STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155859	A. BUILDING 00 B. WING	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BEECH GROVE	501 N 17TH AVE BEECH GROVE, IN 46107

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00418271. This visit included a State Residential Licensure Survey. Complaint IN00418271 - No deficiencies related to the allegations are cited. Survey dates: December 11, 12, 13, 14, 15, 19, and 20, 2023 Facility number: 000391 Provider number: 155859 AIM number: 100274990 Census Bed Type: SNF/NF: 45 Residential: 26 Total: 71 Census Payor Type: Medicare: 5 Medicaid: 32 Other: 8 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 22, 2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 1/11/24	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

David Benson | Executive Director | 01/08/2024

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	research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	F 0578	**F578 Advanced Directives** – It is	01/11/2024

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	Based on interview and record review, the facility failed to ensure a Resident's Advanced Directive (code status) preference was implemented and recorded accurately in the clinical record for 1 of 16 residents reviewed for Advanced Directives. (Resident 46) Finding includes: On 12/13/23 at 2:45 p.m., Resident 46's clinical record was reviewed. Resident 46 was admitted to the facility on 11/4/23. The new admission MDS (Minimum Data Set) assessment, dated 11/9/23, indicated Resident 46 was severely cognitively impaired. Resident 46's baseline care plan indicated "...Focus: Kardex Care Guide, date initiated: 11/6/23 and current through 2/15/23...Goal: The resident's care will be provided...Interventions: Code status/advanced directive [decision regarding health care intervention]: Full code [meaning a desire for all life sustaining measures were to be implemented]..." Resident 46 had an appointed Health Care Power of Attorney (a legal document that grants a trusted person the authority to make healthcare decisions on your behalf). On 12/14/23 at 9:30 a.m., the Administrator provided a copy of Resident 46's Indiana Physician Orders for Scope of Treatment (POST) form. During an interview at that time, the Administrator indicated on 11/4/23 that the facility's Admission Director had assisted Resident 46's Healthcare Power of Attorney in the completion of the POST form on behalf of Resident 46. A review of the document indicated		the consistent practice of this Provider to ensure a residents advanced Directive (code status) preference is implemented and recorded accurately in the clinical record. **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice;** Resident 46 code status was reviewed. POST form was signed by physician on 11/20/23 and represented the appropriate code status preference for this identified resident. Resident 46 continues to reside at this facility with no negative outcomes related to this alleged deficient practice. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken**; All residents residing in the facility have the potential to be affected by the same alleged practice. A review and audit of each resident was completed to ensure that each resident had the appropriate code status preference noted in the clinical recordand was authorized by physician signature. **What measures will be put into place and what systematic changes will be made to ensure that the alleged**	

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	the Resident's code status preference was "Do Not Attempt Resuscitation/DNR." Resident 46's Healthcare Power of Attorney signed the document on 11/4/23. The POST form lacked the physician's signature to indicate "to the best of my knowledge that these orders are consistent with the patient's current medical condition and preference..." Therefore, the DNR code status was unable to be executed due to the missing physician's signature. On 12/14/23 at 2:20 p.m., the Director of Nursing Services provided an updated version of Resident 46's POST form. A review of this POST form indicated Resident 46's Healthcare Power of Attorney had chosen the DNR (Do Not Attempt Resuscitation) code status as indicated by his signature on 11/4/23. This document was also signed by the physician on 11/20/23 which indicated "to the best of my knowledge that these orders are consistent with the patient's current medical condition and preference" Resident 46's Healthcare Power of Attorney's preferred DNR code status was then able to be executed on 11/20/23. During an interview on 12/14/23 at 3:55 p.m., the Corporate Nurse Consultant indicated that Resident 46's code status preference was DNR. The POST form was initiated on 11/4/23 as indicated by the Health Care Power of Attorney's signature. The facility had "misfiled" the POST form and so the required physician's signature on the document was not obtained until 11/20/23. Therefore, Resident 46's preferred code status was not honored until the POST form was completed and executed on 11/20/23. On 12/14/23 at 2:26 p.m., the Corporate Nurse Consultant provided a copy of the		**deficient practice does not recur;** The code status for all residents will be reviewed for accurate documentation of preference. Inservice will be provided to licensed staff by DNS/and or designee regarding process for obtaining and documenting accurate code status preference on or before Jan 10, 2024. The IDT will review resident documents received from the hospital upon admission and/or readmission to identify any information regarding the resident's code status preference and will confirm with the resident and/or resident's responsible party the code status. **How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur**; To ensure ongoing compliance, the DNS/Designee is responsible for the completion of the Advance Directive CQI tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	Comprehensive Care Plan Guideline policy, dated 8/29/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...to ensure appropriateness of services and communication that will meet the resident's needs...care plans need to remain accurate and current..." On 12/15/23 at 9:13 a.m., the Corporate Nurse Consultant provided a copy of the Advanced Directives policy, dated 8/23/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...if the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative...if the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives...the Attending Physician will provide information to the resident and legal representative regarding the Resident's health status, treatment options, and expected outcomes during the development of the initial comprehensive assessment and care plan...plan of care for each resident will be consistent with his or her documented treatment preference and/or advanced directive...the resident has the right to refuse treatment...a resident will not be treated against his or her own wishes...do not resuscitate-indicates that, in case of respiratory or cardiac failure, the resident...legal representative has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used...will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record..."			

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	3.1-4(f)(4)(A)(ii)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:			

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	(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to initiate a baseline care plan for a newly admitted resident for 1 of 2 residents reviewed for baseline careplans. (Resident 27) Finding includes: On 12/12/23 at 1:38 p.m. the clinical record for Resident 27 was reviewed. The diagnoses included, but were not limited to, Diabetes Mellitus and fractured left patella. Resident 27 was admitted on 12/1/23. The clinical record lacked a personalized baseline careplan. During an interview 12/14/23 at 2:12 p.m., RN 2 indicated Resident 27 should have had a baseline careplan initiated within 48 hours of admission. On 12/14/23 at 2:30 p.m., the Director of Nursing provided a policy titled Nursing Admission/Return Admission, dated August of 2022, and indicated it was the current policy being used by the facility. A review of the policy indicated "...6. After completion of the admission nursing assessment a Baseline care plan will be initiated for all new admissions..." 3.1-30(a)	F 0655	**F655 – Baseline Care Plan**: It is the consistent practice of this Provider to initiate a baseline care plan for a newly admitted resident. **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice**; Resident 27 careplan was reviewed and updated as needed to ensure the clinical record had an appropriate personalized care plan specific to the resident. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken;** All new admissions have the potential to be affected by the alleged practice. An audit of new admissions occurred to ensure all new resident admissions have a person centered baseline careplan within 48 hours of admission. If a resident record is identified as missing a baseline care plan, then a person centered care plan was	01/11/2024

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			developed and incorporated with the resident record. **What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur**; Inservice will be provided to licensed staff by DNS/and or designee regarding process of initiating and completing a baseline careplan within 48 hours of admission on or before Jan 10, 2024. IDT team will review resident record the following two business days consecutively to ensure a person centered baseline care plan is completed and present in the resident record within 48 hours of admission. **How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur**; To ensure ongoing compliance, the DNS/Designee is responsible for the completion of the Care Plan CQI tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. Results will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action	

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			plan will be developed to ensure compliance.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily posted nursing hours reflected the actual hours worked by nursing staff for 14 of 14 days reviewed. Findings include: On 12/12/23 at 9:33 a.m., observed the posted nursing hours. The posted nursing hours did not specify the actual nursing hours worked. On 12/12/23 at 9:45 a.m., the Director of Nursing provided copies of the previous posted nursing hours. The posted nursing hours for November 28, 29, 30, December 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11, 2023, lacked the actual hours worked by nursing staff. On 12/12/23 at 10:00 a.m., during an interview the Director of Nursing was not aware the "actual hours" had to be posted and indicated the facility follows the Centers for Medicare and Medicaid Services nursing home requirements. On 12/12/24 at 10:05 a.m., the facility policy was requested from the Director of Nursing. On 12/20/23 at 10:00 a.m., a specific policy for posted nursing hours was not provided by the end of the survey.	F 0732	**F732 Posted Nurse Staffing Information**: It is the consistent practice of this Provider to ensure that the daily posted nursing hours reflect the actual hours worked by nursing staff. **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice**; No residents were noted to be affected by the alleged deficient practice The daily posted nursing form was updated to ensure data is clear and in readable format to reflect the actual nursing hours worked by nursing staff. The form includes Facility name, current date, resident census, and total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, certified nurse aides. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken**;	01/11/2024

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			All residents residing at the facility have the potential to be affected by the alleged practice. Education in-service was provided by the Executive Director and/or designee on or before Jan 11, 2024 to the licensed nursing team and Nursing managers regarding completion of the form for nurse staffing to include Facility name, current date, resident census, and total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, certified nurse aides. **What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice does not recur**; This provider instituted a new and updated form to ensure it is in a clear and readable format used to properly reflect the actual nursing hours worked by nursing staff as required by this regulation. The Director of Nursing and/or designee will post this form prior to the beginning of the shift **How will the corrective actions be monitored or QA will be put into place to ensure the**	

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			alleged deficient practice will not recur; Required Postings CQI tool weekly times 4 weeks, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00418271. Complaint IN00418271 - No deficiencies related to the allegations are cited. Survey dates: December 11, 12, 13, 14, 15, 19 and 20, 2023 Facility number: 000391 Residential Census: 26 Envive of Beech Grove was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 1/11/24	