

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

PRINTED: 06/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 06/13/2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF LAWRENCEBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the PSR survey conducted on 5/14/24 to the Life Safety Code Recertification and State Licensure Survey conducted on 03/18/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 06/13/24</p> <p>Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510</p> <p>At this PSR survey, Envive of Lawrenceburg was found 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.</p> <p>This three story facility with a basement was determined to be of Type II(222) construction and was fully sprinklered except for the detached former outdoor oxygen storage area. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridor, in all areas open to the corridor and in all resident sleeping rooms. Resident sleeping Rooms 101, 102, 103, 104, 105, 106 and 107 on the first floor were being used as vent unit bedrooms during the 03/18/24 visit for a total of eight vent unit bed locations. The facility has a capacity of 100 and had a census of 41 at the time of this visit.</p> <p>All areas where residents have customary access</p>			{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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