STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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

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.

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	During an interview and observation with RN 7, on 03/12/25 at 11:13 A.M., medication administration was observed. The nurse prepared insulin for Resident 12 using an insulin pen. RN 7 indicated the resident was to receive 4 units of Aspart/Novolog insulin scheduled with meals and 6 units per the sliding scale, for a total of 10 units. The nurse removed the insulin pen from the medication cart, checked the label, removed the pen cap, cleaned the end of the pen with an alcohol wipe, applied the needle, and removed the cap of the needle. She turned the pen dose selector to two units, primed the pen holding the pen tip facing the floor, squirted out the two units of insulin, turned the pen dose selector to 10 units, donned gloves, and went into the resident's room. The nurse administered the insulin into the resident's abdomen. During an interview with RN 7, immediately following the procedure, she indicated the purpose of priming the insulin pen was to get the air out of the pen to ensure it would actually administer the insulin. When getting air out of a pen, they primed it to get it out. She was not trained on how to hold the pen when priming it, only to not hold it sideways. If it was a syringe, you would see the air and push it out holding it upright. If she wanted air out of the pen she should have held the insulin pen upright. The package insert for the Novolog insulin pen was provided by the Director of Nursing (DON) on 03/17/25 at 2:23 P.M. The instructions for use indicated, "...Priming your Novolog...Pen...Turn the dose selector to select 2 units...Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...Hold the Pen with the needle pointing		**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 12 was affected by the alleged deficient practice. Resident 12 was immediately assessed for insulin and blood glucose appropriateness. No further action is needed currently. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents requiring insulin have the potential to be affected by the alleged deficient practice. All residents requiring insulin were assessed for appropriateness. Staff was given manufacturer guidelines for proper insulin prepping and administration **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated on the Envive Subcutaneous Injections Policy and procedure with concentration on, but not limited to, Insulin administration.	

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	up. Press and hold in the dose button until the dose counter shows"0"...A drop of insulin should be seen at the needle tip..." The Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) for Resident 12 was reviewed on 03/17/25 at 2:26 P.M. The record indicated she had no critical Blood Sugar values prior to 03/12/25. The current "Administering Medications" policy, with a revised date of 08/2024, was provided by the DON on 03/17/25 at 1:07 P.M. The policy indicated, "...Medications are administered in a safe and timely manner, and as prescribed..." 3.1-37(a) 3.1-47(a)(1)		- Education and training were provided to DON and ADON on 3/14/25 by the clinical support consultant. Education provided: Envive Subcutaneous Injections Policy Insulin Manufacturer Guidelines **4: 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?** DON/designee will complete daily random auditing to ensure that any resident with insulin administration is visualized for proper administration and monitored 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, 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 overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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			5. Date of completion: 05/02/2025	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure an accident hazard was thoroughly investigated after a resident acquired a fracture and laceration to her thumb for 1 of 3 residents reviewed for accident hazards. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 03/12/25 at 3:04 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/10/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, a fracture of the left ilium, seizure disorder, anxiety, and severe intellectual disabilities. A Progress Note, dated 03/01/25 at 12:54 A.M., indicated Licensed Practical Nurse (LPN) 2 entered the resident's room and the resident was observed to have a laceration to her left thumb and the nail bed was red and discolored. During an interview, on 03/12/25 at 10:59 A.M., RN 7 indicated the resident could get herself in and out of her wheelchair, would crawl on the floor, and could only say a few simple words. During an observation, on 03/13/25 at 10:55 A.M., Resident 13 was sitting in her wheelchair in the hallway on the third floor. Her left thumb wound	F 0689	**F 689 – Free of Accident Hazard/Supervision/Devices** *"Facility failed to ensure an accident hazard was thoroughly investigated after a resident acquired a fracture and laceration to her thumb for 1 of 3 residents reviewed for accident hazards. (Resident 13)"* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 13 was affected by the alleged deficient practice. Resident 13 had an incident immediately investigated further root cause. No further action is needed currently. Investigation proved resident had injured self on doorway jam lock mechanism. Mechanism was removed and replaced at the time of incident. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**	05/02/2025

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	was closed and had light bruising. The accident investigation folder was reviewed on 03/14/25 at 10:50 A.M. The folder contained the incident report filed with the State Department of Health, an X-ray report dated, 02/28/25, a follow up orthopedic physician's visit, dated 03/05/25, and a note from the Assistant Director of Nursing (ADON). During an interview on 03/14/25 at 11:30 A.M., the Administrator indicated there wasn't much in the accident investigation folder, it was pretty cut and dry. During an interview on 03/14/25 at 3:39 P.M., LPN 2 indicated the night of the accident she was in another resident's room when the Certified Nurse Aide (CNA) asked her to come to Resident 13's room. She entered the room and saw blood on the resident's hand. She asked what happened, the resident looked at her and said "eat". The CNA was unclear what had happened. LPN 2 cleaned the resident's hand, phoned the ADON and the on-call Nurse Practitioner (NP) who gave the order to send the resident to the emergency room to be evaluated. LPN 2 said she had looked on the wheelchair, the bed, and around the room, and found there was a small amount of blood located on the door frame next to the strike plate. She wrote a Progress Note and put information regarding the incident in the Risk Management part of the electronic health record. During an interview on 03/17/25 at 11:08 A.M., the ADON indicated LPN 2 phoned her and notified her of the accident to Resident 13. The resident was sent to the local emergency room to be treated. The resident wouldn't leave a bandage on her thumb. The wound was healing. The strike		- Independent residents with the ability to ambulate have the potential to be affected by alleged deficient practice. All residents' doorways were investigated and assessed for further potential harm by the maintenance director. No further action is needed currently. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated on the Envive Accidents and Incidents – Investigating and Reporting Policy and procedure with concentration on, but not limited to, complete and thorough investigating. - Education and training were provided to DON and ADON on 3/14/25 by the clinical support consultant. Education provided: Envive Accidents and Incidents – Investigating and Reporting Policy **4: 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?** ED/DON/designee will complete a thorough investigation for all accidents and incidents and monitor 5 days a week for 4	

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	plate was taken off the resident's door. During an interview on 03/17/25 at 11:13 A.M., the Administrator indicated after learning of the accident involving Resident 13, she sent the maintenance man a text message requesting the strike plate on the door be removed. No other rooms were reviewed. The accident folder lacked any investigation of the other resident room strike plates or interviews with staff and cognitively intact residents. The current facility policy, titled "Accidents and incidents - investigating and reporting", with an effective/revision date of 08/2024, was provided by the Director of Nursing on 03/17/25 at 1:07 P.M. The policy indicated, "...All accidents and incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator...The following data, as applicable, shall be included on the Report of Incident/Accident form: ...k. Any corrective action taken..." 3.1-45(a)		weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, 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 overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 05/02/2025	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview, and record review, the facility failed to provide physician ordered nutritional supplements for 1 of 2 residents reviewed for nutrition. (Resident 29) Findings include: On 03/12/25 at 3:24 P.M., Resident 29 was observed in the Activity Room participating in an	F 0692	**F 689 – Free of Accident Hazard/Supervision/Devices** *"Facility failed to ensure an accident hazard was thoroughly investigated after a resident acquired a fracture and laceration to her thumb for 1 of 3 residents reviewed for accident hazards. (Resident 13)"*	05/02/2025

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	ice cream activity. The resident was very thin in appearance. The clinical record was reviewed on 03/12/25 at 2:58 P.M. The resident was admitted to the facility on 10/31/24. A Quarterly Minimum Data Set (MDS) assessment, dated 02/20/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, depression, anxiety, cardiac arrhythmia, and malnutrition. The resident was 72 inches tall, weighed 105 pounds, and was on a physician prescribed weight gain program. The Admission MDS assessment, dated 11/11/24, indicated the resident had a diagnosis of malnutrition, was 72 inches tall, and weighed 113 pounds. The current Nutrition Care Plan, with an initiated date of 11/03/24, was provided by the Director of Nursing (DON) on 03/17/25 at 1:07 P.M. The Care Plan indicated the resident was at risk for malnutrition. The interventions included, but were not limited to, "Provide and serve supplements as ordered" with an initiated date of 11/09/24. An Admission "Nutritional Risk Assessment", with an effective date of 11/07/24, indicated the resident had the nutritional supplement, Boost Plus, in use, three times a day, that was ordered by the MD/Nurse Practitioner (NP) at admission. The reason for the supplement was listed as the resident's risk for malnutrition. The resident's weight was 112 pounds and her "Ideal Body Weight" was listed as 160 pounds. The resident was underweight, had no chewing or swallowing problems, and needed one staff member to physically assist her with eating. The resident was on a regular diet with chopped meats. The November 2024 Electronic Medication		**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 13 was affected by the alleged deficient practice. Resident 13 had an incident immediately investigated further root cause. No further action is needed currently. Investigation proved resident had injured self on doorway jam lock mechanism. Mechanism was removed and replaced at the time of incident. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Independent residents with the ability to ambulate have the potential to be affected by alleged deficient practice. All residents' doorways were investigated and assessed for further potential harm by the maintenance director. No further action is needed currently. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated on the Envive Accidents	

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	Administration Record (EMAR) and the Progress Notes, that included the EMAR notes, were provided by the DON on 03/17/25 at 1:07 P.M. The records indicated the resident was to receive Boost Plus dietary supplement three times a day, with a start date of 11/01/24. The resident did not receive the supplement on the following dates and times: - 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. - On 11/12/24 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., the resident's supplement was not available. - On 11/13/24 at 6:00 P.M., the resident's supplement was not available. - On 11/14/24 at 9:00 A.M., 1:00 P.M., and 6:00 P.M., the resident's supplement was not available. During an interview, on 03/14/25 at 2:00 P.M., the Assistant Director of Nursing (ADON) indicated the pharmacy did not deliver Ensure (dietary supplements). The ADON indicated she ordered the resident's Ensure from another company. If she had a resident on Ensure, she had ordered it weekly. There had been times when they had ordered Ensure from an online retailer. If an order was given on a Friday, she could go to a local pharmacy and pick up Ensure. If they could get a case of it from the online retailer, then they went to a local store and picked up enough to last until the delivery was made. During an interview, on 03/17/25 at 2:02 P.M., Corporate Clinical Support indicated they did not have a policy related to following physician's orders.		and Incidents – Investigating and Reporting Policy and procedure with concentration on, but not limited to, complete and thorough investigating. - Education and training were provided to DON and ADON on 3/14/25 by the clinical support consultant. Education provided: Envive Accidents and Incidents – Investigating and Reporting Policy **4: 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?** ED/DON/designee will complete a thorough investigation for all accidents and incidents and monitor 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, 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 overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining	

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	The current "Resident Rights" policy, 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, "...Federal and state laws guarantee certain basic rights to all resident of this facility...equal access to quality care... 3.1-25(a) 3.1-46(a)(1)		substantial compliance for no less than 6 months. **5. Date of completion:** 05/02/2025	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to store medications appropriately related to labeling medications, cleanliness of medication carts, loose pills, discontinued medications, and expired medications for 2 of 3 Medication Carts reviewed (South Medication Cart on the third floor, North Medication Cart on the second floor) and 1 of 2 Medication Storage areas reviewed (First floor). Findings include: 1. The South Mediation Cart on the third floor was observed on 03/17/25 at 9:59 A.M., with Licensed Practical Nurse (LPN) 4 and contained the following: - An Albuterol inhaler, prescribed on 09/19/24, for Resident 12 , with no open date, - A small side drawer containing bottled liquid medications with a shiny film covering the bottom of the drawer, - One medium round white loose pill, - One small oval white loose pill, and	F 0761	**F 761 – Label/Store Drugs and Biologicals** *"Facility failed to store medications appropriately related to labeling medications, cleanliness of medication carts, loose pills, discontinued medications, and expired medications for 2 of 3 Medication Carts reviewed (South Medication 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) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **2: How other residents having the potential to be affected by the same deficient practice will**	05/02/2025

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	The following cards of discontinued medications: - Cephalexin, an antibiotic, 500 milligrams (mg), 3 pills left, for Resident 13, - Guaifenesin, an expectorant, 600 mg, 3 pills left, for Resident 37, - Cefdinir, an antibiotic, 300 mg, 2 pills left, for Resident 14, - Macrobid, an antibiotic, 100 mg, 2 pills left, for Resident 14, - SMZ-TMP (Bactrim), an antibiotic, 800-160 mg, one pill left, for Resident 14, and - Dabigatran (Pradaxa), an anticoagulant, 150 mg, 3 pills left, for Resident 14. During an interview, at the time of observation, LPN 4 indicated, Resident 14 had been on three antibiotics because they were not working, or she was having a reaction. The Bactrim and the Macrobid had been delivered on 10/24/24. The Cefdinir was delivered in February. The discontinued medications should not have been in the Medication Cart. For discontinued medications, they had a bin they put them in located in the medication room and pharmacy would pick them up. The physician's orders were provided by the Director of Nursing (DON) on 03/17/25 at 1:07 P.M., and indicated the following: - Resident 14's Cefdinir was discontinued on 02/19/25,		**be identified and what corrective action will be taken.** - All Residents have the potential to be affected by alleged deficient practice. All medication carts to include south medication cart on the third floor and north medication cart on the second floor, to include but not limited to, medication storage areas on first, second, and third floors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated on the Envive Medication Labeling and Storage Policy and procedure. - Education and training were provided to DON and ADON on 3/14/25 by the clinical support consultant. Education provided: Envive Medication Labeling and Storage Policy **4: 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?** DON/designee will perform daily medication cart and medication storage area monitoring to cover all shifts during each weekday 5 days a week for 4	

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	- Resident 14's Macrobid was discontinued on 10/28/24, - Resident 14's Bactrim was discontinued on 11/02/24, and - Resident 14's Pradaxa was discontinued on 10/26/24. 2. The North Medication Cart on the second floor was observed on 03/17/25 at 10:17 A.M., with LPN 5 and contained the following: - An Admelog insulin pen, 3/4 full, for Resident 17, with no open date, - A Basaglar/Lantus insulin pen, 1/3 full, for Resident 17, with an open date of 01/05/25, LPN 5 indicated it was good for 30 days after opening, - one medium round yellow loose pill, and - one large white oval loose pill. The physician's orders were provided by the DON on 03/17/25 at 1:07 P.M., and indicated the following: - Resident 17 received Admelog insulin, 5 units, on 03/16/25 at 9:00 P.M., and - Resident 17 received Lantus insulin, 4 units, on 03/17/25 at 9:00 A.M. 3. During an observation 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:		weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, 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 overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 05/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	03/17/2025

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	- An open vial of Flu vaccine, delivered on 11/13/24, 1/2 full, with no open date noted on the vial or the box. During an interview, at the time of observation, RN 6 indicated the floor staff administered the flu vaccine to the incoming 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. The current "Medication Labeling and Storage" policy, with a revised date of 08/2024, was provided by the DON on 03/17/25 at 1:07 P.M. The policy indicated, "...The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner...If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items...Multi-dose vials that have been opened or accessed...needle punctured...are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial..." 3.1-25(j)			

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F 0880 SS=D Bldg. 00	3.1-25(o) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to follow appropriate infection control guidelines during medication administration related to hand hygiene for 2 of 5 residents observed. (Residents 28 and 18) Findings include: Medication administration was observed on 03/12/25 at 9:05 A.M., with Qualified Medication Aide (QMA) 8. The QMA prepared a cup of medications and a cup of water for Resident 3. She passed the cups back and forth while assisting the resident, went back to the computer on the 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 drops, removed her gloves, took the cup of medications back out to the medication cart, and crushed them. She mixed the medications with a spoonful of applesauce, entered the resident's room and assisted the resident with their medications by spooning the mixture into her mouth. The QMA held the resident's insulated cup and touched the resident's straw using both hands during medication administration. The QMA went back to the medication cart, touched the computer keys, touched the mouse, unlocked the cart with a key and started preparing medications for Resident 18. The QMA failed to use hand sanitizer or wash her hands and	F 0880	**F 880 – Infection Prevention & Control** *"Facility failed to follow appropriate infection control guidelines during medication administration related to hand hygiene for 2 of 5 residents observed. (Residents 28 and 18)"* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 28 and 18 were affected by the alleged deficient practice. Residents 28 and 18 immediately had complete assessments for infection. No further action is needed currently. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All Residents have the potential to be affected by alleged deficient practice. All residents were assessed for infection. No further action needed at this time. **3: What measures will be put**	05/02/2025

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	continued touching the keyboard of the computer, the mouse, medication cards, the medication cart keys, the medicine cup of pills and the water cup. The QMA used hand sanitizer then entered Resident 18's room to administer her medications. During an interview, immediately following the observation, the QMA indicated staff should use hand sanitizer between residents. If a staff members' hands were soiled, they should wash them with soap and water. The current "Handwashing and Hand Hygiene" policy, with a revised date of 08/2024, was provided by the Director of Nursing on 03/17/25 at 2:23 P.M. The policy indicated, "...Hand hygiene is indicated...after touching the resident's environment..." The current "Administering Medications" policy, 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 manner...Staff follows established facility infection control procedures...handwashing...for the administration of medications..." 3.1-18(l)		**into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated on the Envive Handwashing and Hand Hygiene Policy and procedure. - Education and training were provided to DON and ADON on 3/14/25 by the clinical support consultant. Education provided: Envive Handwashing and Hand Hygiene Policy **4: 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?** DON/designee will perform daily random handwashing audits weekdays during medication administration times 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, 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 overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review,	

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			update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 05/02/2025	