STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 27, 28, 29, 30 and June 2, 2025 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF: 38 Total: 38 Census Payor Type: Medicare: 8 Medicaid: 25 Other: 5 Total: 38 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 12, 2025.	F 0000	**Plan of Correction FOR ENVIVE OF SULLIVAN** **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 June 2, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 30, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0605 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2), 483.45(c)(3) Right to be Free from Chemical Restraints Based on record review and interview, the facility failed to ensure AIMS (abnormal involuntary movement scale) assessments were completed for 1 of 5 residents were reviewed for unnecessary medications (Resident 18). Findings include:	F 0605	**F 605- Right to be Free from Chemical Restraints** *"Facility failed to ensure AIMS (abnormal involuntary movement scale) assessments were completed for 1 or 5 residents were reviewed for unnecessary*	06/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Jo Parker	Executive Director	06/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	Resident 18's record was reviewed on 1/23/25 at 11:06 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (mental health condition characterized by persistently low or depressed mood and loss of interest or please in activities). An annual Minimum Data Set (MDS) assessment, dated 3/5/25, indicated the resident had severe cognitive impairment and was on anti-psychotic and anti-depressant medications. A care plan, dated 5/24/22, indicated the resident had impaired cognitive function related to Alzheimer's, dementia. Interventions included, but were not limited to, administer medication as ordered, assist resident with making safe decisions, and monitor/document/report as needed any changes in cognitive function. A care plan, dated 5/25/22, indicated the resident used antipsychotic medications related with depression with psychotic features. Interventions included, but were not limited to, administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness, consult with pharmacy, and discuss with medical doctor, and family about ongoing need for use of medication. A physician order, dated 4/5/25, with an original start date of 5/18/22, indicated to administer one tablet of Risperidone (a drug used to treat certain		*medications."* **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. Completed AIMS assessment for resident #18. **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 with medications requiring AIMS have the potential to be affected by the alleged deficient practice. All current in-house residents were audited for AIMS assessments on 06/11/2025 none identified to need AIMS assessments at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided all Nursing Staff In-service education was on Envive Psychotropic Medication Use Policy with a focus on completing AIMS assessments timely. Teachable Moment given to DON, MDS and SSD related to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	mental disorders) 0.25 mg (milligrams) by mouth two times a day. Review of Resident 18's record indicated an AIMS assessment had been completed on 7/13/24 but the record lacked documentation of an AIMS assessment being completed since July of 2024. During an interview, on 5/28/25 at 11:23 a.m., Licensed Practical Nurse (LPN) 3 indicated AIMS assessments should be completed on admission and every 3 months. During an interview, on 5/28/25 at 11:33 a.m., the Director of Nursing (DON) indicated she was not aware of how the previous staff completed the AIMS assessments and didn't know if they were on the computer or on paper. She was unable to find documentation for an AIMS assessment being completed on Resident 18 since July 2024. On 5/28/25 at 1:58 p.m., the Regional Nurse Consultant provided a document with a revised date of 8/24, titled, "Psychotropic Medications Use," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Purpose ...60. Assessment: Lift, AIMS (Recommended Quarterly) ...." 3.1-48(b)		timely completion of AIMS assessments. **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?** Performance Improvement tool-initiated monitoring timely completion of AIMS Assessments which randomly reviews 5 residents weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee and reviewed by QAPI. If completion of 95% or greater is not achieved, action plans will be initiated for further compliance. **5. Date of completion:** 06/30/2025	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 1 of 16 residents reviewed for care plan meetings (Resident 9), and failed to ensure care plans were implemented and updated for 2 of 5 residents reviewed for care plans	F 0657	**F 657- Care Plan Timing and Revision** *"Facility failed to ensure that care plan meetings were conducted quarterly for 1 of 16 residents reviewed and failed to ensure care*	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	(Residents 32 and 14). Findings include: 1. During a phone interview, on 5/2725 at 2:01 p.m., Resident 9's daughter indicated she did not remember being invited to a care plan meeting ever. She indicated she would be happy to attend via phone call if someone would reach out to her. Resident 9's record was reviewed on 5/29/25 at 11:27 a.m. An annual Minimum Data Set (MDS) assessment, dated 3/3/25, indicated the resident had severe cognitive impairment. Census information indicated that the resident was admitted to the facility on 6/27/24. A care conference review note, dated 2/13/25, indicated a care plan meeting was conducted on this day. The record lacked documentation of a care plan meeting being conducted before 2/13/25. During an interview, on 5/29/25 at 1:39 p.m., the Social Service Director (SSD) indicated she conducted the care plan meetings once a quarter with the residents and/or family representatives. She had not invited Resident 9's daughter because she did not have an address on file to send her an invitation. The SSD indicated she would conduct a care plan meeting over the phone with family if they did not live close to the facility. During an interview, on 5/30/25 at 9:07 a.m., the SSD indicated she was unable to find any documentation for a care plan meeting being conducted for Resident 9 prior to 2/13/25, she further indicated she had a care plan meeting with the resident yesterday on 5/29/25. The SSD was		*plans were implemented and updated for 2 or 5 residents reviewed for care plans."* **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. Residents # 32 and #14 plans of care were updated/revised. Resident # 9 care plan was completed. **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 the alleged deficient practice. All current in-house residents were audited for Quarterly care plan meetings and none were appropriate for action at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided IDT Team education on Envive Comprehensive care plan policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	unaware of where or how the previous SSD documented the care plan meetings. During an interview, on 5/20/25 at 9:09 a.m., the Administrator indicated she was aware there was no documentation available to verify care plan meetings had been conducted quarterly as per policy. On 5/30/25 at 10:10 a.m., the Administrator provided a document with a revised date of 8/24, titled, "Care Planning - Interdisciplinary Team," and indicated it was the policy currently being used by the facility. The policy indicated, " ...4. The resident, the resident's family and/or resident's legal representative/guardian or surrogate are encouraged to participate in the development of a revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record ...." 2. During an interview, on 5/27/25 at 1:40 p.m., Resident 32 indicated she had frequent pain and was on pain medication as needed. Resident 32's record was reviewed on 5/28/25 at 2:56 p.m. The profile indicated the resident's diagnosis included, but were not limited to, acute and chronic respiratory failure with hypoxia (the lungs are unable to adequately supply oxygen to the blood, leading to low oxygen levels in the blood and potentially low oxygen levels in the tissues), chronic pain (defined as pain that persists longer than three months or beyond the typical healing period of an illness or injury), and		with a focus on timely quarterly meetings, and revisions. Teachable Moment given to IDT team related to conducting quarterly care plan meetings and implementing revisions and updates for care plans in a timely manner. **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?** Performance Improvement tool-initiated monitoring timely completion of Care Plan Meetings and Care plan revisions which randomly review 5 residents weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee and reviewed by QAPI. If completion of 95% or greater is not achieved, action plans will be initiated for further compliance. **5. Date of completion:** 06/30/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). Census information indicated that the resident was admitted to the facility on 1/21/25. A quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, indicated the resident had no cognitive impairment and was taking a opioid (a class of drug that were used primarily for pain relief) medication. The MDS assessment indicated the resident received as needed pain medication and had frequent complaints of pain and the pain frequently interfered with activities of daily living. A physician order, dated 1/21/25, indicated to administer one tablet of Hydrocodone-Acetaminophen (opioid pain medication) tablet 7.5-325mg (milligrams) by mouth every 8 hours as needed for pain. Review of the resident's Medication Administration Record (MAR) for the months of March, April, and May indicated Resident 32 received the Hydrocodone medication daily except for a few days when she was in the hospital in March 2025. Resident 32's record lacked documentation of a care plan being implemented for pain management or the use of opioid pain medication. During an interview, on 5/30/25 at 11:00 a.m., the Director of Nursing (DON) indicated Resident 32 had been on an as needed pain medication since admission and acknowledged the resident was taking the pain medication on a regular basis. The nurse practitioner was aware and would be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	looking into the matter. The DON indicated she was not aware that the resident didn't have a care plan for pain management or opioid medication use. During an interview, on 5/30/25 at 11:17 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident 32 had been on pain medication since admission and that she complained of generalized all over pain. During an interview, on 5/30/25 at 2:00 p.m., the MDS coordinator indicated she was not aware that Resident 32 didn't have a care plan implemented for pain management or for use of pain medication. She was in the process of going through all the care plans to get them updated. 3. Resident 14's record was reviewed on 5/28/25 at 10:26 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia, mild, with psychotic disturbance (when a person has a type of cognitive decline where the specific cause or type of brain damage leading to the decline is not clearly identified and are experiencing psychotic symptoms [loss of touch with reality] as part of the dementia). A current care plan, dated 11/14/24, indicated the resident had venous access device in her midline right arm related to antibiotic (a medication used to treat bacterial infections) administration. A current care plan, dated 11/14/24, indicated the resident was receiving IV medications for a urinary tract infection (UTI-an infection of the urinary system) due to ESBL (Extended-Spectrum Beta-Lactamase: an enzyme produced by certain bacteria that makes them resistant to many commonly used antibiotics) in her urine.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	A physician's order, dated 11/14/24, with an end date of 11/19/24, indicated to administer 1 gram of Ertapenem Sodium Injection Solution Reconstituted (a way of administering the antibiotic Ertapenem via IV to treat moderate to severe bacterial infections) one time daily for ESBL in the urine for 5 days. A progress note, dated 11/13/24 at 1:14 p.m., indicated the resident had returned to the facility from a hospital stay. The resident had a midline IV access in her right arm. A progress note, dated 11/14/24 at 2:34 p.m., indicated the resident had an order to administer 1 gram of Ertapenem Sodium Injection Solution Reconstituted one time daily for ESBL in the urine for 5 days. A progress note, dated 11/26/25 at 1:00 p.m., indicated the resident's midline IV access had been removed. A quarterly Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the resident had no cognitive deficit. The assessment lacked documentation that the resident had received an antibiotic or that the resident had IV (intravenous access-a safe and reliable access to a vein for the purpose of administering fluids, medications, or other substances directly into the bloodstream) during the assessment period. An annual MDS assessment (in progress), dated 5/23/25, indicated the resident had no cognitive deficit. The assessment lacked documentation that the resident had received an antibiotic or that the resident had IV access during the assessment period.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	During an interview, on 5/28/25 at 11:23 a.m., the resident indicated she no longer had the IV access line where she was getting her antibiotic through. She had the IV access right after she returned from the hospital in November. She had not had the line for quite some time. During an interview, on 5/28/25 at 12:03 p.m., the Director of Nursing (DON) indicated she was not surprised about the care plan not being updated. She and the Administrator had only been in the facility for a few months. Since that time, they had been finding all kinds of things that had not been done. On 5/28/25 at 1:56 p.m., the Regional Nurse Consultant provided a document, dated 8/2024, titled, "Care Plans, Comprehensive Person-Centered," and indicated it was the policy currently being used by the facility. The policy indicated, "...A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation...3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment...11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change...." 3.1-35(a) 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	Based on observation, record review, and interview, the facility failed to ensure residents were provided assistance to shave for 2 of 16 residents reviewed for activities of daily living (ADL) care (Residents 33 and 21). Findings include: 1. During an observation, on 5/27/25 at 11:11 a.m. Resident 33 was up in his wheelchair, in the therapy gym. Resident 33 had untrimmed beard and mustache facial hair growth. During an observation, on 5/28/25 at 1:52 p.m., Resident 33 was up in his wheelchair, in the hallway. The resident had untrimmed beard and mustache facial hair growth. At the same time, the resident indicated he did not want to have facial hair and wanted to be shaved at least once a week. During an observation, on 5/29/25 at 10:33 a.m., Resident 33 was sitting up in his wheelchair, in the therapy gym. The resident had untrimmed beard and mustache facial hair growth. During an observation, on 5/29/25 at 1:20 p.m., the resident was observed up in his wheelchair, in his room. The resident had untrimmed beard and mustache growth. At the same time, the resident indicated he received a shower the day before, but the staff had not asked him if he wanted shaved. The resident indicated he would have let the staff assist him with shaving if they had asked. Resident 33's record was reviewed on 5/28/25 at 2:03 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 3/29/25, indicated the resident had a severe cognitive impairment and required substantial/maximal staff assistance with personal	F 0677	**F 677- ADL Care for Dependent Residents** *"Facility failed to ensure residents were provided assistance to shave for 2 of 16 residents reviewed for ADL Care."* **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. Residents # 33 and #21 were shaved immediately. **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 have the potential to be affected by the alleged deficient practice. All current in-house residents were audited for unwanted facial hair and none were identified for further assistance. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided education for All Nursing staff reviewing Envive Activities of Daily Living and Nursing Support policy.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	hygiene. The assessment lacked documentation the resident refused care. Diagnoses on the resident's profile included, but were not limited to, muscle wasting and atrophy (decrease in muscle mass and strength) and need for assistance with personal care. A care plan, last revised on 4/15/25, indicated the resident had an ADL self-care performance deficit. Interventions indicated the resident usually required substantial/maximal staff assistance with personal hygiene and bathing. Progress Notes, dated May 2025, lacked documentation the resident refused care. Shower Sheets, dated May 2025, indicated the resident received a shower on 5/3/25, 5/7/25, 5/10/25, 5/14/25, 5/17/25, 5/21/25, 5/24/25, and 5/28/25. The shower sheet, dated 5/3/25, indicated the resident was shaved. All other shower sheets lacked documentation the resident was shaved or was offered to be shaved and refused. During an interview, on 5/29/25 at 1:22 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident 33 should have been shaved on shower days, however, sometimes he refused. LPN 3 indicated shaving or refusal should have been documented on the shower sheets. 2. On 5/27/25 at 11:25 a.m., during initial observation and interview, Resident 21observed in his room sitting in a wheelchair. Resident had a strong urine odor. His hair was oily and disheveled with extensive facial hair. On 5/28/25 11:35 a.m., observed resident in his room. During an interview the resident indicated he had his hair washed and was unshaven. The		Teachable Moment provided to LPN # 3 and C.N.A #4 related to ADL care with a focus on unwanted facial hair. **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?** Performance Improvement tool-initiated monitoring ADL Support and unwanted facial hair which randomly reviews 5 residents weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee and reviewed by QAPI. If completion of 95% or greater is not achieved, action plans will be initiated for further compliance. **5. Date of completion:** 06/30/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	resident indicated he did not like having facial hair. On 5/28/25 at 11:37 a.m., during an interview, Certified Nurse Aide (CNA) 4 indicated the resident preferred to be shaved. On 5/28/25 at 12:06 p.m., during an interview, Licensed Practical Nurse (LPN) 3 indicated residents were shaved on shower days. On 5/28/25 at 2:34 p.m., The medical record of Resident 21 was reviewed. The resident was admitted to the facility on 12/27/23. Admitting diagnoses included but not limited to Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A care plan, dated 8/26/24, indicated the resident had an ADL (activities of daily living) (bathing, dressing grooming) self-care performance deficit related to Parkinson's, impaired respiratory status. Interventions included but were not limited to personal hygiene. Usual performance fluctuated, usual performance was dependent on assistance of 2, bathing/showering usual performance may fluctuate with usual performance of dependent on assistance of 2. A Minimum Data Set (MDS) assessment, dated 5/3/25, indicated the resident had mild cognitive impairment and required extensive assistance with ADL care. On 5/29/2025 at 2:30 p.m., the Director of Nursing provided a document titled, "Activities of daily			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	living," dated 8/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation ...2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) ...." 3.1-38(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen equipment was changed and dated according to facility policy for 1 of 1 residents reviewed for respiratory care (Resident 28). Findings include: On 5/27/25 at 11:17 a.m., during an initial observation an oxygen concentrator was in the resident's room next to the bed. Oxygen tubing was in a clear storage bag dated 4/27/25. During an interview the resident indicated she was not receiving oxygen. On 5/28/25 at 11:50 a.m., observed oxygen tubing inside of a clear storage bag, dated 4/27/25, which was attached to the oxygen concentrator next to the resident's bed. During an interview the resident again indicated she had not been receiving oxygen at any time including at night. On 5/28/25 at 11:55 a.m., during an interview	F 0695	**F 695- Respiratory/Tracheostomy Care and Suctioning** *"Facility failed to ensure oxygen equipment was changed and dated according to facility policy for 1 or 1 residents reviewed."* **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. Residents # 28 tubing was changed and dated immediately. **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.**	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	Licensed Practical Nurse (LPN) 3 indicated the oxygen tubing was changed weekly on Sunday nights. She indicated Resident 28 did not use her oxygen very often. On 5/29/25 at 9:39 a.m., the medical record of Resident 28 was reviewed. The resident was admitted on 12/31/24. Admitting diagnoses included but was not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), shortness of breath and chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). A Physician order, dated 2/22/25, indicated to administer oxygen at 2L (liters) per nasal cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels) at night for SOB (shortness of breath), check oxygen saturation (a measurement of the percentage of hemoglobin in your blood that is carrying oxygen) every shift at bedtime for shortness of breath and PRN (as needed), and may wean off (gradually reduce amount of oxygen). A Physician order, dated 5/9/25, indicated to change oxygen tubing every night shift every Sun and PRN for oxygen use. Review of the Medication administration record (MAR) from 3/1/25 through 5/27/25 indicated the resident was administered oxygen nightly. The medical record lacked documentation of a		- Residents utilizing oxygen have the potential to be affected by the alleged deficient practice. - In-house audit completed for all residents regarding O2 equipment not being changed or dated and none were identified for further appropriate action. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided all Nursing staff In-service education reviewing Envive Policy on dating and changing respiratory equipment. **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?** Performance Improvement tool-initiated monitoring changing and dating of oxygen tubing and respiratory supplies which randomly reviews 5 residents weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee and reviewed by QAPI. If completion of 95% or greater is not achieved, action plans will be initiated for further compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	care plan related to oxygen use. A quarterly Minimum Data Set (MDS) assessment, dated 3/19/25, indicated the resident was cognitively intact and received oxygen during the assessment period. On 5/29/25 at 10:00 a.m., during an interview the Director of Nursing (DON) indicated she discontinued the oxygen order because the resident did not use oxygen, and the storage bag and tubing was not changed due to being overlooked. On 6/2/2025 at 11:00 a.m., the Administrator provided a document titled, "Respiratory Therapy," dated 8/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Infection Control Considerations Related to Oxygen Administration ...13. Change the oxygen cannula and tubing every seven (7) days, or as needed ...." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)		**5. Date of completion:** 06/30/2025	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure a resident's antibiotic was not administered past the stop date for 1 of 2 residents reviewed for antibiotic use (Resident 33). Findings include: Resident 33's record was reviewed on 5/28/25 at 2:03 p.m. A quarterly Minimum Data Set (MDS)	F 0757	**F 757- Drug Regimen is Free from unnecessary Drugs** *"Facility failed to ensure a residents antibiotic was not administered past the stop date for 1 or 2 residents."* **1: What corrective action(s) will be accomplished for those residents found to have been**	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	assessment, dated 3/29/25, indicated the resident had a severe cognitive impairment and received an antibiotic during the assessment look-back period. A chest x-ray, dated 5/12/25, showed the resident had an infiltrate (pneumonia). A May 2025 Medication Administration Record (MAR) included a physician's order, dated 5/12/25. The physician's order indicated doxycycline (an antibiotic) 100 milligrams (mg) by mouth twice daily for seven days for infection. The medication was documented as administered, from the evening of 5/12/25 to the evening of 5/27/25, and was not stopped after seven days. A pharmacy delivery log indicated 14 doxycycline 100 mg tablets were delivered to the facility for Resident 33 on 5/12/25. An Emergency Drug Kit (EDK) log indicated doxycycline 100 mg was removed from the EDK twice on 5/21/25, twice on 5/22/25, once on 5/24/25, once on 5/26/25, and once on 5/27/25. During an interview, on 5/28/25 at 2:39 p.m., the Director of Nursing (DON) indicated she reviewed Resident 33's doxycycline order and administration. The resident received doxycycline until the evening of 5/27/25. The pharmacy filled the medication because the stop date was in the text of the order, but it was not put in the system correctly so the order was not stopped when it should have been. On 5/24/25 at 2:00 p.m., the DON provided a document titled, "Antibiotic Stewardship," last revised in August 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...4. If an antibiotic is indicated,		**affected by the deficient practice?** Resident #33 currently resides at the facility. The physician was immediately notified on 5/28/25 of the extended administration of Doxycycline to Resident #33. The antibiotic was immediately discontinued as of the time of notification. Resident #33's medical record was reviewed by the NP for any potential adverse effects related to the prolonged antibiotic administration. No adverse effects were noted. **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 current residents receiving antibiotic therapy have had their medication orders reviewed to verify start dates stop dates, and that current administration aligns with physicians' orders. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON Educated All nursing staff on Envive medication and treatment orders policy and the antibiotic stewardship policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	prescribers will provide complete antibiotic orders including the following elements...d. Duration of treatment: (1) start and stop date; or (2) Number of days of therapy...." 3.1-48(a)(2)		Education will emphasize the importance of adhering to antibiotic stop dates to prevent unnecessary drug administration. Teachable Moment for DON regarding administering medication past stop dates **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 Director of Nursing, or designee, will conduct ongoing audits of residents with active antibiotic orders to ensure accurate transcription, proper stop date entry, and adherence to the prescribed duration. Audits will review 5 residents weekly, monthly , then monthly in QAPI for 6 months. This tool will be completed by the DON or designee and reviewed by QAPI. If completion of 95% or greater is not achieved, action plans will be initiated for further compliance. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
			according to the outcomes. **5. Date of completion:** 06/30/2025	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly and the facility failed to ensure expired medications were disposed of for 1 of 1 medication storage rooms reviewed and for 2 of 3 medication carts reviewed (Residents 193 and 24). Findings include: 1. On 5/29/25 at 3:10 p.m., the medication storage room contained an undated multi use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution. During an interview, on 5/29/25 at 3:10 p.m., Licensed Practical Nurse (LPN) 3 indicated she was not aware of how long Aplisol was good for once opened, but was aware the vial should be dated once opened. During an interview, on 5/29/25 at 3:15 p.m., the Regional Nurse Consultant indicated the vial of Aplisol was good for 30 days once opened. During an interview, on 5/29/25 at 3:16 p.m., the Director of Nursing indicated the vial of Aplisol should be dated once opened. On 5/29/25 at 4:04 p.m., the Regional Nurse Consultant provided an undated document, titled,	F 0761	**F 761- Label/Store Drugs and Biologicals** *"Facility failed to ensure medications were labeled properly and the facility failed to ensure expired medications were disposed of for 1 of 1 medication storage rooms reviewed and for 2 of 3 medication carts reviewed."* **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. Expired undated medications were disposed of immediately. **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 the alleged deficient practice. - In-house audit completed for	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	"Medications with Shortened Expiration Dates," and indicated it was the current policy used by the facility. The policy indicated, " ...Aplisol solution discard 30 days after initial use...." 2. On 5/29/25 at 3:11 p.m., the medication storage room contained 3 prefilled syringes of hepatitis B Vaccines (a preventive shot that protects against the hepatitis B virus, a common cause of liver disease and cancer) intended for facility stock. The vaccines contained a label that they were delivered to the facility on 1/29/25 from the pharmacy and had an expiration date of 5/19/25. During an interview, on 5/29/25 at 3:11 p.m., LPN 3 indicated the hepatitis B vaccines should have been discarded. On 5/29/24 at 4:00 p.m., the Regional Nurse Consultant provided an undated document, titled, "Expired Medications and Medications with Shortened Expiration Dates," and indicated it was the current policy used by the facility. The policy indicated, " ...Ensure that all medications in the facility are rotated and/ or reviewed on a consistent basis to prevent having expired medications in the facility ...2. The Director of Nursing or other authorized personnel will delegate to appropriate personnel the task of ensuring that all "outdated" or "expired" medications (with the exception of controlled substances, refer to controlled substances policy) are removed from the medication cart or other area that medication may be stored in ...." 3. On 5/29/25 at 4:41 p.m., the 300-hall medication cart contained an insulin (medication used to lower blood sugar) pen injector that had no open date. The pen contained a label that indicated it was for Resident 193.		Med storage rooms and 3 medication carts and no other expired/undated medications were identified. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided education to all nursing staff on Envive medication labeling, storage and medications with shortened expiration dates 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?** Performance Improvement tool-initiated monitoring Med carts and Med storage room for expired medications and medications which are not labeled or dated this tool reviews 3 Medication carts and Medication Storage Room weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee. **5. Date of completion:** 06/30/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	During an interview, on 5/29/25 at 4:42 p.m., Licensed Practical Nurse (LPN) 3 indicated the insulin pens and vials should be dated once opened. She further indicated that the insulin pens and vials were good for 28 days once they were opened. Resident 193's record was reviewed on 5/30/25 at 8:43 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A physician order, dated 5/15/25, indicated Glargine (insulin medication) solution 100 unit/ml (milliliter) inject 30 units subcutaneous (under the skin) at bedtime for diabetes. 4. On 5/29/25 at 4:44 p.m., the 200-hall medication cart contained 2 insulin pen injectors that had no open dates on them. The insulin pens contained a label that indicated they were for Resident 24. Resident 24's record was reviewed on 5/30/25 at 8:44 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A physician order, dated 4/18/25, indicated Glargine (insulin medication) solution 100 unit/ml (milliliter) inject 45 units subcutaneous (under the skin) at bedtime. During an interview, on 5/29/25 at 4:44 p.m., LPN 3 indicated she was not aware of how long the insulin pens had been opened.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	On 5/29/24 at 4:00 p.m., the Regional Nurse Consultant provided an undated document, titled, "Expired Medications and Medications with Shortened Expiration Dates," and indicated it was the current policy used by the facility. The policy indicated, " ...Ensure that all medications in the facility are rotated and/ or reviewed on a consistent basis to prevent having expired medications in the facility ...3. All medications will be labeled per State Board of Pharmacy and Regulations that includes specific directions pertaining to expired or discard after language. 4. In the event that a medication has a "shortened" expiration date once opened the medication (open-dated) will be labeled with the date opened and the initials of the nurse ...." 3.1-25(j) 3.1-25(o)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on record review and interview, the facility failed to ensure the facility tracked infections and antibiotic use within the facility and failed to ensure tuberculin testing was completed for 7 of 16 residents reviewed for immunizations and tuberculin testing administration (Residents 28, 4, 9, 14, 38, 192, and 5). Findings include: On 5/30/25 at 10:00 a.m., the medical record of Resident 28 was reviewed. The resident was admitted on 12/31/24. A Tuberculin skin test (a Mantoux test involves injecting a small amount of fluid called tuberculin or purified protein	F 0880	**F 880- Infection Control and Prevention** *"Facility failed to ensure tuberculin testing was completed for 7 of 16 residents reviewed for immunizations and tuberculin testing administration."* **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.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	derivative, PPD under the skin, and then checking for a reaction a few days later) was administered on 1/1/25. The record lacked evidence the results of the test were read. The record lacked documentation of a second TB test being administered after a minimum of seven days after administration of the initial test. A second TB test was required upon admission to the facility to determine exposure to tuberculosis. On 5/30/25 at 10:05 a.m., the medical record of Resident 4 was reviewed. The record indicated the last TB test had been administered to the resident on 5/16/24. The record lacked evidence of an annual TB test being completed. On 5/30/25 at 10:10 a.m., the medical record of Resident 9 was reviewed. The resident was admitted to the facility on 4/14/24. The record lacked evidence of a second TB test being administered a minimum of seven days or a maximum of three weeks after initial TB test was administered. On 6/2/25 at 9:45 a.m., the medical record of Resident 14 was reviewed. The resident was admitted to the facility on 5/20/24. The record lacked evidence of an initial TB test or a second TB test being administered. On 6/2/25 at 9:50 a.m., the medical record of Resident 38 was reviewed. The resident was admitted to the facility on 1/17/25. The record lacked evidence of a second TB test being administered a minimum of seven days or a maximum of three weeks after the initial TB test was administered. On 6/2/25 at 10:05 a.m., the medical record of Resident 192 was reviewed. The resident was		Residents #28 , #4, #9, #14, and #192 were given annual TB screening assessments immediately. **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 that reside in the facility have the potential to be affected by the alleged deficient practice. All current residents were audited to ensure compliance for completed annual TB assessment. Screening was initiated for any residents needing the annual TB testing. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON provided education to all nursing staff on Envive policy for completion of annual TB assessment and documentation of TB testing. **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?** Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	admitted to the facility on 5/19/25. The initial TB test was administered on 5/20/25. The record lacked evidence of the second TB test being administered a minimum of seven days or a maximum of three weeks after the initial TB test was administered. On 6/2/25 the medical record of Resident 5 was reviewed. The resident was admitted to the facility on 4/22/25. The initial TB test was administered on 4/22/25. The record lacked evidence of a second TB test being administered a minimum of seven days to a maximum of 3 weeks after the initial TB test was administered. On 6/2/25 at 10:30 a.m., during interview the Director of Nurses (DON) indicated she was the current Infection Preventionist (IP) Nurse, at the facility and acknowledged the IP nurse was responsible to oversee immunizations and TB testing of all residents within the facility. She acknowledged unless contraindicated, residents must have 2 initial TB tests upon admission. On 5/30/25 review of the facility risk assessment, dated 4/30/25, indicated the county was at moderate risk for communicable disease infections. Review of the Infection control program identified no antibiotic (ATB) tracking or infection surveillance was completed between May of 2024 to November 2024. The DON indicated she started working at the facility in December of 2024 and began tracking according to infection control policy. On 5/28/2025 at 10:00 a.m., the Administrator provided a document titled, "Surveillance for Infections," dated 8/2024, and indicated it was the		tool-initiated auditing All new residents admitted to the facility as available. Audits will be conducted Monday- Friday for 4 weeks, every other week for 2 months, monthly for 3 months then QAPI for 6 months. This tool will be completed by the DON or designee. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes. **5. Date of completion:** 06/30/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	policy currently being used by the facility. The policy indicated, "...The infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions ...3. Infections that will be included in routine surveillance include those with a. evidence of transmissibility in a healthcare environment ...Gathering surveillance data ...1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data ...The surveillance should include a review of any or all of the following information to help identify possible indicators of infections ...d. Laboratory records ...k. Antibiotic review ....hh. Monthly collect information from individual resident infection reports and enter line listing of infections ...." On 5/30/2025 at 10:55 a.m., the provided a document titled, "Tuberculosis Screening Residents," dated 8/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...This facility shall screen all residents for tuberculosis infection and disease (TB) ...If a potential resident has been exposed to active TB or is at increased risk of TB infection he or she will be screened for latent tuberculosis infection (LTBI) using tuberculin skin test (TST) ...6. Screening of new admissions or readmissions for tuberculosis infection and disease is in compliance with state regulations ...Serial testing of residents ...The facility will conduct annual risk assessments to determine risk of exposure ...." 3.1-18(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on record review and interview, the facility failed to ensure an Infection Preventionist (IP) Nurse other than the Director of Nursing (DON) was designated to oversee the Infection Prevention and Antibiotic Stewardship programs within the facility. This deficiency had the potential to affect 38 of 38 residents residing at the facility. Findings include: A review of the Infection control program identified antibiotic tracking and infection surveillance was not completed between 5/1/24 to 11/30/24. On 5/30/25 at 2:34 p.m., during interview the DON indicated she started working at the facility in December 2024 and began tracking at that time according to infection control policy. She indicated she was the only IP nurse in the facility and acknowledged she was responsible for tracking infections including TB testing and surveillance and the antibiotic stewardship program. She indicated she did not know the DON could not be the IP nurse and must have an additional nurse who has had the infection preventionist training appointed as the IP nurse. On 5/30/25 review of the facility risk assessment, dated 4/30/25, indicated the facility had designated one full time DON and one full time IP nurse. On 5/28/2025 at 10:00 a.m., the Administrator provided a document titled, "Surveillance for	F 0882	**F 882- Infection Preventionist Qualifications/Role** *"Facility failed to ensure an IP Nurse other than the Director of Nursing was designated to oversee the infection prevention and antibiotic stewardship programs within the facility."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified to have been affected. An Infection Preventionist Nurse, other than the Director of Nursing, has been formally designated to oversee the Infection Prevention and Antibiotic Stewardship programs within the facility and will coordinate the development and monitoring of the infection prevention program. The Infection preventionist will complete ongoing infection surveillance and antibiotic tracking according to facility policy and current best practices. **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.**	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
	Infections," dated 8/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...The infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions ...3. Infections that will be included in routine surveillance include those with a. evidence of transmissibility in a healthcare environment ...Gathering surveillance data ...1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data ...The surveillance should include a review of any or all of the following information to help identify possible indicators of infections ...d. Laboratory records ...k. Antibiotic review ....hh. Monthly collect information from individual resident infection reports and enter line listing of infections ...." On 5/30/2025 at 11:00 a.m., the Administrator provided a document titled, "Infection Preventionist," dated 8/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...1. The infection Preventionist (or designee) coordinates the development and monitoring of the infection prevention program ...4. The infection preventionist has the background and ability to fully carry out the requirements of the IP ...Hours of Work ...7. The infection preventionist is employed at least part time ...p Additional hours are scheduled as indicated by the needs identified in the facility assessment ...."		An audit was conducted to ensure that antibiotic tracking and infection surveillance was completed and current to identify any missed infections or trends and will take immediate corrective action for any identified resident care needs. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All residents have the potential to be affected. The Administrator or Director of Nursing will ensure that the designated Infections preventionist is not concurrently serving as the Director of nursing or another full-time management role that would impede their ability to fulfill the IP responsibilities. The newly designated Infection Preventionist's credentials and completion of specialized infection prevention and control training will be verified and documented in their personnel file following completion. If the new IP has not yet completed the CDC Nursing Home Infection Preventionist Training course, enrollment will occur by 06/23/25 and completion by 08/ 15/25. The facility's annual Facility Assessment was reviewed and updated to accurately reflect the designation of a separate,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

(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
			qualified, and dedicated Infection Preventionist, ensuring adequate hours and resources for the IPCP. An in-service was completed with administrative and nursing leadership staff, along with the Administrator and Director of Nursing, regarding the requirements of the Infection Prevention program, the Antibiotic Stewardship program, and surveillance for infections. **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 Director of Nursing or designee will complete random audits of the antibiotic tracking and infection surveillance program weekly, monthly, then monthly in QAPI for 6 months. This tool will be completed by the DON or designee. **5. Date of completion:** 06/30/2025	