9.6.1.3 states a fire alarm system

required for life safety shall be installed, tested, and maintained in accordance with the applicable

requirements of NFPA 70, National Electric Code

and NFPA 72, National Fire Alarm and Signaling

with the schedules in Table 14.4.5. Table 14.4.5 at

Code. NFPA 72, 2010 Edition, Section 14.4.5

states testing shall be performed in accordance

15(e) states the requirements of 14.4.5.5 shall

apply to heat detectors. Section 14.4.5.5 states

restorable fixed-temperature, spot-type heat

detectors shall be tested in accordance with

devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC

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taken?

and Testing

practice?

all heat detectors.

same deficient

1 What corrective action(s) Will

Residents found to have been

be accomplished for those

The Campus has contracted

Elwood Fire Protection to replace

2. How other residents have the

potential to be affected by the

practice will be identified and

what corrective action will be

affected by the deficient

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  12/05/2024		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
ENVIVE	OF HARTFORD CI	ГΥ	715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE		
		4.4.5.5.4. Two or more sted on each initiating circuit		This deficient practice could a all residents, staff and visitors			
		detectors shall be tested each		the	5 111		
	•	2 Test Methods at (14)(d)(2), (3)		facility. The Campus has			
	· ·	d for fixed-temperature		contracted Elwood Frie Prote	ction		
	nonrestorable heat of	letectors. Records shall be		to replace all heat detectors			
		owner specifying which		3. What measures will be			
		tested. Within 5 years, each		putting place or what syster	nic		
		been tested. This deficient		changes will be made to			
	practice could affec	t all clients, staff and visitors.		ensure that the deficient			
	Findings include:			practice does not occur?			
	rindings include.			The Director of Maintenance	was l		
	Based on review of	the "Heat Detectors" section		educated by the Executive	was		
		stem inspection contractor's		Director on K345 Fire Alarm -	Mtn		
	_	" documentation dated		and Testing. Heat detectors			
	06/14/23, 01/03/24	and 06/19/24 with the		to be tested or replaced annu			
		Director of Nursing, the		This task has been added to	the		
	Director of Mainten			Tels building system for requi	ired		
	_	visor during record review		timely testing. This task requ			
		1:20 p.m. on 12/05/24,		review of the deficiencies sec	etion		
		eat detector testing for facility		and signature before	11		
		n the most recent twelve ot available for review.		documentation can be upload	iea		
	-	or's 06/14/23, 01/03/24 and		<ul><li>and task completed.</li><li>4. How the corrective action</li></ul>			
		documentation indicated a		will be monitored to ensure			
	•	emperature heat detectors are		deficient practice will not re			
	installed in the facil	ity none of which were tested		i.e., what quality assurance			
		ent twelve month period. The		program will be put into pla	ce?		
		and 06/19/24 inspection					
		ed each inspection was a		This Tels task will be reviewe	d by		
	_	and none of the heat detectors		the Safety/QAPI committee			
		o report to the fire alarm nterview at the time of record		Lead by the Executive Director and/or Maintenance Director.	or		
	-	of Maintenance and the Field		The results will be reviewed f	or		
		visor did not know if facility		patterns, trends and continue			
	•	restorable or nonrestorable		recommendations for process			
		ector testing documentation		monitoring and improvement			
	_	twelve month period was not		100% compliance is achieved			
	available for review	<b>7.</b>		·			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY  COMPLETED  12/05/2024		
	PROVIDER OR SUPPLIER OF HARTFORD CI		715 N	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F	Director of Mainten Maintenance Super conference.  3.1-19(b)  NFPA 101	Director of Nursing, the		5. Date of Completion: 1-29-25	
Bldg. 01	failed to maintain and accordance with NF sprinkler systems shall be replaced or be tested and then required by this star shall be performed by this star shal		K 0353	K353 Sprinkler System - Maintenance and Testing  1 What corrective action(s) Will accomplished for those Reside found to have been affected by deficient practice?  Full Sprinkler head replacement be completed. The Campus has reached out to two different sprinkler vendors to assess and quote the system for sprinkler head replacement.  2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?	nts the  t to s
	Based on review of	the sprinkler system		This deficient practice could aff	ect

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		r '	COMPLETED	
		155699	B. W	ING		12/05/2024	
		<u> </u>	1	CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R		715 N N	ADDRESS, CITY, STATE, ZIP COD		
FN\/I\/F	OF HARTFORD CI	TY			ORD CITY, IN 47348		
LINVIVE	OF HARTIOND CI		_	LICINIE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		or's letter dated 04/03/19 with			all residents, staff and visitors	in	
		the Director of Nursing, the			the facility. The campus is		
	Director of Mainter				obtaining quotes to replace		
	-	visor during record review			sprinkler heads		
		1:20 p.m. on 12/05/24, a total of					
		inkler heads from the facility					
		site laboratory for 10-year					
	~	laboratory testing results			3. What measures will be put	-	
		ed 04/15/24, indicated two of			place or what systemic chang		
	_	ent for testing were found to be			will be made to ensure that th		
		terflow" and three of the			deficient practice does not oc	cur?	
		inklers sent for testing were					
		l-Visual No Test" due to the					
		n of the received sample					
	-	on interview at the time of			The Director of Maintenance	was	
		Field Maintenance Supervisor			educated by the Executive		
		ware of the status of sprinkler			Director on K353 Sprinkler		
	-	facility on or after 04/15/19 due			System - Mtn and Testing.		
	_	nership of the facility within			Sprinkler systems are require	d to	
	-	nd agreed sprinkler system			be tested timely		
	_	nentation on or after 04/15/19					
	was not available for	or review at the time of the			and any deficiencies fixed		
	survey.				promptly. This task has been		
					added to the Tels building sys		
	_	re reviewed with the			for required timely testing. Th	is	
		Director of Nursing, the			task requires review of the		
	Director of Mainter				deficiencies section		
	_	visor during the exit					
	conference.				and signature before		
					documentation can be upload	ed	
	3.1-19(b)				and task completed.		
					4. How the corrective action v		
					monitored to ensure the defic		
					practice will not recur i.e., who		
					quality assurance program wi	ll be	
					put into place?		

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155699	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/05/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0372 SS=E Bldg. 01	Barrie Based on observation failed to ensure 1 of protected to maintain the smoke barrier was requires smoke barrier was accordance with LS minimum ½ hour find efficient practice of staff and visitors in door set by the Median Dining Room.  Findings include:  Based on observation	Iding Spaces - Smoke on and interview, the facility is 5 smoke barrier walls were in the fire resistance rating of all. LSC Section 19.3.7.5 iers to be constructed in in C Section 8.5 and shall have a re resistive rating. This build affect over 20 residents, the vicinity of the corridor ical Supply Room by the in the Administrator, sing, the Director of	K 0372	This Tels task will be reviewed the Safety/QAPI committee Liby the Executive Director and Maintenance Director. The rewill be reviewed for patterns, trends and continued recommendations for process monitoring and improvement 100% compliance is achieved.  5. Date of Completion:  Waiver filed  6/29/2025  K372 Subdivision of Buildin Spaces - Smoke Barrier Door 1 What corrective action(s) to be accomplished for those Residents found to have been affected by the deficient practice?  A contractor has been schedulate to remove all the old foam and drywall. Add new drywall and caulk all penetrations with the approved rated caulk	g 01/29/2025 Will en uled define		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLE	ETED
		155699	B. W	ING		12/05/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t					
FNVIVE	OF HARTFORD CI	TY		715 N MILL ST HARTFORD CITY, IN 47348			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY 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		R LSC IDENTIFYING INFORMATION		TAG			DATE
		e Field Maintenance			2. How other residents have		
		tour of the facility from 1:20			potential to be affected by th	e	
		1 12/05/24, the annular space			same deficient		
		parate sprinkler pipes and the unding a four inch in diameter			practice will be identified and		
	-	of which penetrated the attic			what corrective action will be taken?	,	
		above the corridor door set			taveii:		
		Supply Room by the Main			This deficient practice could a	ffect	
	Dining Room were not firestopped. The smoke				over 20 residents, staff and	,,,,,,,,	
	barrier wall above the corridor door set was a				visitors in the vicinity of the		
		and had a rectangular section			corridor door set by the Medic	al	
		to the attic wall above the			Supply Room by the Main Din		
	corridor door set to cover an access opening to				Room. All fire wall penetration	-	
	the adjoining smoke	e compartment in the attic.			be fixed and fire caulk to meet		
	Foam was used at the	he edges of the drywall to seal			regulations		
	the dry wall edges.	Based on interview at the time			:		
	of the observations,	the Director of Maintenance					
	and the Field Maint	enance Supervisor stated			3. What measures will be		
		ne fire resistance rating/UL			putting place or what system	ic	
	-	used to seal the drywall edges			changes will be made to		
		or review and agreed the			ensure that the deficient		
	_	enings in the smoke barrier wall			practice does not occur?		
		door set by the Medical					
		not firestopped to maintain the					
	fire resistance rating	g of the smoke barrier wall.					
	Tl C 1:	i 4id- d			The Director of Maintenance v	vas	
	These findings were	Director of Nursing, the			educated by the Executive	,	
	Director of Mainten				Director on K372 Subdivision of		
		visor during the exit			Building Spaces - Smoke Barr All fire wall penetrations requi		
	conference.	visor during the exit			approved fire caulk to prevent		
	251110101100.				passage of fire and smoke. A		
	3.1-19(b)				wall inspection has been adde		
	- ( )				the Tels system for quarterly		
					review. Visual inspections wee	ekly	
					for 24 weeks totaling 6 months	-	
					Paper documentation will kept		
					weekly checks.		

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155699	B. WI	NG		12/05/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			715 N N			
ENVIVE	OF HARTFORD CI	ТҮ			ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					4. How the corrective action will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. This Tels task will be reviewed the Safety/QAPI committee. Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement to 100% compliance is achieved.  5. Date of Completion:	e? d by r or d	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC						
-	failed to ensure 6 of	riew and interview, the facility 344 fire dampers in the facility ssary maintenance in	K 0:	521	K521 HVAC Heating and ventilation		01/29/2025
	heating, ventilating ductwork and relate accordance with NF Installation of Air-C Systems. NFPA 90 states fire dampers	PA 90A. LSC 9.2.1 requires and air conditioning (HVAC) dequipment shall be in PA 90A, Standard for the Conditioning and Ventilating A, 2012 Edition, Section 5.4.8.1 shall be maintained in PA 80, Standard for Fire			What corrective action(s) Will be accomplished for those Residents found to have bee affected by the deficient practice?  A contractor will be abtained to replace/repair the		
	Doors and Other Op 2010 Edition, Section shall be tested and installation. Section	pening Protectives. NFPA 80, on 19.4.1 states each damper inspected 1 year after in 19.4.1.1 states the test and y shall then be every 4 years			obtained to replace/repair the non-working dampers  2. How other residents have	the	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/05/2024 155699 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 715 N MILL ST **ENVIVE OF HARTFORD CITY** HARTFORD CITY, IN 47348 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE except for hospitals where the frequency is every potential to be affected by the 6 years. If the damper is equipped with a fusible same deficient practice will be identified and link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The what corrective action will be damper shall not be blocked from closure in any taken? way. All inspections and testing shall be documented, indicating the location of the fire This deficient practice damper, date of inspection, name of inspector and could affect all residents, staff deficiencies discovered. The documentation shall and visitors have a space to indicate when and how the A contractor will be obtained to deficiencies were corrected. This deficient replace/repair the non-working practice could affect all residents, staff and dampers visitors. Findings include: 3. What measures will be putting place or what systemic Based on review of the fire damper inspection changes will be made to contractor's "Fire and Smoke Damper Inspection ensure that the deficient Report" documentation dated 03/24/22 with the practice does not occur? Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during record review from 10:10 a.m. to 1:20 p.m. on 12/05/24, a total of The Director of 44 fire dampers in the facility were inspected and Maintenance was educated by the tested within the most recent four year period. A Executive Director on K521 HVAC total of six fire dampers failed 03/24/22 inspection Heating and Ventilation and testing. Repair or replace documentation on Damper inspections are required or after 03/24/22 for the six fire damper locations and all deficiencies repaired which failed four year testing was not available for promptly. This task has been review at the time of the survey. The fire damper added to the Tels building system locations which failed 03/24/22 were listed as for required timely testing. This "Damper No. 22" which "is seized and needs task requires review of the replaced" and "Dampers No. 25, 26, 27, 36 and 37" deficiencies section and signature each "failed due to rust and corrosion-Need before documentation Replaced". Based on interview at the time of can be uploaded and task

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record review, the Field Maintenance Supervisor

agreed repair or replacement documentation on or after 03/24/22 for the six fire damper locations

which failed four year testing was not available for

review at the time of the survey.

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completed

4. How the corrective action

will be monitored to ensure the

deficient practice will not recur

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE S		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPL	ETED
		155699	B. W	NG		12/05/	2024
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					MILL ST		
ENVIVE (	OF HARTFORD CI	IY		HARIF	ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					i.e., what quality assurance		
	These findings were	e reviewed with the			program will be put into plac	e?	
	Administrator, the Director of Nursing, the Director of Maintenance and the Field Maintenance Supervisor during the exit						
					This Tels task will be	,	
					reviewed by the Safety/QAPI		
	conference.	_			committee		
					Lead by the Executiv	∕e	
	3.1-19(b)				Director and/or Maintenance		
	, ,				Director.		
					The results will be		
					reviewed for patterns, trends a	and	
					continued recommendations	for	
					process monitoring and		
					improvement Until 100%		
					compliance is achieved.		
					5. Date of Completion:		
					1/29/2025		
K 0522	NFPA 101						
SS=D	HVAC - Any Heat	ing Device					
Bldg. 01	Based on observation	on and interview, the facility	K <sub>0</sub>	522	K522 HVAC All Heating Device	ces	12/23/2024
	failed to ensure 1 of	f 1 dryer rooms was		-			
	continuously provid	ded with intake combustion air			What corrective action(s) Wil	ii l	
	from the outside for	r rooms containing fuel fired			be accomplished for those		
	equipment. This de	eficient practice could create an			Residents found to have bee	n	
	atmosphere rich wit	th carbon monoxide which			affected by the deficient		
	could cause physica	al problems for all staff in the			practice?		
	vicinity of the room	n. This deficient practice could					
	affect at least two s	taff in the Laundry.			The Maintenance		
					Director repaired the fresh air		
	Findings include:				intake vent. The vents now		
					function as they require	÷d	
	Based on observation	ons with the Administrator,			,		
	the Director of Nurs	sing, the Director of			2. How other residents have	the	
		e Field Maintenance			potential to be affected by th	e	
	Supervisor during a	tour of the facility from 1:20			same deficient		
		n 12/05/24, one wall mounted			practice will be identified and	t	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155699	B. WI	NG		12/05/2024	
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			MILL ST		
FNVIVE	OF HARTFORD CI	TY			ORD CITY, IN 47348		
				17,41511			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		d Louvre system was installed			what corrective action will be	е	
		ehind the natural gas fired			taken?		
	1 .	room area of the Laundry to					
	1 -	with intake air from the outside.			This deficient practic		
		n to open and close the Louvre			could affect at least two staff in	n	
	l <sup>-</sup>	ly with dryer activation was			the Laundry. Vent has been		
		the motor for the Louvre			repaired		
	l <sup>-</sup>	uvre's in the fully closed			2 What magazines will be		
	position. When the dryers were turned on by Laundry staff, the Louvre's failed to open due to				3. What measures will be	nio.	
		being disconnected from the			putting place or what system	IIC	
		Field Maintenance			changes will be made to ensure that the deficient		
	· ·	the mechanical arm to the			practice does not occur?		
		re system opened with dryer			practice does not occur?		
		on interview at the time of the			The Director of Maintenance v	1/25	
		irector of Maintenance and			educated by the Executive	vas	
		nce Supervisor stated they did			Director on K522 HVAC all		
	not know why the n				Dryer fresh air intake must		
	1	ald become disconnected			function as required. task has	:	
	1	could not be assured the			been added to the Tels buildir		
		yers would be continually			system for weekly inspections	•	
		bustion air taken directly from			This task will auto populate	•	
	the outside.	Ž			weekly and is required to be		
					signed off. The Director of		
	These findings were	e reviewed with the			Maintenance will perform daily	/	
	Administrator, the I	Director of Nursing, the			inspections x4 weeks then we		
	Director of Mainter	nance and the Field			inspections x 20 totaling 6 mo	-	
	Maintenance Super	visor during the exit			will be kept on paper audit.		
	conference.						
					4. How the corrective action		
	3.1-19(b)				will be monitored to ensure t	the	
					deficient practice will not rec	cur	
					i.e., what quality assurance		
					program will be put into place	e?	
					This Tels task will be reviewed	d by	
					the Safety/QAPI committee		
					Lead by the Executive Directo	r	
					and/or Maintenance Director.		
					The results will be reviewed for	or	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155699	A. BUILDING <u>01</u> B. WING			COMPLETED 12/05/2024	
		155699	B. WI	NG		12/05	72024
NAME OF 1	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF HARTFORD CI	TY			MILL ST FORD CITY, IN 47348		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY 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 OR LSC IDENTIFYING INFORMATION		TAG				DATE
					patterns, trends and continued recommendations for process		
					monitoring and improvement l		
					100% compliance is achieved.		
					5. Date of Completion:		
					12/23/2024		
K 0918	   NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 01		2 Eddonia Eldano dydio					
	Based on observation	on and interview, the facility	K 0	918	K918 – Electrical System –		01/29/2025
	failed to ensure 1 o	f 1 automatic transfer switches			Essential Electric		
		accordance with NFPA 110.					
		rd for Emergency and Standby			What corrective action(s) Wi	11	
		10 edition, Section 6.2.16.2			be accomplished for those		
		nts with identification			Residents found to have bee	n	
	_	r approved position indicators o indicate the switch position.			affected by the deficient		
	_	tice could affect all residents,			practice?		
	staff and visitors.	nee could affect aff residents,			The generator service	<u>'e</u>	
	Starr and visitors.				provider Evapar has been call		
	Findings include:				replace the indicator lights		
					that do not function.		
		ons with the Administrator,					
		sing, the Director of					
		ne Field Maintenance					
		a tour of the facility from 1:20			2. How other residents have		
		n 12/05/24, neither position			potential to be affected by th	е	
		tomatic transfer switch located al room was illuminated to			same deficient		
		position. One pilot position			practice will be identified and what corrective action will be		
		nal" and the second pilot			taken?	•	
		as "Emergency." Based on					
		ne of the observations, the			This deficient practic	:e	
		nance stated the automatic			could affect all residents, staff		
	transfer switch is o	perable but agreed neither			and visitors. Indicator lights		
		or the automatic transfer			will be replaced		
	switch was illumina	ated to indicate the switch					

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

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155699	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/05/2024		
	PROVIDER OR SUPPLIE OF HARTFORD C		STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	position.  These findings were Administrator, the Director of Mainte	re reviewed with the Director of Nursing, the mance and the Field rvisor during the exit		3. What measures will be putting place or what system changes will be made to ensure that the deficient practice does not occur?  The Director of Maintenance was educated by Executive Director on K918 Electrical All lights on transfer switch should work as required Light check added to weekly generator inspection sheets  4. How the corrective action will be monitored to ensure deficient practice will not recipie, what quality assurance program will be put into place. This Tels task will be reviewed by the Safety/QAPI committee  Lead by the Execution Director.  The results will be reviewed for patterns, trends continued recommendations process monitoring and improvement Until 100% compliance is achieved.  5. Date of Completion:	nic  y the red.  the cur ce? e		

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED			
		155699	B. WING		12/05/2024		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF HARTFORD CITY			STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
				·	1/29/25		

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