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	01/31/2025

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 the Investigation of Complaints IN00451119, IN00451735, IN00450270, IN00449663, and IN00452377. Complaint IN00451119 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00451735 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00450270 - Federal/state deficiencies related to the allegations are cited at F725. Complaint IN00449663 - No deficiencies related to the allegations are cited. Complaint IN00452377 - Federal/state deficiencies related to the allegations are cited at F755. Survey dates: January 30 and 31, 2025 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 5 Medicaid: 23 Other: 14 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 4, 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 complaint Survey conducted January 31, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 16, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Jo Parker	Executive Director	02/12/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on interview and record review, the facility failed to ensure a licensed nurse was on duty 24 hours a day for 1 of 61 days reviewed on a shift when two residents fell (Residents W and T). This deficient practice had the potential to affect 42 of 42 residents who resided in the facility. Findings include: 1. During an anonymous interview Employee C indicated, on 12/25/24, there was no nurse in the facility on day shift, 6:00 a.m. to 6:00 p.m. The Director of Nursing (DON) came in at breakfast and lunch and administered insulin. Residents W and T fell on the shift, and there was no nurse at the facility at the time of the falls. A Facility Assessment, dated 10/24/24, indicated the facility's staffing pattern included two licensed nurses on day shift and one licensed nurse on night shift. A Daily Nursing Assignment Sheet, dated 12/25/24, indicated a Registered Nurse (RN) was scheduled as the charge nurse from 6:00 a.m. to 6:00 p.m., but the name was crossed out. Two Qualified Medication Aides (QMAs) were scheduled on day shift. The top of the document included the DON's name and phone number. A Facility Bed Board, dated 12/25/24, indicated 42 residents resided in the facility. A written statement, dated 1/31/25, indicated, "On 12/25/24, I, [DON's name], was notified at on or around 7am [sic] that the agency nurse never showed up. I went down to the building to pass	F 0725	**F 725 – Sufficient Nursing Staff** *It is the practice of this Facility to ensure a licensed nurse is on duty 24 hours a day.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON was educated on the Policy that the nursing services department shall always be under the direct supervision of an RN or LPN at all times. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	02/16/2025

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	the insulins. I stayed through the morning, left for an hour around 10am [sic] and was back to check accu checks and insulins at 11am [sic]. During the time I was gone, I was always available by phone and less than 40 minutes away. The Qs [QMAs] did not practice outside their scope. I stayed and helped with what I could and tried to get coverage. I had to leave again on or around 5pm [sic] and night shift came in at 6pm [sic]...." Resident W's record was reviewed on 1/31/25 at 12:11 p.m. A 5-day Minimum Data Set (MDS) assessment, dated 12/25/24, indicated the resident had a moderate cognitive impairment and required substantial assistance with transfers. Diagnoses on the resident's Face Sheet included, but were not limited to, history of falling. A Progress Note was written by the DON and dated 12/25/24. The note was opened at 3:50 p.m. and indicated the effective time was 3:43 p.m. The note indicated the resident fell in his room when he attempted to self-transfer without using the call light. There was a skin tear to the resident's right elbow. Two staff members assisted the resident back to bed. The DON was notified, oxygen was started as a nursing measure, and the physician was notified. The resident's oxygen level was 79 percent (normal is between 95 and 100 percent), and the oxygen level continued to fall to 41 percent. The resident's blood pressure was 59/44 (normal is around 120/80), and the pulse was 48 beats per minute (bpm) (normal is 60 to 100 bpm). There was no response from the physician so 911 was called and the resident was sent to the hospital. "This nurse" called report to the hospital. 2. Resident T's record was reviewed on 1/31/25 at		**program will be put into place?** ED or DON/designee will complete daily monitoring of schedules 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **5. Date of completion:** 02/16/2025	

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	11:59 a.m. Diagnoses on the resident's Face Sheet included, but were not limited to anoxic brain injury (occurs when the brain is deprived of oxygen) and dementia in other disease classified elsewhere severe with mood disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 12/24/24, indicated the resident had two or more falls since the prior assessment, and the resident required substantial assistance with transfers. A Progress Note, dated 12/25/24, indicated it was created by the DON at 3:59 p.m. The effective time of the note was 1:57 p.m. The note indicated the resident fell while ambulating in his room. The resident had a scrape on his forehead and an abrasion on his left knee. The resident was assisted into his wheelchair by two staff members. The physician and family were called. During an interview, on 1/31/25 at 9:29 a.m., the DON indicated the agency nurse had not shown up as scheduled on 12/25/24. The DON was at the facility for most of the shift from 6:00 a.m. to 6:00 p.m., but she had to leave for part of the day. There was no way for her to show exactly what hours she worked because she was a salaried employee and did not clock in and out for shifts. During an interview, on 1/31/25 at 10:56 a.m., the DON indicated she was at the facility when one of the falls occurred on 12/25/24, but she could not remember which resident's fall it was. On 1/31/25 at 11:56 a.m., the DON provided a document titled, "POLICIES AND PROCEDURES MANUAL," last revised in August 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy			

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	Statement: The nursing services department shall be under the direct supervision of a registered or licensed practical/vocational nurse at all times. Policy Interpretation and Implementation: 1. A licensed nurse...is on duty twenty-four hours per day, seven (7) days per week, to provide resident care services and supervise the nursing services activities provided by unlicensed staff. A licensed nurse is designated as a charge nurse on each shift...." This citation relates to Complaint IN00450270. 3.1-17(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure medications were reordered in a timely manner so they were available for administration for 1 of 18 residents reviewed for pharmaceutical services (Resident D). Findings include: Resident D's record was reviewed on 1/31/25 at 11:04 a.m. An annual Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident was cognitively intact. Diagnoses on the resident's face sheet included, but were not limited to, unspecified polyneuropathy (nerve damage throughout the body). A care plan, initiated on 8/30/22, indicated the resident had the potential for pain related to polyneuropathy. Interventions included, but were not limited to, administer medications as ordered.	F 0755	**F 755 – Pharmacy Services** *It is the practice of this Facility to ensure that medications are reordered in a timely manner so they will be available for 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. **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.	02/16/2025

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	A Medication Administration Record (MAR), dated December 2024, indicated pregabalin (nerve pain medication) 75 milligrams (mg), 1 capsule 3 times daily for unspecified polyneuropathy. The MAR indicated the pregabalin was not available for administration on 12/27/24, 12/28/24, and 12/29/24. A Narcotic Count Sheet indicated 60 capsules of pregabalin 75 mg were delivered to the facility on 11/30/24. The last capsule was signed for on 12/25/24. A Progress Note, dated 12/25/24, indicated a message was left with the physician to call or write a prescription for pregabalin. A Progress Note, dated 12/26/24, indicated the nurse called the physician and requested a prescription for the resident's pregabalin. The physician physically wrote prescriptions and did not use an electronic prescription service. The physician had not returned the call. Progress Notes, dated 12/26/24 and 12/27/24, indicated the pregabalin was "on order" and awaiting delivery. A Progress Note, dated 12/27/24, indicated the nurse called the pharmacy and attempted to get the pregabalin refilled. The pharmacy indicated a new prescription was needed. The Director of Nursing (DON) planned to call the physician for a prescription. A Progress Note, dated 12/28/24, indicated the pregabalin was not available for administration. A Progress Note, dated 12/29/24, indicated the		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing Staff was educated on Medication Orders with a focus on re-ordering so that the medication is available for administration. A new Medical Director Team contract had already been obtained with a focus on more frequent visits. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DON/designee will complete daily monitoring of Medication availability and timely reordering, 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **5. Date of completion:** 02/16/2025	

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	pregabalin was not available for administration and awaiting arrival from pharmacy. A Progress Note, dated 12/30/24, indicated another call was placed to the physician to request the prescription for the resident's pregabalin. The physician had not returned the calls. The nurse called the hospital to check if another physician was available on call, but there was no one on call for the resident's physician. A Narcotic Count Sheet indicated 28 capsules of pregabalin 75 mg were delivered to the facility on 12/30/24. The first capsule was signed for on 12/30/24. The Narcotic Count Sheets lacked documentation doses of pregabalin were available from 12/25/24 to 12/30/24. The last capsule was signed for on 1/8/25. A Progress Note, dated 1/9/25, indicated the pregabalin was "on order." A Progress Note, dated 1/10/25, indicated the staff was awaiting the medication to be sent from the pharmacy. A MAR, dated January 2025, indicated pregabalin was not available for administration on 1/11/25. Census information indicated the resident was hospitalized from 1/11/25 to 1/12/25. An Emergency Room (ER) Physician Report, dated 1/11/25, indicated the resident reported not feeling well for several days with generalized pain. The nursing home reported the resident had high blood pressure. The resident's daughter reported the resident had not received the pregabalin for over a week.			

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	A Hospital History and Physical, dated 1/11/25, indicated, "...he has been out of his Lyrica [pregabalin] for the past week due to miscommunication with nursing home staff, and he has been having increasing amounts of his chronic leg neuropathy...." A Narcotic Count Sheet indicated 8 capsules of pregabalin 75 mg were delivered to the facility on 1/13/25. The first capsule was signed for on 1/13/25. The Narcotic Count Sheets lacked documentation doses of pregabalin were available from 1/8/25 to 1/13/25. During an interview, on 1/30/25 at 12:32 p.m., Qualified Medication Aide (QMA) 6 indicated there had been some issues obtaining narcotic medications when they switched Medical Directors. Their new Medical Director started around a week ago. There was an Emergency Drug Kit (EDK) available, but it required a prescription authorization to obtain narcotic medications from there. During an interview, on 1/30/25 at 3:25 p.m., the DON indicated there was an issue getting the resident's pregabalin when the prior Medical Director had not answered calls or sent a prescription. The physician needed to come into the facility and write a prescription. During an interview, on 1/31/25 at 10:50 a.m., the DON indicated the resident missed pregabalin doses from 12/25/24 to 12/30/24 according to the Narcotic Count Sheets. There was one dose of pregablin pulled from the EDK on 12/27/24. There was no documentation provided to support a dose of pregabalin was removed from the EDK on 12/27/24.			

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During an interview, on 1/31/25 at 10:56 a.m., the DON indicated the resident missed pregabalin doses from 1/8/25 to 1/11/25 because the medication ran out. The resident went to the hospital on 1/11/25.

On 1/31/25 at 9:30 a.m., the DON provided undated drug guidance for pregabalin and indicated it was the information currently being used by the facility. The document indicated, "...Increased Risk of Adverse Reactions with Abrupt or Rapid Discontinuation...Following abrupt or rapid discontinuation of LYRICA [pregabalin], some patients reported symptoms including insomnia, nausea, headache, anxiety, hyperhydrosis [excessive sweating], and diarrhea. If LYRICA is discontinued, taper the drug gradually over a minimum of 1 week rather than discontinue the drug abruptly...."

On 1/31/25 at 9:30 a.m., the DON provided a policy titled, "Medication Orders," dated 2020, and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe...D. Renewed or recapitulated orders...The prescriber renews the order either by repeating the entire order process or with a statement such as 'continue medication for ten days.' The prescriber writes a new order for continued therapies that require different direction, dosage form, or strength...."

This citation relates to complaints IN00451119, IN00451735, and IN00452377.

3.1-25(a)