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	07/26/2024

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 a Recertification and State Licensure Survey. This visit included Investigation of Complaints IN00433083 and IN00434056. Complaint IN00433083-No deficiencies related to the allegations are cited. Complaint IN00434056- No deficiencies related to the allegations are cited. Survey dates: July 22, 23, 24, 25, and 26, 2024 Facility number: 000027 Provider number: 155690 AIM number: 100266180 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 5 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 1, 2024.	F 0000	**The facility requests desk review for these citations.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and			

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

Ryan Kinzie | Executive Director | 08/16/2024

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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	separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to manage Resident Funds in accordance with acceptable accounting principles for 1 of 4 residents reviewed for management of Resident Funds. (Resident 29) Findings include: A review of the facility's Resident Funds was completed on 7/24/24 at 3:55 p.m. The Business Office Manager provided a "Resident Funds Trial Balance" sheet. The facility managed personal resident funds for 37 residents. Resident 29 was listed with two separate accounts; account B had a current negative balance of $2,911.47 and account C had a current negative balance of $15.16. Resident 29's account B "Resident Funds" record indicated the following: On 11/1/23, the resident's account balance was $0.53. On 11/13/23, a personal check was credited for the amount of $3,000.00. On 11/13/23, a care cost auto withdrawal for the amount of $2,948.00. On 11/17/23, a return deposit item for the amount of $3,000.00.	F 0568	**F568- Accounting and Records of Personal Funds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?An accounting of resident funds was completed for Resident 29.Any concerns with accounts for Resident 29 have been resolved and statements provided. 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 with accounts have the potential to be affected by the alleged deficient practice.All current resident accounts were audited by the Corporate BOM. Statements were issued for all resident trust accounts. What measures will be put into place or what systemic changes will be made to ensure that the deficient**	08/19/2024

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	On 11/17/23, a return deposit item fee for the amount of $16.00. On 11/30/23, a personal check was credited for the amount of $ 3,300.00 On 11/20/23, a care cost auto withdrawal for the amount of $3,248.00. Resident 29's resident fund account B balance on 12/1/23 was in the negative of $2,911.47. During an interview, on 7/24/24 at 3:35 p.m., the Corporate Business Office Consultant indicated Resident 29 had a returned check in November 2023, and this resulted in the account having a negative balance. The check was covered a few weeks later. Care cost withdrawals were automated and deducted after deposits were made and a second care cost charge was made in error for November 2023. Additionally, the funds had been deposited into an inappropriate account for medical expenses. The facility Business Office Manager corrected this in December 2023, resulting in two accounts for Resident 29. During an interview, on 7/25/24 at 1:07 p.m., the Business Office Manager and Corporate Business Office Consultant indicated they had reached out by electronic mail (e-mail) to the third party billing company in December 2023 about the inappropriate charges, but had not received any response. The Business Office Manager did not send follow-up e-mails related to the inappropriate charges. The Corporate Business Office Consultant indicated she had spoken with a representative of the third party billing by phone on 7/24/24, and the charge error would be refunded no later than 7/25/24. A current facility policy, dated 10/23, titled, "Resident Funds Management System", provided		**practice does not recur?BOM has been re-educated relative to Accounting and Records of Personal Funds, including but not limited to, Acceptable Accounting Principles and Resident Accounts Policy.BOM/designee will provide monthly accounting of resident transactions to ED/designee, until substantial compliance of proper accounting has been maintained for at least 6 months.Quarterly statements will be provided to residents or their responsible party ongoing, including notification of resource limits. 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? BOM/designee will provide monthly accounting of resident transactions to ED/designee, until substantial compliance of proper accounting has been maintained for at least 6 months.ED/designee will be responsible for monitoring compliance of resident accounts monthly ongoing. Completion Date: August 19, 2024**	

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	by the Regional Nurse Consultant, on 7/25/24 at 2:54 p.m., indicated the following: "...Established to manage resident funds by following acceptable accounting principles.... Audits on resident accounts will occur monthly. LTC (consulting partners) and BOM will both audit accounts to ensure liabilities are paid monthly...." 3.1-6(e)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to ensure protective Peripherally Inserted Central Catheter (PICC) dressings were intact and changed as ordered for 1 of 6 residents reviewed for infection control. (Resident 151) Finding includes: During an observation on 7/22/24 at 2:51 p.m., to the left of the door, Resident 151's room indicated Enhanced Barrier Precautions. The resident was accompanied back to her room from the therapy room by an unknown staff member with an intravenous (IV) pole on her right side. Her single lumen PICC on her right upper arm was connected to the IV tubing and the PICC dressing was visible and loose from the skin around the top half of the dressing. During an interview on 7/22/24 at 3:58 p.m.,	F 0694	**F- 694 Parenteral/IV Fluids/PICC Dressing** **1) Immediate actions taken for those residents identified:** **Resident #151's PICC dressing was changed at the time of survey. Resident did not have any adverse effects as a result of the cited occurrence. Resident #151 was discharged home the day after this occurrence; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents:**	08/19/2024

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	Resident 151 indicated her PICC dressing was loose and had not been changed since before admission to the facility. The PICC dressing to her right upper arm was dated 7/16/24. The facility staff last administered her antibiotic through the PICC line on 7/22/24 at 2:30 p.m. and had not offered to change the PICC dressing. Resident 151's clinical record was reviewed on 7/23/24 at 4:31 p.m. The resident admitted to the facility on 7/17/24. Diagnoses included cellulitis of the left upper limb and sepsis due to streptococcus group A (bacteria type). A current physician order, dated 7/18/24, included cefazolin sodium solution (antibiotic)- administer 2 grams intravenously every eight hours for bacteremia (infection). A current physician order, dated 7/17/24, included a PICC line IV dressing change every seven days and as needed. Review of the Treatment Administration Record (TAR) included IV antibiotic administration every eight hours from 7/22/24 through 7/24/24. The clinical record lacked evidence of PICC line dressing changes during the above mentioned times while the dressing was non-occlusive. An admission Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was cognitively intact. The resident received specialized services including IV medication and IV access. A current care plan, dated 7/18/24, indicated the resident had sepsis due to left upper arm cellulitis with a PICC line in the left upper arm. Interventions included the following: administer		**Residents with central venous catheters have the potential to be affected, an audit was conducted to identify these residents. No other residents were identified as having a central venous catheter.** **3) Measures put into place/ System changes:** **All Licensed Nurses were re-educated relative to Parenteral/IV Fluids, including but not limited to, professional standards of practice relative to ensuring dressings are intact and changed as ordered for central venous catheters.** **4) How the corrective actions will be monitored:** DNS/Designee, daily on scheduled days of work, will visually observe the IV site dressings of all residents with a central venous catheter to ensure dressings are intact and occlusive for 4 weeks to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, DNS/Designee will visually observe the IV site dressings of all residents with a central venous catheter weekly for 5 months to	

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	medications per orders, IV assessments as indicated, and treatments as ordered. A nurse's note, dated 7/25/24, indicated the resident's PICC was in the right upper arm. During an observation on 7/24/24 at 9:56 a.m., Resident 151 exited her room, walked down the 300 unit hallway into the main lobby, and continued to the activity room for an activity. The PICC line dressing to her right upper arm was visible and loose, with the top of the dressing hanging down midway. The dressing was dated 7/16/24. During an observation on 7/24/24 at 11:00 a.m., Resident 151 stood in the main lobby area. The PICC line dressing remained to her right upper arm, dated 7/16/24. During an IV administration observation on 7/24/24 at 2:25 p.m., RN 6 indicated she had just changed the resident's right upper arm PICC dressing because it was loose and hanging down the resident's arm. The resident received IV antibiotics several times a day and last received it on 7/24/24 at approximately 6:00 a.m. The PICC line dressing was ordered to be changed weekly and as needed when the dressing was loose. During an interview on 7/24/24 at 4:44 p.m., the DON indicated PICC line dressings should be changed every seven days or immediately when the dressing was not occlusive. PICC line dressings should be assessed to ensure they were occlusive each time the staff administered the resident's IV antibiotic. Non-occlusive PICC line dressings were an infection prevention and control concern.		ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). DNS/Designee will be responsible to present the results of these audits for review in QAPI meeting monthly times 6 months or until an average of 90% compliance or greater is achieved time 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: August 19, 2024	

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	A current facility policy, revised March 2022, titled "Central Venous Catheter Care and Dressing Changes," provided by the DON on 7/24/24 at 5:13 p.m., indicated the following: "Purpose...The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings... General Guidelines 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised [e.g., damp, loosened or visibly soiled]...." 3.1-47(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of			

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	1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. A. Based on observation and interview, the facility failed to ensure insulin pens were labeled with appropriate resident identifier information on 1 of 3 carts reviewed for medication storage. (Front treatment cart) B. Based on observation and interview, the facility failed to ensure that expired vaccinations were disposed of timely for 1 of 1 medication rooms reviewed for medication storage. (Front medication room) Findings include: A. During a medication storage observation of the front treatment cart, accompanied by RN 6, on 7/25/24 at 9:31 a.m., the following were observed without resident identifiers or directions: One Humalog Kwikpen (insulin), dated 6/24/24, containing 130 units. One Humalog Kwikpen, dated 6/28/24, containing 220 units. One Humalog Kwikpen, dated 6/28/24, containing 150 units. One undated Humalog Kwikpen, containing 120 units. During an interview, at the time of the observation, RN 6 indicated she was unsure how long the unlabeled pens had been in the treatment cart, and the pens should have resident identifier information labels. There were 6 different residents who received insulin from the front treatment cart.	F 0761	**F761 – Label/Store Drugs and Biologicals** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A The insulin pens were removed from the medication cart at the time of survey. B The flu vaccine was discarded at the time of survey. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have orders for medications; therefore, this plan of correction applies to all residents currently residing in the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been re-educated relative to Label/Store Drugs and Biologicals, including but not limited to, ensuring medications are correctly	08/19/2024

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	B. During a medication storage observation of the front medication room, accompanied by RN 6, on 7/25/24 at 9:37 a.m., two boxes of Influenza Vaccine, containing 10 pre-filled single use dose syringes, with expiration dates of 5/2/24 and 6/30/24, were stored in the refrigerator. During an interview, at the time of the observation, RN 6 indicated these vaccines were expired, should not be given to residents, and should be disposed of promptly. A current facility policy, dated 2020, titled "Medication Labels", provided by the Regional Nurse Consultant on 7/25/24 at 3:36 p.m., indicated the following: "...1. Each prescription medication label includes: Resident's name, specific direction for use, including route of administration...strength of medication, physician's name, date medication is dispensed, quantity, expiration date, name, address, and telephone number of PharmcareUSA, prescription number..." A current facility policy, dated 2020, titled "Medication Storage in the Facility", provided by the regional Nurse Consultant on 7/25/24 at 2:54 p.m., indicated the following: "...13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock..." 3.1-25(k) 3.1-25(o)		labeled with resident identifying, and expired medications are removed and destroyed. 1.How the corrective action(s) will be monitored? DNS/Designee will be responsible daily, on scheduled days of work, to audit 1 medication cart and 1 medication room for 4 weeks, then 1 medication cart and 1 medication room 2 times weekly for 4 weeks, then 1 medication cart and 1 medication room 1 time weekly for 4 months to ensure medications are stored properly, expired medications disposed of, and medications are correctly labeled with resident identifying information. Any identified concerns will be promptly addressed with the responsible individual(s). DNS/Designee will provide and review inspection/audit results in QAPI meeting monthly for 6 months. Audit results will be discussed monthly in QAPI, and adjustments will be made as needed to ensure on-going compliance. 1.Completion date: August 19, 2024	
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems			

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	and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse			

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	events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their			

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	causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on observation, interview, and record	F 0867	**F867 – QAPI/QAA Improvement**	08/19/2024

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review, the facility failed to implement corrective and preventive actions to ensure systemic issues related to resident funds, medication labeling, and medication expiration were identified and quality assessment and performance improvement (QAPI) plans were implemented to prevent deficiencies from re-occurring. Findings include: On 7/25/24 at 3:13 p.m., the Administrator provided a QAPI action plan, dated 5/17/24. The root cause analysis indicated medication carts and rooms were not routinely inspected to ensure removal of expired medications. The concern included medication carts and rooms with expired medications. Action items of the plan included: the front medication room would be inspected with expired medications removed and destroyed. The actual completion date was 5/16/24. The back unit medication room was to be inspected with expired medications destroyed and lacked a completion date. An additional action plan indicated the medication rooms would be inspected weekly for four weeks from 5/23/24 through 6/20/24 and then weekly for two months from 6/27/24 through 8/22/24. During an interview on 7/26/24 at 4:28 p.m., the Administrator indicated the QAPI team met monthly and had last met on 6/28/24. The QAPI meeting agenda/ minute notes from that meeting addressed compliance issues noted on the last ISDH annual survey from 7/14/23. The included action plan development indicated the DON would perform the medication room and medication cart audits. At the same time, the Chief Operating Officer indicated he was unable to provide any audits related to acceptable accounting principles to manage resident funds.		**activities** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A QAPI meeting was held on 8.1.24 to discuss and implement plans for correction for areas of concern that were presented at the time of exit from annual survey. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? This plan of correction applies to all residents currently residing in the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? QAPI members have been re-educated relative to the importance of identifying areas for improvement and a process to monitor progress in these areas through an effective action plan implemented through the QAPI process. 1.How the corrective action(s) will be monitored? ED/Designee will be responsible will be responsible monthly for 6	

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	07/26/2024

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	Survey Plan of Correction (POC) Audit tools for May, June, and July 2024 were provided by the Chief Operating Officer on 7/26/24 at 5:20 p.m. No identified concerns were indicated on the audit sheets. Comments on all three audits included: Any adjustments will be made as needed to ensure on-going compliance. Review of an undated current facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Plan, provided by the Administrator on 7/23/24 at 9:18 a.m., indicated the following: " ...The objectives of the QAPI Plan are to:... 3. Provide structure and processes to correct identified quality and/ or safety deficiencies; 4. Establish and implement plans to correct deficiencies ...7... as a basis for demonstrating that there is an effective ongoing program ...." Cross reference F568. Cross reference F761. 3.1-52(b)(2)		months to determine the effectiveness of the action plans set out during the QAPI process and provide and review inspection/audit results in QAPI meeting monthly for 6 months. Audit results will be discussed monthly in QAPI, and adjustments will be made as needed to ensure on-going compliance. 1.Completion date: August 19, 2024	