STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	1821 LINDBERG RD ANDERSON, IN 46012

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00407090 and IN00407500. Complaint IN00407090 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00407500 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: May 11 and 12, 2023 Facility number: 000027 Provider number: 155690 AIM number: 100266180 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 1 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 19, 2023.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF ANDERSON F000 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 Complaint Survey IN00407090 and IN00407500 on May 11 & 12, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Miller	Chief Nursing Officer	06/16/2023

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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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure insulin was administered timely according to physician orders, for 3 of 4 residents reviewed for medication administration. (Residents C, D, and E) Findings include: Confidential interviews were conducted during the course of the survey. A confidential interview indicated residents had reported delayed medication administration to a staff member twice a week, every week. Some residents were getting medications extremely late. The interim ADON and the Corporate RN 10 had been made aware of these concerns. A confidential interview indicated the medication administration pass was delayed on this date due to a call in. Everyone had to wait on LPN 3 to get the medication cart keys on the days when LPN 3 worked. This had taken up to one and one half hours some days. They were uncertain what caused a regular delay for LPN 3. QMAs obtained the blood sugars, but did not administer insulin. Some nurses had to be reminded to administer the insulin. The blood sugars had been delayed by a QMA on this date. A confidential interview indicated a resident reported delayed insulin administration to two QMAs about two weeks ago. This continued to be a problem as recent as 5/10/23, and had been a problem for months. Corporate RN 10 had been	F 0684	**F684- Quality of Care** **SS=E** *"Based on observation, interview and record review, the facility failed to ensure insulin was administered timely according to physician orders, for 3 of 4 residents reviewed for medication administration. (Residents C, D, and E)"* **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 this alleged deficient practice. · Residents C, D and E were assessed with no findings. **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 Insulin dependent residents have the potential to be affected by the alleged deficient practice. · ·	05/13/2023

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	made of aware of these concerns, but the insulin was still administered up to two hours late, three to four times a week. They had not reported it to other management because another QMA had previously reported insulin administration concerns to Corporate RN 10 and received a lot of backlash. The insulin was not refused by residents. Instead, the insulin had been requested from the nurse due to the significant delay. LPN 4 regularly administered the insulin late during their scheduled shifts. A confidential interview indicated Resident D's blood glucose results were sometimes high. The high blood glucose results were reported to the nurse, per protocol. During an interview on 5/11/23 at 10:54 a.m., RN 9 indicated she normally passed medications in the morning between 8:00 a.m. and 9:00 a.m. for the 500 unit and 600 unit. She still had to pass her medications for the 500 unit for the day. She was behind because she had to administer insulin for the whole building. During an interview on 5/11/23 at 11:47 a.m., QMA 8 indicated she had worked five shifts with LPN 4. LPN 4 had only administered insulin to one resident during those five shifts. She had worked with other nurses who administered the insulin. QMA 8's shift started at 6:00 a.m., but the third shift nurse was delayed turning the medication cart over to the next shift until 7:00 a.m. to 8:00 a.m. She was not able to get her medications administered in a timely manner. During an interview on 5/11/23 at 12:29 p.m., the DON indicated insulin was normally stored in the medication cart on the front hall.		**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff administering medication were educated on 5/13/2023. Education provided: o Relias training related to Timely administration of medication. o Medication Administration Policy o Blood Glucose Policy · Frequency and intensity of monitoring and oversight has been increased in accordance with our QAPI Program Procedures as indicated below. **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?** · The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until	

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	During an interview on 5/11/23 at 12:50 a.m., the DON indicated QMAs did not administer insulin. She needed the keys from the QMA to get into the medication room to get an insulin pen for a resident. During a medication observation on 5/11/23 at 12:57 p.m., Resident C was pulled from therapy for the administration of the resident's scheduled and sliding scale lispro insulin (rapid acting insulin). 1. Resident C's clinical record was reviewed on 5/11/23 at 4:29 p.m. Diagnoses included type two diabetes mellitus with diabetic retinopathy and glaucoma. A current, 12/8/22 physician order indicated lispro insulin 100 units/milliliter - inject subcutaneously per sliding scale daily before meals. It was scheduled for 7:00 a.m., 11:30 a.m., and 4:30 p.m. A current, 4/27/23 physician order indicated insulin lispro 100 units/milliliter - inject 25 units subcutaneously daily with meals. It was scheduled for 7:30 a.m., 12:00 p.m., and 5:00 p.m. Hold insulin for blood sugar less than 150. The insulin was to be given in addition to sliding scale coverage. A current, 2/3/23 physician order included insulin glargine (long acting insulin) 100 units/milliliter - inject 50 units daily at bedtime (scheduled for 9:00 p.m.). Review of the Medication Administration Audit Report from 4/20/23 to 5/11/23 indicated the insulin glargine had been administered at the following times: a. 4/27/23 at 11:09 p.m.		100% compliance is achieved. **5. Date of completion: 5/13/2023**	

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	b. 4/29/23 at 11:16 p.m. c. 5/01/23 at 3:26 a.m. (for 4/30/23) d. 5/01/23 at 11:35 p.m. e. 5/04/23 at 12:30 a.m. (for 5/3/23) f. 5/05/23 at 3:41 a.m. (for 5/4/23) g. 5/07/23 at 12:12 a.m. (for 5/6/23) h. 5/10/23 at 5:39 p.m. (for 5/10/23) The resident's insulin glargine was not administered on 5/2/23 and 5/7/23. A quarterly Minimum Data Set assessment, dated 2/17/23, indicated the resident was cognitively intact. Rejection of care behaviors were not exhibited during the assessment period. The resident required extensive assistance with activities of daily living. She received insulin injections seven out of seven days in the assessment period. 2. Resident D's clinical record was reviewed on 5/11/23 at 11:10 a.m. Diagnosis included type two diabetes mellitus with hyperglycemia. A 4/14/23 physician order indicated detemir insulin (long acting insulin) 100 units/milliliter - inject 18 units subcutaneously two times a day. It was scheduled for 9:00 a.m. and 9:00 p.m. This order was discontinued on 5/3/23. A current, 5/3/23 physician order indicated insulin detemir 100 units/milliliter - inject 20 units subcutaneously two times a day. It was scheduled for 9:00 a.m. and 9:00 p.m. A current, 3/30/23 physician order included insulin lispro - inject subcutaneously per sliding scale daily before meals and at bedtime. It was scheduled for 7:00 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m.			

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	Review of the resident's Medication Administration Record indicated the resident's insulin detemir, and lispro sliding scale, scheduled to be administered at 9:00 p.m., was not administered on 5/1/23 and 5/2/23. Blood glucose results were not documented on the above mentioned dates and times. Review of the Medication Administration Audit Report from 4/20/23 to 5/11/23 indicated the resident's insulin detemir was scheduled to be administered to the resident each day at 9:00 p.m. The insulin was not administered according to the physician order on the following dates and times: a. 4/20/23 at 6:00 p.m. b. 4/21/23 at 10:19 p.m. c. 4/24/23 at 4:00 a.m. (for 4/23/23) d. 4/27/23 at 2:26 a.m. (for 4/26/23) e. 4/28/23 at 2:26 a.m. (for 427/23) f. 4/28/23 at 4:32 p.m. g. 4/29/23 at 11:04 p.m. h. 5/1/23 at 3:23 a.m. (for 4/30/23) i. 5/4/23 at 12:22 a.m. (for 5/3/23) j. 5/5/23 at 3:39 a.m. (for 5/4/23) k. 5/5/23 at 4:35 p.m. l. 5/7/23 at 12:08 a.m. (for 5/6/23) m. 5/7/23 at 10:26 p.m. n. 5/11/23 at 10:24 p.m. Review of the Medication Administration Audit Report from 4/20/23 to 5/11/23 indicated the insulin lispro was scheduled to be administered to the resident each day at 9:00 p.m. The insulin was not administered according to the physician order on the following dates and times: a. 4/23/23 at 2:18 a.m. (for 4/22/23) b. 4/24/23 at 4:00 a.m. (for 4/23/23)			

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	c. 4/24/23 at 10:44 p.m. d. 4/27/23 at 2:25 a.m. (for 4/26/23) e. 4/28/23 at 2:27 a.m. (for 4/27/23) f. 4/28/23 at 4:32 p.m. g. 4/29/23 at 11:04 p.m. h. 5/1/23 at 3:22 p.m. (for 4/30/23) i. 5/4/23 at 12:22 a.m. (for 5/3/23) j. 5/5/23 at 3:38 a.m. (for 5/4/23) k. 5/5/23 at 4:35 p.m. l. 5/7/23 at 12:08 a.m. (for 5/6/23) m. 5/7/23 at 10:26 p.m. n. 5/11/23 at 10:21 p.m. On 4/24/23 at 7:13 a.m., the resident's blood sugar was 421. The clinical record lacked action taken related to the blood sugar result being out of parameters. On 4/28/23 at 12:04 p.m., the resident's blood sugar was 451. The clinical record lacked action taken related to the blood sugar result being out of parameters. On 5/2/23 at 11:23 a.m., the resident's blood sugar was 500. The clinical record lacked action taken related to the blood sugar result being out of parameters. An admission Minimum Data Set assessment, dated 4/6/23, indicated the resident was cognitively intact. The resident required limited assistance with activities of daily living. 3. During an observation on 5/11/23 at 12:50 p.m. the DON administered Resident E's insulin aspart (rapid acting insulin). The resident indicated she ate most of her food. Resident E's clinical record was reviewed on 5/11/23 at 2:29 p.m. Diagnoses included type two			

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	diabetes mellitus with other diabetic kidney complications and end stage renal disease. A current, 10/24/22 physician order indicated insulin detemir 100 units/milliliter - inject 25 units subcutaneously at bedtime. It was scheduled for 9:00 p.m. A current, 1/26/23 physician order indicated insulin lispro - inject subcutaneously per sliding scale before meals and at bedtime. It was scheduled for 7:00 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m. Review of the resident's Medication Administration Record indicated the resident's insulin detemir and lispro sliding scale, scheduled to be administered at 9:00 p.m., was not administered on 5/1/23, 5/2/23, and 5/7/23. The resident's blood glucose not measured on the above mentioned dates and times. Review of the Medication Administration Audit Report from 4/20/23 to 5/11/23 indicated the resident's insulin detemir was scheduled to be administered to the resident each day at 9:00 p.m. The insulin was not administered according to the physician order on the following dates and times: a. 4/24/23 at 3:58 a.m. (for 4/23/23) b. 4/24/23 at 10:41 p.m. c. 4/28/23 at 2:30 a.m. (for 4/27/23 d. 4/29/23 at 11:05 p.m. e. 5/4/23 at 12:14 a.m. (for 5/3/23) f. 5/5/23 at 3:36 a.m. (for 5/4/23) g. 5/7/23 at 12:03 a.m. (for 5/6/23) h. 5/9/23 at 10:56 p.m. Review of the Medication Administration Audit Report from 4/20/23 to 5/11/23 indicated the			

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	resident's insulin lispro was scheduled to be administered to the resident each day at 9:00 p.m. The insulin was not administered according to the physician order on the following dates and times: a. 4/24/23 at 3:58 a.m. (for 4/23/23) b. 4/28/23 at 2:29 a.m. (for 4/27/23 c. 4/29/23 at 11:05 p.m. d. 5/4/23 at 12:14 a.m. (for 5/3/23) e. 5/5/23 at 3:36 a.m. (for 5/4/23) f. 5/7/23 at 12:04 a.m. (for 5/6/23) g. 5/9/23 at 10:56 p.m. A quarterly Minimum Data Set assessment, dated 4/22/23, indicated the resident was cognitively intact. During an interview on 5/11/23 at 3:33 p.m., Resident E indicated she did not always receive her insulin. She had more problems with her insulin administration when they had one nurse responsible for insulin for the whole building. During an interview on 5/11/23 at 4:32 a.m., the ADON indicated she was aware residents had voiced concerns of late insulin administration. She had found Medication Administration Records that lacked documentation. She had received complaints regarding LPN 4's lack of insulin administration. She did not have any verification the medications were administered if they were not documented in the clinical record. Two or three of the residents reported they had not received their insulin. The staff were required to report blood sugars out of parameters and were to record the action taken in the clinical record. During an interview on 5/11/23 at 4:54 p.m., the DON indicated she was aware of two residents who complained they had not received their			

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	insulin. During an interview on 5/12/23 at 10:32 a.m., LPN 4 indicated, at the beginning of May, she had discussed timely medication administration with the previous Administrator, Corporate RN 10 and the ADON. It was not acceptable practice to have any blanks on the Medication Administration Record. Even if a medication was not administered, it should have documentation in the clinical record indicating why the medication was not administered. Anyone could report concerns to any staff member to be submitted through the grievance process. These should be placed on a grievance form and submitted to the manager on duty. Department heads were required to follow up on all resident concerns. During an interview on 5/12/23 at 11:35 a.m., LPN 3 indicated a resident had reported concerns with timely medication administration approximately one week ago. He was uncertain if he had reported this concern to management staff. Medications should have been administered between an hour before to an hour after the scheduled medication time. In the last couple of weeks, his medication administration was delayed. He had administered medications late for approximately 10 residents on four different dates. He had not properly documented late medication administration in the residents' medical record. During an interview on 5/12/23 at 3:51 p.m., RN 10 indicated she had been monitoring the medication administration documentation. A QMA had reported concerns regarding a lack of insulin administration. The clinical records lacked timely medication administration for Residents C, D, and E. Medications should have been administered according to the physician orders. Blood sugars			

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	outside of parameters should have been reported to the physician. The clinical record should contain documentation of the action taken. A current facility policy, dated 12/2022, titled "Medication Administration," provided by the Assistant Clinical Operations Manager on 5/12/23 at 3:40 p.m., indicated the following: "...Policy...Medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications. This includes Registered Nurses, Licensed Practical Nurses and Qualified Medication Aides...." A current facility policy, dated 8/2022, titled "Blood Glucose Monitoring," provided by the Assistant Clinical Operations Manager on 5/12/23 at 3:40 p.m., indicated the following: "...POLICY... It is the policy of this facility to monitor and treat any hypoglycemic or hyperglycemic event... Procedure... A resident with blood glucose greater than call orders requires an assessment for symptoms of hyperglycemia. Document assessment in nursing progress notes and notify MD immediately... Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record...." Review of a National Library of Medicine article titled "When Should You Take Your Medicines?," retrieved from www.ncbi.nlm.nih.gov indicated the following: ..."When taken once a day, Levemir [detemir], a long-acting insulin, is supposed to be taken with your last meal or at bedtime. This serves to provide better blood glucose control while sleeping...." Review of patient information retrieved from www.humalog.com indicated the following:			

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	"...Humalog [lispro] is a fast-acting insulin that starts working faster and works for a shorter period of time than regular human insulin. Humalog is taken within 15 minutes before eating or right after eating a meal...." This Federal tag relates to Complaints IN00407090 and IN00407500. 3.1-37(a)			