						PRIN	TED:	04/21/2025
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FO	RM APPI	ROVED
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 09	38-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155061	B. WI	NG		03/17	/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF LAWRENCEBURG				403 BIE	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025	•		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	3	COMP	LETION

	1		CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000				
Bldg. 00				
	This visit was for a Recertification and State	F 0000	Plan of Correction FOR Envive	
	Licensure Survey.		of lawrenceburg	
			INITIAL COMMENTS	
	Survey dates: March 11, 12, 13, 14, and 17, 2025.		Preparation or execution of this	
			plan of correction does not	
	Facility number: 000022		constitute admission or agreement	
	Provider number: 155061		of provider of the truth of the facts	
	AIM number: 100274510		alleged or conclusions set forth on	
			the Statement of Deficiencies. The	
	Census Bed Type:		Plan of Correction is prepared and	
	SNF/NF: 48		executed solely because it is	
	Total: 48		required by the position of Federal	
			and State Law. The Plan of	
	Census Payor Type:		Correction is submitted to respond	
	Medicare: 8		to the allegation of noncompliance	
	Medicaid: 29		cited during the Annual Survey	
	Other: 11		conducted March 11-17, 2025.	
	Total: 48		Please accept this Plan of	
	10ta1. 40		Correction as the provider's	
	These deficiencies reflect State Findings cited in		credible allegation of compliance	
	accordance with 410 IAC 16.2-3.1.		-	
	accordance with 410 IAC 10.2-3.1.		as of April 3, 2025. The provider	
	Quality raviay completed on March 24, 2025		respectfully requests desk review	
	Quality review completed on March 24, 2025.		with paper compliance to be	
			considered in establishing that the	
			provider is in substantial	
			compliance.	
F 0684	492.25			
SS=D	483.25			
	Quality of Care			
Bldg. 00	Decelor description internal	F 0 60 4	5 004 Ovelity of Oom	05/02/2025
	Based on observation, interview, and record	F 0684	F 684 – Quality of Care	05/02/2025
	review, the facility failed to follow the		"Facility failed to follow the	
	manufacturer's guidelines related to insulin pen		manufacturer's guidelines related	
	usage for 1 of 5 residents observed for medication		to insulin pen usage for 1 of 5	
	administration. (Resident 12)		residents observed for medication	
			administration. (Resident 12)"	
	Findings include:			
				<u> </u>

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

TITLE

(X6) DATE

Peninah Wood **Executive Director** 04/16/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 16VI11 Facility ID: 000022 If continuation sheet Page 1 of 15

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155061	B. W	NG		03/17/	2025
		l		CTREET	ADDRESS CITY STATE TIP COP		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
END //\/E	OF LAWDENGER!	DO.			ELBY RD		
ENVIVE	OF LAWRENCEBU	KG		LAWRE	ENCEBURG, IN 47025		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					1: What corrective action(s)	will	
		and observation with RN 7,			be accomplished for those		
on 03/12/25 at 11:13 A.M., medication				residents found to have been	n		
		observed. The nurse prepared			affected by the deficient		
	insulin for Resident 12 using an insulin pen. RN 7				practice?		
	indicated the resident was to receive 4 units of				Resident 12 was affected	d by	
	Aspart/Novolog ins	ulin scheduled with meals and			the alleged deficient practice.		
	6 units per the sliding scale, for a total of 10 units.				Resident 12 was		
	The nurse removed	the insulin pen from the			immediately assessed for insu	ılin	
	medication cart, che	ecked the label, removed the			and blood glucose		
	pen cap, cleaned the end of the pen with an				appropriateness. No further a	ction	
	alcohol wipe, applied the needle, and removed the				is needed currently.		
	cap of the needle. She turned the pen dose						
	selector to two units, primed the pen holding the				2: How other residents havir	ng	
	pen tip facing the fl	oor, squirted out the two units			the potential to be affected b	у	
		e pen dose selector to 10			the same deficient practice v	vill	
		s, and went into the resident's	be identified and what				
	room. The nurse ad	ministered the insulin into the			corrective action will be take	n.	
	resident's abdomen.				 Residents requiring 		
					insulin have the potential to be	Э	
	_	with RN 7, immediately			affected by the alleged deficie	nt	
		dure, she indicated the			practice.		
		the insulin pen was to get the			All residents requiring ins	sulin	
	1 ^	ensure it would actually			were assessed for		
		in. When getting air out of a			appropriateness.		
		to get it out. She was not			Staff was given manufacturer		
		old the pen when priming it,			guidelines for proper insulin		
	I	ideways. If it was a syringe,			prepping and administration		
		ir and push it out holding it					
		ed air out of the pen she			3: What measures will be pu	t	
	should have held th	e insulin pen upright.			into place or what systemic		
					changes will be made to		
		for the Novolog insulin pen			ensure that the deficient		
		e Director of Nursing (DON)			practice does not recur?		
		P.M. The instructions for use			The DON and ADON we	re	
	indicated, "Priming your NovologPenTurn				educated on the Envive		
		select 2 unitsHold the Pen			Subcutaneous Injections Police	-	
	_	nting up. Tap the top of the			and procedure with concentra	tion	
		nes to let any air bubbles rise			on, but not limited to, Insulin		
	to the topHold the Pen with the needle pointing		1		administration.		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	COMPLETED	
		155061	B. WI	NG		03/17/	/2025	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
	OF LAWDENGER	IDO			ELBY RD			
ENVIVE	OF LAWRENCEB	JRG		LAWRE	ENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	up. Press and hold	in the dose button until the			 Education and trainir 	ıg		
	dose counter show	s"0"A drop of insulin should			were provided to DON and AD	OON		
	be seen at the need	le tip"			on 3/14/25 by the clinical supp	ort		
					consultant.			
	The Electronic Me	dication Administration			Education provided:			
	Record/Electronic	Treatment Administration			Envive Subcutaneous Inject	ions		
	Record (EMAR/ETAR) for Resident 12 was				Policy			
	reviewed on 03/17	/25 at 2:26 P.M. The record			Insulin Manufacturer Guideli	ines		
	indicated she had no critical Blood Sugar values							
	prior to 03/12/25.				4: How the corrective action			
					will be monitored to ensure t	the		
	The current "Admi	nistering Medications" policy,			deficient practice will not red	cur		
	with a revised date of 08/2024, was provided by				i.e., what quality assurance			
	the DON on 03/17	/25 at 1:07 P.M. The policy			program will be put into place	:e?		
	indicated, "Medi	cations are administered in a			DON/designee will comp	lete		
	safe and timely ma	nner, and as prescribed"			daily random auditing to ensur	re		
					that any resident with insulin			
	3.1-37(a)				administration is visualized for	٢		
	3.1-47(a)(1)				proper administration and			
					monitored 5 days a week for 4	ļ		
					weeks, 3 days a week for 4 we	eeks		
					and 2 days a week for 4 week	s,		
					then monthly in QAPI for 6			
					months.			
					DON/designee will be			
					responsible for monitoring			
					compliance for 6 months. The			
					results of these audits will be			
					reviewed by the QA committee	е		
					overseen by the Executive			
					Director. If a threshold of 95%	is		
					not achieved, an action plan v			
					be developed. The facility thi	-		
					the QAPI program, will review			
					update, and make changes to			
					DPOC as needed for sustaining	ng		
					substantial compliance for no	less		
					than 6 months.			
1								

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Event ID:

16VI11

Facility ID: 000022

If continuation sheet Page 3 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155061		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 03/17/2025	
	PROVIDER OR SUPPLIED		403 B	FADDRESS, CITY, STATE, ZIP COD IELBY RD RENCEBURG, IN 47025	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				5. Date of completion: 05/02/2025	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervis	sion/Devices			
bldg. 00	Based on observati review, the facility hazard was thoroug resident acquired a thumb for 1 of 3 re hazards. (Resident Findings include: The clinical record on 03/12/25 at 3:04 Data Set (MDS) as indicated the reside impaired. The reside were not limited to seizure disorder, and disabilities. A Progress Note, dindicated Licensed entered the resident observed to have a and the nail bed was During an interview RN 7 indicated the and out of her when floor, and could on During an observat	failed to ensure an accident ghly investigated after a fracture and laceration to her sidents reviewed for accident 13) for Resident 13 was reviewed P.M. A Quarterly Minimum sessment, dated 02/10/25, ent was severely cognitively lent's diagnoses included, but a fracture of the left ilium, exiety, and severe intellectual ated 03/01/25 at 12:54 A.M., Practical Nurse (LPN) 2 t's room and the resident was laceration to her left thumb as red and discolored. v, on 03/12/25 at 10:59 A.M., resident could get herself in elchair, would crawl on the ly say a few simple words.	F 0689	F 689 – Free of Accident Hazard/Supervision/Devices "Facility failed to ensure an accident hazard was thorough investigated after a resident acquired a fracture and laceral to her thumb for 1 of 3 resident reviewed for accident hazards. (Resident 13)" 1: What corrective action(s) who is accomplished for those residents found to have been affected by the deficient practice? Resident 13 was affected the alleged deficient practice. Resident 13 had an incide immediately investigated further root cause. No further action in needed currently. Investigation proved resident injured self on doorway jarlock mechanism. Mechanism was removed and replaced at time of incident. 2: How other residents having the same deficient practice with the same deficient practice with the potential to be affected by the same deficient practice with the potential to be affected by the same deficient practice with the potential to be affected by the same deficient practice.	tion ts will by ent er s dent m the
		ting in her wheelchair in the		be identified and what	n

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Event ID:

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Facility ID: 000022

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155061	B. W	ING		03/17/2025	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			ELBY RD		
FNI\/I\/E	OF LAWRENCEBU	IRG			ENCEBURG, IN 47025		
LINVIVE	- LAVVINLINGEDO				-110_DONO, 111 47 020		
(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	ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	was closed and had light bruising.				- Independent residents wi		
					the ability to ambulate have th		
		igation folder was reviewed on			potential to be affected by alle	ged	
	03/14/25 at 10:50 A.M. The folder contained the				deficient practice.		
	incident report filed with the State Department of				All residents' doorways w		
		port dated, 02/28/25, a follow			investigated and assessed for		
		ician's visit, dated 03/05/25,			further potential harm by the		
		Assistant Director of Nursing			maintenance director. No furt	her	
	(ADON).				action is needed currently.		
	During an interview	y on 03/14/25 at 11:30 A.M., the			3: What measures will be put	ı	
	Administrator indicated there wasn't much in the				into place or what systemic		
	accident investigation folder, it was pretty cut and				changes will be made to		
	dry.				ensure that the deficient		
					practice does not recur?		
	During an interview	v on 03/14/25 at 3:39 P.M., LPN			The DON and ADON we	re l	
	2 indicated the nigh	nt of the accident she was in			educated on the Envive Accid	ents	
	another resident's re	oom when the Certified Nurse			and Incidents – Investigating a	and	
	Aide (CNA) asked	her to come to Resident 13's			Reporting Policy and procedu	re	
	room. She entered t	he room and saw blood on the			with concentration on, but not		
	resident's hand. She	asked what happened, the			limited to, complete and thoro	ugh	
	resident looked at h	er and said "eat". The CNA			investigating.		
	was unclear what h	ad happened. LPN 2 cleaned			 Education and training 	g	
	the resident's hand,	phoned the ADON and the			were provided to DON and AD	OON	
		itioner (NP) who gave the order			on 3/14/25 by the clinical supp	ort	
		to the emergency room to be			consultant.		
		aid she had looked on the			Education provided:		
		, and around the room, and			Envive Accidents and Incide	nts	
		mall amount of blood located			 Investigating and Reporting 		
		ext to the strike plate. She			Policy		
		ote and put information					
		ent in the Risk Management			4: How the corrective action		
	part of the electroni	c health record.			will be monitored to ensure t	he	
					deficient practice will not rec	ur	
	_	v on 03/17/25 at 11:08 A.M., the			i.e., what quality assurance		
		PN 2 phoned her and notified			program will be put into place	e?	
	her of the accident to Resident 13. The resident				ED/DON/designee will		
		l emergency room to be			complete a thorough investiga		
		t wouldn't leave a bandage on			for all accidents and incidents	and	
	her thumb. The wound was healing. The strike				monitor 5 days a week for 4		

16VI11

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155061	B. WI	NG		03/17/	/2025
			<u> </u>	CED FEET	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
END (1) (E.	OF LAWDENGER!	IDO.		403 BIELBY RD			
ENVIVE	OF LAWRENCEBU	RG		LAWRE	ENCEBURG, IN 47025		
(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	тс	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	plate was taken off	the resident's door.			weeks, 3 days a week for 4 we	eeks	
	•				and 2 days a week for 4 week		
	During an interview on 03/17/25 at 11:13 A.M., the Administrator indicated after learning of the				then monthly in QAPI for 6	-,	
					months.		
		Resident 13, she sent the			montale.		
	_	text message requesting the			DON/designee will be		
		loor be removed. No other			responsible for monitoring		
	rooms were reviewe				compliance for 6 months. The		
	TOOMS WELL LEVIEWS	cu.			results of these audits will be		
	The accident folder	lacked any investigation of			reviewed by the QA committee	^	
	The accident folder lacked any investigation of				-	5	
	the other resident room strike plates or interviews with staff and cognitively intact residents.				overseen by the Executive Director. If a threshold of 95%	io	
	with start and cognitively intact residents.						
	The current facility policy titled "Accidents and				not achieved, an action plan w		
	The current facility policy, titled "Accidents and incidents - investigating and reporting", with an				be developed. The facility thr	•	
	_				the QAPI program, will review		
		ate of 08/2024, was provided			update, and make changes to		
	_	Nursing on 03/17/25 at 1:07			DPOC as needed for sustainir	-	
		licated, "All accidents and			substantial compliance for no	iess	
	_	residents, employees, visitors,			than 6 months.		
		ring on our premises shall be					
	investigated and rep				5. Date of completion:		
		following data, as applicable,			05/02/2025		
	shall be included or	-					
		orm:k. Any corrective action					
	taken"						
	3.1-45(a)						
E 0600	400.05(.)(4).(0)						
F 0692	483.25(g)(1)-(3)						
SS=D	Nutrition/Hydration	n Status Maintenance					
Bldg. 00							
		on, interview, and record	F 06	592	F 689 – Free of Accident		05/02/2025
		failed to provide physician			Hazard/Supervision/Devices		
		supplements for 1 of 2			"Facility failed to ensure an		
	residents reviewed	for nutrition. (Resident 29)			accident hazard was thorough	ly	
					investigated after a resident		
	Findings include:				acquired a fracture and lacera		
					to her thumb for 1 of 3 resider		
		P.M., Resident 29 was			reviewed for accident hazards	:_	
	observed in the Act	ivity Room participating in an			(Resident 13)"		

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Event ID:

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Facility ID: 000022

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CENTERS FOR	NTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039						
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	COMPLETED		
		155061	B. WING		03/17/2025		
	PROVIDER OR SUPPLIER		403	EET ADDRESS, CITY, STATE, ZIP COD B BIELBY RD WRENCEBURG, IN 47025	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFE	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE		
	ice cream activity.	The resident was very thin in					
	appearance.			1: What corrective action	n(s) will		
				be accomplished for tho	· ·		
	The clinical record	was reviewed on 03/12/25 at		residents found to have	been		
	2:58 P.M. The resid	lent was admitted to the facility		affected by the deficient			
	on 10/31/24. A Qua	rterly Minimum Data Set		practice?			
	(MDS) assessment,	dated 02/20/25, indicated the		Resident 13 was affe	ected by		
	resident was severely cognitively impaired. The			the alleged deficient pract	tice.		
	resident's diagnoses included, but were not			Resident 13 had an i	incident		
	limited to, depression, anxiety, cardiac arrhythmia,			immediately investigated			
	and malnutrition. The resident was 72 inches tall,			root cause. No further ac	tion is		
	weighed 105 pounds, and was on a physician			needed currently.			
	prescribed weight gain program. The Admission			Investigation proved			
	MDS assessment, dated 11/11/24, indicated the			had injured self on doorwa	• •		
	_	nosis of malnutrition, was 72		lock mechanism. Mechar			
	inches tall, and weig	ghed 113 pounds.		was removed and replace	ed at the		
	TI AT A CAST	C N H H H H H H		time of incident.			
		on Care Plan, with an initiated					
		as provided by the Director of		2: How other residents h	_		
		03/17/25 at 1:07 P.M. The Care esident was at risk for		the potential to be affect	=		
		nterventions included, but were		the same deficient practi	ice will		
		vide and serve supplements as		corrective action will be	takan		
		itiated date of 11/09/24.		- Independent resident			
	ordered with an in	triated date of 11/09/24.		the ability to ambulate have			
	An Admission "Nut	tritional Risk Assessment",		potential to be affected by			
		te of 11/07/24, indicated the		deficient practice.	45904		
		ritional supplement, Boost		All residents' doorwa	ivs were		
		mes a day, that was ordered		investigated and assesse	-		
		ractitioner (NP) at admission.		further potential harm by t			
	_	supplement was listed as the		maintenance director. No			
		alnutrition. The resident's		action is needed currently			
	weight was 112 pour	ınds and her "Ideal Body					
		as 160 pounds. The resident		3: What measures will be	e put		
	was underweight, h	ad no chewing or swallowing		into place or what syster	-		
	problems, and need	ed one staff member to		changes will be made to			
	physically assist her	r with eating. The resident was		ensure that the deficient			
	on a regular diet wit	th chopped meats.		practice does not recur?	•		
				The DON and ADON	l were		

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The November 2024 Electronic Medication

Event ID:

16VI11

Facility ID: 000022

If continuation sheet

educated on the Envive Accidents

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2025	
	PROVIDER OR SUPPLIE		403 BII	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025		
(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 APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Administration Red	cord (EMAR) and the Progress		and Incidents – Investigating a	nd	
	Notes, that include	d the EMAR notes, were		Reporting Policy and procedur	е	
	provided by the DO	ON on 03/17/25 at 1:07 P.M. The		with concentration on, but not		
	records indicated th	ne resident was to receive		limited to, complete and thorou	ıgh	
	Boost Plus dietary supplement three times a day,			investigating.		
	with a start date of 11/01/24. The resident did not			 Education and training 	g	
	receive the supplement on the following dates and			were provided to DON and AD	ON	
	times:			on 3/14/25 by the clinical supp	ort	
				consultant.		
	- On 11/06/24 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., the resident's supplement was not available.			Education provided:		
				Envive Accidents and Incide	nts	
				 Investigating and Reporting 		
		00 A.M., 1:00 P.M., and 6:00		Policy		
	P.M., the resident's supplement was not available.					
				4: How the corrective action		
		00 P.M., the resident's		will be monitored to ensure the	-	
	supplement was no	t available.		deficient practice will not rec	ur	
				i.e., what quality assurance		
		00 A.M., 1:00 P.M., and 6:00		program will be put into place	∍?	
	P.M., the resident's	supplement was not available.		ED/DON/designee will		
		00/44/07 00 00 73.5 1		complete a thorough investigation		
	-	w, on 03/14/25 at 2:00 P.M., the		for all accidents and incidents	and	
		of Nursing (ADON) indicated		monitor 5 days a week for 4		
		ot deliver Ensure (dietary		weeks, 3 days a week for 4 we	 	
	**	ADON indicated she ordered		and 2 days a week for 4 weeks	3 ,	
		re from another company. If		then monthly in QAPI for 6		
		on Ensure, she had ordered it		months.		
	-	been times when they had		5001/1 : 311		
		m an online retailer. If an order		DON/designee will be		
	-	day, she could go to a local		responsible for monitoring		
		up Ensure. If they could get a		compliance for 6 months. The		
		online retailer, then they went		results of these audits will be		
		picked up enough to last until		reviewed by the QA committee	·	
	the delivery was m	auc.		overseen by the Executive	io	
	During on interview	y on 03/17/25 at 2:02 D.M		Director. If a threshold of 95%		
		w, on 03/17/25 at 2:02 P.M., Support indicated they did not		not achieved, an action plan w		
	_	ed to following physician's		be developed. The facility through	•	
	* *	to to following physician's		the QAPI program, will review,	 	
	orders.	orders.		update, and make changes to	ui c	

DPOC as needed for sustaining

•		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155061	B. W	NG		03/17/	2025
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 403 BIELBY RD LAWRENCEBURG, IN 47025				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	n l		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	revised date of 08/2 Director of Nursing policy indicated, " guarantee certain ba	ent Rights" policy, with a 024, was provided by the on 03/17/25 at 1:07 P.M. The Federal and state laws asic rights to all resident of access to quality care			substantial compliance for no lithan 6 months. 5. Date of completion: 05/02/2025	ess	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs	and Biologicals					
	review, the facility of appropriately related cleanliness of medical discontinued medical medications for 2 of (South Medication Cart on Medication Storage) Findings include: 1. The South Media observed on 03/17/2 Practical Nurse (LP) following: - An Albuterol inhal Resident 12, with no clean side draws.	Cart on the third floor, North the second floor) and 1 of 2 areas reviewed (First floor). tion Cart on the third floor was 25 at 9:59 A.M., with Licensed N) 4 and contained the ler, prescribed on 09/19/24, for to open date,	F 07	761	F 761 – Label/Store Drugs an Biologicals "Facility failed to store medications appropriately relatolabeling medications, cleanliness of medication cartsloose pills, discontinued medications, and expired medications for 2 of 3 Medicat Carts reviewed (South Medicat Cart on the third floor, North Medication Cart on the second floor) and 1 of 2 Medication Storage areas reviewed (First floor)." 1: What corrective action(s) where the second floor is a complished for those residents found to have been affected by the deficient practice?	ted s, ion tion	05/02/2025
	of the drawer, - One medium round	shiny film covering the bottom			No residents were affected by the alleged deficient practice. 2: How other residents havin	e.	
	- One small oval wh	• •			the potential to be affected by the same deficient practice w	y	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155061		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2025		
NAME OF P	PROVIDER OR SUPPLIER	•		ET ADDRESS, CITY, STATE, ZIP COD	•
	OF LAWRENCEBU			BIELBY RD RENCEBURG, IN 47025	
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	be identified and what	DATE
	The following cards	s of discontinued medications:		corrective action will be tal - All Residents have the	ken.
	- Cephalexin, an antibiotic, 500 milligrams (mg), 3			potential to be affected by a	leged
	pills left, for Resident 13,			deficient practice.	
				All medication carts to	
	- Guaifenesin, an expectorant, 600 mg, 3 pills left, for Resident 37,			include south medication ca	
	To Resident 37,			the third floor and north med cart on the second floor, to i	
	- Cefdinir, an antibiotic, 300 mg, 2 pills left, for			but not limited to, medication	
	Resident 14,			storage areas on first, secor	
			and third floors.		
	- Macrobid, an antibiotic, 100 mg, 2 pills left, for				
	Resident 14,			3: What measures will be p	
	CM7 TMD (Deater	im), an antibiotic, 800-160 mg,		into place or what systemic	
	one pill left, for Res			changes will be made to ensure that the deficient	
	one pin ien, for Kes	ident 14, and		practice does not recur?	
	- Dabigatran (Prada	xa), an anticoagulant, 150 mg, 3		The DON and ADON w	vere
	pills left, for Reside			educated on the Envive Med	dication
				Labeling and Storage Policy	and
	_	, at the time of observation,		procedure.	
		esident 14 had been on three		- Education and train	
		they were not working, or she on. The Bactrim and the		were provided to DON and A	
	- C	delivered on 10/24/24. The		on 3/14/25 by the clinical su consultant.	pport
		red in February. The		Education provided:	
		ations should not have been		Envive Medication Labelin	g and
		art. For discontinued		Storage Policy	
		ad a bin they put them in			
		cation room and pharmacy		4: How the corrective actio	
	would pick them up).		will be monitored to ensure	
	The physician's ord	ers were provided by the		deficient practice will not r i.e., what quality assurance	
		(DON) on 03/17/25 at 1:07		program will be put into pla	
	P.M., and indicated			DON/designee will perf	
				daily medication cart and	
		linir was discontinued on		medication storage area	
	02/19/25,			monitoring to cover all shifts	_
			1	each weekday 5 days a wee	k for 4

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155061	B. W	ING		03/17	/2025
		<u> </u>		OTP PPT	ADDRESS SITU STATE TO SOF		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
	OF LAWDENIOES:	IDO.			ELBY RD		
ENVIVE	OF LAWRENCEBU	IRG		LAWRE	ENCEBURG, IN 47025		
(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	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
	- Resident 14's Macrobid was discontinued on				weeks, 3 days a week for 4 we	eeks	
	10/28/24,				and 2 days a week for 4 week		
					then monthly in QAPI for 6	,	
	- Resident 14's Bactrim was discontinued on 11/02/24, and				months.		
	ĺ				DON/designee will be		
	- Resident 14's Pradaxa was discontinued on 10/26/24.				responsible for monitoring		
					compliance for 6 months. The		
					results of these audits will be		
	2. The North Medication Cart on the second floor				reviewed by the QA committee	е	
	was observed on 03/17/25 at 10:17 A.M., with LPN				overseen by the Executive		
	5 and contained the following:				Director. If a threshold of 95%	is	
					not achieved, an action plan v		
	- An Admelog insulin pen, 3/4 full, for Resident				be developed. The facility thi		
	17, with no open date,				the QAPI program, will review		
					update, and make changes to		
	- A Basaglar/Lantus	s insulin pen, 1/3 full, for			DPOC as needed for sustaining		
	Resident 17, with a	n open date of 01/05/25, LPN 5			substantial compliance for no	-	
	indicated it was goo	od for 30 days after opening,			than 6 months.		
	_						
	- one medium roun	d yellow loose pill, and			5. Date of completion:		
					05/02/2025		
	- one large white ov	val loose pill.					
	The physician's ord	ers were provided by the DON					
	on 03/17/25 at 1:07	P.M., and indicated the					
	following:						
	- Resident 17 receiv	ved Admelog insulin, 5 units,					
	on 03/16/25 at 9:00	P.M., and					
	- Resident 17 receiv	ved Lantus insulin, 4 units, on					
	03/17/25 at 9:00 A.	M.					
	_	vation on 03/17/25 at 10:54					
	A.M., on the first floor, RN 6 indicated they did						
	not really have a medication room on the first floor. They had a supply room, and a small, locked						
	refrigerator located	at the nurse's station. The					
	refrigerator contained the following:						

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AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER 155061	A. BUILDING B. WING	00	COMPLETED 03/17/2025		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 403 BIELBY RD				
ENVIVE OF LAWRENCEBURG			LAWRE	ENCEBURG, IN 47025			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	-	u vaccine, delivered on with no open date noted on the					
	-	y, at the time of observation, floor staff administered the fluning residents.					
	During an interview, on 03/17/25 at 1:54 P.M., RN 6 indicated medications in the medication carts should be labeled with an open date when put into service. Discontinued medications should be removed from the medication carts and either returned to the pharmacy or destroyed based on the medication.						
	The package insert for the Lantus insulin pen was provided by the DON on 03/17/25 at 2:23 P.M. The record indicated prefilled pens should be discarded after 28 days at room temperature or in use.						
	policy, with a revision provided by the DC policy indicated, " responsible for main and preparation are mannerIf the facility or deteriorated med dispensing pharmac regarding returning itemsMulti-dose waccessedneedle publicarded within 28 specifies a shorter of vial"	ation Labeling and Storage" ed date of 08/2024, was N on 03/17/25 at 1:07 P.M. The The nursing staff is ntaining medication storage as in a clean, safe, and sanitary lity has discontinued, outdated ications or biologicals, the ey is contacted for instructions or destroying these vials that have been opened or uncturedare dated and days unless the manufacturer or longer date for the open					
	3.1-25(j)						

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Facility ID: 000022

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00	COMPLETED	
155061		B. WING 03/			03/17/	3/17/2025	
	ROVIDER OR SUPPLIER		<u> </u>	403 BIE	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025	•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	3.1-25(o)						
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility		F O	880	F 880 – Infection Prevention	&	05/02/2025
	failed to follow appropriate infection control		F 0880		Control		03/02/2023
	guidelines during medication administration				"Facility failed to follow appropriate infection control guidelines during		
	related to hand hygiene for 2 of 5 residents						
	observed. (Residents 28 and 18)				medication administration rela	-	
	Findings include:				to hand hygiene for 2 of 5		
					residents observed. (Residents 28		
					and 18)"		
	Medication administration was observed on						
	03/12/25 at 9:05 A.M., with Qualified Medication				1: What corrective action(s)	will	
	Aide (QMA) 8. The QMA prepared a cup of				be accomplished for those		
	medications and a cup of water for Resident 3. She				residents found to have beer	1	
	passed the cups back and forth while assisting				affected by the deficient		
	the resident, went back to the computer on the				practice?	_	
	medication cart, touched the keys on the computer, then used hand sanitizer. The QMA proceeded to prepare medications for Resident 28, retrieving medications from the cart and documenting on the computer. She prepared a cup of medications, took the medications into the resident's room, donned gloves, administered eye				Residents 28 and 18 wer		
					affected by the alleged deficie	nı	
					practice. Residents 28 and 18		
					immediately had complete		
					assessments for infection. No	,	
					further action is needed currer		
		gloves, took the cup of				y.	
	_	at to the medication cart, and			2: How other residents havin	q	
	crushed them. She mixed the medications with a spoonful of applesauce, entered the resident's				the potential to be affected b	-	
					the same deficient practice v	-	
	room and assisted the resident with their				be identified and what		
	medications by spooning the mixture into her mouth. The QMA held the resident's insulated cup and touched the resident's straw using both				corrective action will be take	n.	
					- All Residents have the		
					potential to be affected by alle	ged	
	hands during medication administration. The				deficient practice.		
	QMA went back to the medication cart, touched				All residents were assess		
		touched the mouse, unlocked			for infection. No further action	1	
		and started preparing			needed at this time.		
	medications for Resident 18. The QMA failed to						
	use hand sanitizer or wash her hands and				3: What measures will be put	t	

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155061		B. WING			03/17/	2025	
				CTREET	ADDRESS SITE OF THE SID COD		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
	OF LAWDENIOEDI	IDO			ELBY RD		
ENVIVE	OF LAWRENCEBL	IRG		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)	12	DATE
	continued touching	the keyboard of the computer,			into place or what systemic		
	the mouse, medicat	ion cards, the medication cart			changes will be made to		
	keys, the medicine	cup of pills and the water cup.		ensure that the deficient practice does not recur?			
	The QMA used har	nd sanitizer then entered					
	Resident 18's room to administer her medications.				The DON and ADON we	re	
					educated on the Envive		
	During an interview	v, immediately following the			Handwashing and Hand Hygie	ene	
	observation, the QN	MA indicated staff should use			Policy and procedure.		
	hand sanitizer betw	reen residents. If a staff			- Education and trainin	ıg	
	members' hands we	ere soiled, they should wash			were provided to DON and AD	-	
	them with soap and	l water.			on 3/14/25 by the clinical supp		
	them with soup and water.				consultant.		
	The current "Handy	washing and Hand Hygiene"			Education provided:		
	policy, with a revised date of 08/2024, was				Envive Handwashing and H	and	
		rector of Nursing on 03/17/25 at			Hygiene Policy		
	2:23 P.M. The poli	cy indicated, "Hand hygiene					
	_	ouching the resident's			4: How the corrective action		
	environment"				will be monitored to ensure t	:he	
					deficient practice will not red	ur	
	The current "Admir	nistering Medications" policy,			i.e., what quality assurance		
	with a revised date of 08/2024, was provided by the Director of Nursing on 03/17/25 at 1:07 P.M. The policy indicated, "Medications are administered in a safe and timely mannerStaff follows established facility infection control procedureshandwashingfor the administration of medications"				program will be put into place	:e?	
					DON/designee will perfor		
					daily random handwashing au		
					weekdays during medication		
					administration times 5 days a		
					week for 4 weeks, 3 days a we	eek	
					for 4 weeks and 2 days a wee	k for	
					4 weeks, then monthly in QAF	'l for	
	3.1-18(1)				6 months.		
					DON/designee will be		
					responsible for monitoring		
					compliance for 6 months. The		
					results of these audits will be		
					reviewed by the QA committee	Э	
					overseen by the Executive		
					Director. If a threshold of 95%	is	
					not achieved, an action plan w	<i>i</i> ill	
					be developed. The facility thr	ough	
					the QAPI program, will review	,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2025 FORM APPROVED OMB NO. 0938-039

` '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/17/2025		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF LAWRENCEBURG				STREET ADDRESS, CITY, STATE, ZIP COD 403 BIELBY RD LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)			Ē	(X5) COMPLETION DATE	
					update, and make changes to a DPOC as needed for sustainin substantial compliance for no lethan 6 months. 5. Date of completion: 05/02/2025	g		

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