STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00420684. Complaint IN00420684 - Federal/State deficiencies related to the allegations are cited at F744. Survey date: November 3, 2023. Facility number: 000290 Provider number: 155699 AIM number: 100379970 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 3 Medicaid: 22 Other: 6 Total: 31 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 9, 2023.	F 0000	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 November 3, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 4, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to develop and implement individualized	F 0744	**F744 Treatment/Service for Dementia**	12/04/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Jackman	HFA	11/21/2023

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	interventions for a cognitively impaired resident who displayed sexual behaviors for 1 of 3 residents reviewed for behaviors (Resident C). Findings include: Resident C's clinical record was reviewed on 11/3/23 at 10:16 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, wandering in diseases classified elsewhere and unspecified dementia, moderate, with other behavioral disturbance. An order initiated on 11/3/23 at 10:03 a.m. indicated to monitor the resident for behaviors related to being sexual in nature: roaming/wandering in other resident's rooms, inappropriate gestures, and seeking male residents. Notify the RN immediately. Redirect her immediately and document the outcomes every two hours. A 10/24/23, quarterly, Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired and had delusions (misconceptions or beliefs that are firmly held, contrary to reality). She had a current care plan problem of sexually inappropriate behaviors such as flashing her breast to staff/residents/guests and inappropriately touching male residents (initiated on 10/1/23 and revised on 10/29/23). Her interventions included redirect her to an area with less stimulus (10/1/23), psychiatric evaluation/treatment as needed (10/1/23), behavior monitoring program (10/1/23), she was to wear a one-piece undergarment under her clothing (10/29/23), staff was to assist her to and from all		*"Facility failed to develop and implement individualized interventions for a cognitively impaired resident who displayed sexual behaviors for 1 of 3 residents reviewed for behaviors (Resident C).* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C immediately had care plan audited by DNS and MDS and appropriately modified to include dementia related behaviors monitoring and interventions. **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.** - Dementia diagnosed residents have the potential to be affected by the alleged deficient practice. All current in-house residents with Dementia diagnosis had care plan audited on 11/6/23 by the DNS for appropriate interventions. No residents qualified to have care plan modified at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	meals (10/29/23), provide diversion by offering her an activity that interested her (10/29/23), remove her from the stimulus/situation (10/29/23), 15 minute checks (11/1/23) and labs as ordered (11/1/23). A nurses note, dated 9/10/23 at 12:15 p.m., indicated she was being sexually inappropriate, as she raised her top and showed other residents and staff her breasts. Redirecting her was unsuccessful. A female resident came to the nurses' station and said Resident C had come into her room while she was sleeping in her chair and rubbed her hands. Yesterday, she did the same thing, and rubbed her stomach and then put her hand down by her private area. They told her they would watch Resident C more closely and keep Resident C out of her room. The ADON was notified, and she would notify the Administrator. The ADON called back to the facility, and they were told to do one on ones with Resident C and social services would work on getting a psychiatric evaluation for her. Social services indicated the doctor needed notified to get an order for a urine analysis and to continue one on ones with Resident C. A nurses note, dated 9/11/23 at 5:56 a.m., indicated she lifted her shirt and exposed her breast three times since 5:50 a.m. She was provided snack and fluids for a distraction. Staff sat with her and she continued to lift her shirt. The ADON was notified. A nurses note, dated 9/11/23 at 10:36 a.m., indicated she had increased behaviors and an order was obtained for a urine analysis. A nurses note, dated 9/11/23 at 2:14 p.m., indicated a new order was obtained to start		**practice does not recur?** The DNS and MDS were educated on the comprehensive care plan policy and procedure with concentration on, but not limited to, monitoring behaviors, and intervening where necessary. - Education and training were provided to DNS and MDS on 11/17/23 by the clinical support consultant. Education provided: Comprehensive Care Plan Policy Individualized Personal Care Policy Behavior Monitoring **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?** DNS/designee will complete daily monitoring through the clinical care meeting to ensure that any resident with Dementia diagnosis is reviewed as an IDT for appropriate care plan, interventions, and proper monitoring procedures 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. DNS/MDS/designee will be responsible for the Comprehensive Care Plan monitoring for 6	

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	cefuroxime (antibiotic) 500 mg twice a day for 10 days for a urinary tract infection (UTI). A psychiatric nurse practitioner note, dated 10/29/23 at 12:55 p.m., indicated Resident C was involved in a reportable sexual behavior with another resident on 10/29/23. The behavior was isolated and the residents were separated. Resident C would continue on one on one observation and then switch to 15 minute checks. Resident C posed no threat to herself or others at that time. A social service note, dated 11/1/23 at 10:58 a.m., indicated one on one observations ended and 15-minute checks had been initiated. During an interview with CNA 9, on 11/3/23 at 9:51 a.m., she indicated she was walking down the hall on 10/29/23 and noticed Resident C's wheelchair was at the entrance to Resident B's room. When she walked to the room, Resident C was sitting in her wheelchair and Resident B was standing in front of her. Resident C had her hand inside the front of Resident B's pants. The CNA told Resident C she couldn't do that, and told Resident B he shouldn't let her do that. She removed her from his room and took her to the nurses station. Resident B didn't normally have sexual behaviors. Resident C would say things like that guy was handsome and she would like to get with him. She would say and do things but she wouldn't remember doing them after 30 seconds. During an interview with CNA 11, on 11/3/23 at 9:59 a.m., she indicated when Resident C had a UTI, she liked pulling up her shirt, so they started putting her in a body suit. Resident C liked to wheel herself near the dining room, which was near Resident B's room, and they had encouraged		months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 12/4/2023	

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	Resident B and Resident C to stay separated. Resident B would blame Resident C for following him. She observed Resident C try to touch Resident B in his private area about a handful of times, in the hallway, but he would back up and not allow her to touch him. They had been drawn towards each other for about a month. During an interview with CNA 13, on 11/3/23 at 10:08 a.m., she indicated Resident C had a UTI and was lifting her shirt up and exposing her breasts. If she caught Resident C in Resident B's doorway, she would redirect her. She had caught them together before, but nothing happened. They had been trying to keep them separated for a month or so. Resident C didn't remember what she had done. During an interview with CNA 15, on 11/3/23 at 11:12 a.m., she indicated Resident C lifted her shirt and exposed her breasts. They had found out she had a UTI. She now wore a body suit. She felt Resident B liked the attention from Resident C, and he would come out of his room with just a brief on and he looked for Resident C. They would sit together, and he would look around to see who was watching them. While doing one on ones with Resident C, she indicated she had sexual desires. While Resident C was in the activity room today, she tried to fix Resident C's shirt and Resident C indicated she liked to show them her breasts. During an interview with the DON, on 11/3/23 at 12:16 p.m., she indicated Resident C liked men. She had heard that she was a "flasher" in the bars when she was younger. They ordered onesies for her, but they only had two of them and they tried to make sure they had them washed. She was on an antibiotic for a UTI and they thought that had			

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	cured her from exposing herself, but then, she had this incident with Resident B. Resident B was cognitively intact and he was the type that he would not encourage Resident C, but would not stop her either. During an interview with Resident C, on 11/3/23 at 2:10 p.m., she indicated she was leaving here in a couple days. She had never touched anyone or been touched by anyone inappropriately, she did not have a boyfriend but was looking for a husband. During an interview with Resident B, on 11/3/23 at 4:20 p.m., he indicated Resident C had been "flashing" him about everyday for the last couple of weeks. If she started to do it, he would turn his back to her. He came out of the bathroom and he had a Velcro zipper on his pants, and the Velcro was open. She had touched him through his pants and indicated to him that she wanted to play with "it" and he told her she shouldn't do that. One of the aides came and told her she wasn't supposed to do that. Resident C had told him that she had the "hots" for him and she wanted to have sex with him, but he had erectile dysfunction. He felt that she was just a hard-up old lady. During an interview with Resident C's roommate, on 11/3/23 at 4:38 p.m., she indicated she had been in the common area with Resident C and Resident B. Resident C had lifted her shirt and told him that she would like him to perform oral sex on her. One time, she had caught Resident C going into another male resident's room while he was in bed and she pulled her out of his room. Resident C indicated to her that she wanted to crawl in bed with him and have sex with him. A current facility policy, dated 8/2022, titled			

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	"Behavior Assessment/Monitoring," provided by the Administrator on 11/3/23 at 4:10 p.m., indicated the following: "...General Guidelines...a. Behavior is regulated by the brain and is influenced by past experiences, personality traits...Management 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly...a. Atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident(s) or staff, or behavior that signals underlying distress. b. If the behavior is atypical but not problematic or dangerous and the resident does not appear to be in distress, then the IDT will monitor for changes but not necessarily intervene to "normalize" the behavior...7. Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior...." This citation relates to Complaint IN00420684. 3.1-37(a)			