STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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. This visit included the Investigation of Complaint IN00392002 . Complaint IN00392002 - Unsubstantiated due to lack of evidence. Survey dates: January 3, 4, 5, 6, and 9, 2023. Facility number: 000022 Provider number: 155061 AIM number: 100274510 Census Bed Type: SNF/NF: 31 SNF: 1 Total: 32 Census Payor Type: Medicare: 2 Medicaid: 24 Other: 6 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 18, 2023.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF LAWRENCEBURG F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey completed On January 3, 4, 5, 6 and 9, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 7, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Miller	Chief Nursing Officer	02/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	(iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop Care Plans related to a resident having a tracheostomy, an intravenous catheter, and an indwelling urinary catheter for 3 of 17 residents' care plans reviewed. (Residents 26, 27, and 30) Findings include: 1. Resident 26 was observed on 01/05/23 at 2:39 P.M., laying in bed. Suction equipment was at the bedside. The resident's tracheostomy was visible and had the respirator tubing attached. During an interview on 01/05/23 at 11:01 A.M., RT (Respiratory Therapist) 5 indicate the resident could go for short periods of time off of the ventilator. He would try to pull on the ventilator apparatus when he got restless. A few weeks ago, they tried using a speaking valve, but the resident had a lot of secretions making it difficult. He had moderate to copious amounts of secretions. The clinical record was reviewed on 01/04/23 at 11:28 A.M. The resident was admitted to the facility on 10/27/22. A Quarterly MDS (Minimum Data Set) assessment, dated 11/12/22, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, encephalopathy, heart failure, dementia, and respiratory failure. Special treatments the resident received while residing in the facility included, but were not limited to, oxygen, tracheostomy care, and the use of an invasive mechanical ventilator. The complete Care Plan record was provided by the DON (Director of Nursing) on 01/06/23 at 11:00 A.M. The record lacked a Care Plan related to the	F 0656	**F656 – Develop/Implement Comprehensive Care Plan SS=D** *"The facility failed to develop Care Plans related to a resident having a tracheostomy, an intravenous catheter, and an indwelling urinary catheter for 3 of 17 residents' care plans reviewed. (Residents 26, 27, and 30)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 26, 27 and 30's care plans were reviewed and updated related to having tracheostomy, intravenous catheter and indwelling urinary catheter. **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 who with tracheostomies, intravenous catheters and indwelling urinary catheters have the potential to be affected by this alleged deficient practice. · All residents with	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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's respiratory condition and tracheostomy. 2. During an interview on 01/09/23 at 11:45 A.M., RN 2 indicated Resident 27 had a PICC (Peripherally Inserted Central Catheter) line since she came back to the facility after a hospitalization in November 2022. They were going to discontinue the PICC in November but needed to send the resident to the hospital to have it removed. The resident was diagnosed with a urinary tract infection in December, and since the PICC had not been removed yet, they kept it in place and administered an antibiotic through it. On 01/09/23 at 11:53 A.M., Resident 27's PICC line was observed with RN 2. There was a tunneled PICC line in the right upper area of the resident's chest. A gauze dressing covered by a transparent dressing was dated 01/08/23 and initialed. There were two needless connection ports visible hanging below the dressing. The dressing was clean and dry and there were no signs of infection, but the entry point in the skin was unable to be visualized as it was covered by the gauze dressing that was in place. The resident's clinical record was reviewed on 01/08/23 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/02/22, indicated the resident required total staff assistance for all ADLs (Activities of Daily Living). The diagnoses included, but were not limited to, stroke, hemiplegia, seizure disorder, and respiratory failure. The complete Care Plan record was provided by the Administrator on 01/09/23 at 3:24 P.M. The record lacked a Care Plan related to the resident's PICC line. 3. During an observation and interview on 01/03/23, Resident 30 indicated she had an		tracheostomies, intravenous catheters and indwelling urinary catheters care plans were reviewed to ensure related care plans are in place. All care plans are in place. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS and MDS will be in-serviced on: o "Comprehensive Care Plan Guideline 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?** · MDS/designee will audit 5 residents with IV catheters, urinary catheters or tracheostomies three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure developed care plans are in place. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	indwelling urinary catheter. The urinary catheter bag was hanging under the resident's wheelchair and off the floor. The clinical record for Resident 30 was reviewed on 01/06/23 at 9:24 A.M. A Quarterly MDS assessment, dated 11/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, diabetes, UTI (Urinary Tract Infection), and anxiety. The resident had a urinary catheter. The complete Care Plan record for Resident 30 was provided by the Administrator on 01/09/23 at 3:27 P.M. The record lacked a Care Plan for the urinary catheter. During an interview on 01/09/23 at 2:44 P.M., the CNO (Chief Nurse Officer) indicated the resident Care Plans were developed through the MDS assessments, Interdisciplinary meetings, initial assessments, and the nursing clinical team. The resident will have an initial 24-hour care plan and then an extensive care plan will be developed. The residents should be care planned for urinary catheters, tracheostomy, oxygen, wounds, and infections. The current Comprehensive Care Plan Guideline policy, with a revised date of 08/2022, was provided by the Administrator on 01/09/23 at 3:35 P.M. The policy indicated, "...PURPOSE...The ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease...A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment...Problem areas should identify the relative concerns...Comprehensive care plans		monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	need to remain accurate and current...New interventions will be added and updated during or directly following Clinical care meeting..." 3.1-35(a)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on record review and interview, the facility	F 0661	F661 – Discharge Summary	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	failed to complete a discharge summary for 1 of 4 residents reviewed for discharge. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 01/09/23 at 2:13 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 11/03/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture, anemia, heart failure, malnutrition, and depression. A Progress Note, dated 12/22/22, indicated the resident discharged home with her husband in a private car with medications. A Discharge Assessment was opened and incomplete in the electronic health record. During an interview on 01/05/23 at 9:37 A.M., QMA (Qualified Medication Aide) 3 indicated the resident had been admitted to the facility for therapy services. She was able to discharge home the week of Christmas after completion of therapy. During an interview on 01/09/23 at 11:32 A.M., RN 2 indicated the resident had chosen to discharge home. When a resident was going to discharge home a discharge assessment would be opened in the electronic health record and all departments had their own part of the assessment to complete. The day of discharge the assessment would get printed off and the nurse would review the assessment with the resident or family member. During an interview on 01/09/23 at 4:05 P.M., the Social Service Director indicated the resident had discharged home with family. When a resident discharged home a discharge assessment should be completed. Each department had their own		**SS=D** *"The facility failed to complete a discharge summary for 1 of 4 residents reviewed for discharge. (Resident 6)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 6 was not affected by this 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 discharging residents have the potential to be affected by this alleged deficient practice. · Residents with pending discharges have been audited to ensure discharge summaries are complete. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS, SSD, MDS, Therapy Director and all licensed clinical staff will be in-serviced on: "Discharge policy"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	section on the assessment that should have been filled out. The resident should be provided with a copy of the assessment when they discharged. During an interview on 01/09/23 5:08 P.M., the ADON (Assistant Director of Nursing) indicated the resident's discharge summary should have been completed. The current facility policy titled, "Discharge", dated 8/2022, was provided by the ADON on 01/09/23 at 5:08 P.M. The policy indicated, "...When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment..." 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(b)		**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 audit all pending discharges daily Monday thru Friday for 6 months and ongoing to ensure discharge summaries are complete. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. . **5. Date of completion:** 01/07/2023	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure residents had not acquired in house pressure ulcers and the worsening of pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. This deficient practice resulted in two residents' pressure ulcers worsening to a Stage 4 and Stage 3 and one residents' wound identified as a deep tissue injury. (Residents 25, 9, and 13) Findings include: 1. During an interview and observation on 01/03/23 at 12:04 P.M., Resident 25's right elbow was in a padded heel protector. The resident indicated he had an open wound on his right elbow. The clinical record for Resident 25 was reviewed on 01/05/23 at 12:17 P.M. The 5 day MDS (Minimum Data Set) assessment, dated 10/13/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, hemiparesis, anxiety, depression, and dementia. The resident required the extensive assistance of one staff member for most ADLs (Activities of Daily Living). The resident was at risk for developing pressure ulcer and had no pressure ulcers at the time of the assessment. An Initial Wound Assessment, dated 11/09/22, indicated the resident had a Stage 2 (full thickness tissue loss) pressure ulcer on his right elbow measuring 3 cm (centimeter) x (by) 2 cm x 0.1 cm. The pressure ulcer was acquired in the facility. The treatment was to apply a medicated pink foam	F 0686	F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer **SS=G** *"The facility failed to ensure residents had not acquired in house pressure ulcers and the worsening of pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. This deficient practice resulted in two residents' pressure ulcers worsening to a Stage 4 and Stage 3 and one residents' wound identified as a deep tissue injury. (Residents 25, 9, and 13)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 25, 9 and 13's wounds assessed and ongoing treatment with improvement occurring. **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 this alleged deficient practice. · DNS and wound nurse	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	dressing every three days. An additional order was included on the ETAR (Electronic Treatment Administration Record) to ensure the pink dressing was intact to the right elbow every shift. The ETAR lacked documentation nursing staff ensured the dressing was in place from 11/09/22 to 11/14/22. On 11/15/22 A new treatment was obtained to cleanse the right elbow with normal saline or sterile water, apply honey gel and cover with bordered foam dressing every day and as needed for soilage. The ETAR indicated the treatments were completed as ordered except for 11/20/22, when the resident refused. A Weekly Wound Assessment, dated 11/16/22, indicated the resident had a Stage 2 pressure ulcer on his right elbow measuring 3 cm x 2 cm x 0.2 cm. A Weekly Wound Assessment, dated 11/23/22, indicated the resident was seen by the wound doctor in the facility. The pressure ulcer on the right elbow had worsened and was now a Stage 4(full thickness tissue loss with bone, tendon, or muscle exposed, slough or eschar maybe present). The wound measured 3 cm x 3 cm x 1 cm. The resident was sent to the local hospital on 11/23/22 for cellulitis and wound evaluation of the right elbow and returned on 12/01/22. A Weekly Wound Assessment, dated 12/07/22, indicated the resident had a Stage 4 pressure ulcer on his right elbow measuring 2.5 cm x 2 cm x 0.7 cm. A Weekly Wound Assessment, dated 12/28/22, indicated the resident had a Stage 4 pressure ulcer		completed Skin sweep of 100% of residents to ensure preventative skin interventions in place and all current wounds being treated per physician orders to prevent worsening. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in-serviced on: o “Pressure/Stasis/Arterial/Diabetic Wounds” **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 random audits on 3 residents with current wounds and 3 residents with wound prevention interventions three times a week x4 weeks, then twice a week x8 weeks, then weekly x3 months to ensure residents with wound prevention interventions have interventions in place and are not developing wounds and residents with current wounds are not worsening. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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 his right elbow measuring 1.7 cm x 1.2 cm x 0.2 cm. During an interview on 01/09/23 at 12:03 P.M., RN 2 indicated the resident was added to her wound rounding list on 11/09/22 when the Stage 2 pressure ulcer was discovered. Prior to the development of the pressure ulcer the resident had pain relieving patches placed on the right elbow and believed that was what caused the pressure. His wound was evaluated weekly. 2. During an interview on 01/03/23 at 1:44 P.M., Resident 9 indicated she had a wound on her right heel. She would go to the wound clinic once a week and they would change the dressing there. The facility no longer changed the dressing. She had the wound for several months. The clinical record for Resident 9 was reviewed on 01/04/23 at 3:33 P.M. A Quarterly MDS assessment, dated 11/20/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, acute osteomyelitis of the right ankle and foot, anemia, diabetes, and sacral spina bifida. The resident had impairments to both sides of the lower extremities and a diabetic foot ulcer. A Progress Note, dated 08/08/22 at 4:06 P.M., indicated staff called the ADON to the resident's room. The resident had an open area to the right heel that was a Stage 2 pressure area. New orders were obtained to cleanse the wound bed with wound cleanser, apply collagen to the right heel wound bed, and cover with a dry dressing. An Initial Wound Assessment, dated 08/08/22, indicated the resident right heel wound measured 1.3 cm x 1.3 cm x 0.2 cm.		for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved **5 Date of completion:** 01/07/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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 Weekly Wound Assessment, dated 08/10/22, indicated the resident had a diabetic wound to the right heel that was acquired in house. The wound measured 1.3 cm x 1.3 cm x 0.2 cm. There was 76 to 100% (percent) granulation tissue to the wound bed. A Weekly Wound Assessment, dated 09/07/22, indicated the resident had a diabetic wound to the right heel that was acquired in house. The wound measured 2 cm x 1.9 cm x 0.2 cm. There was 76 to 100 % epithelial tissue present. The wound had deteriorated. A Weekly Wound Assessment, dated 10/12/22, indicated the resident had a diabetic wound to the right heel that was acquired in house. The wound measured 2.5 cm x 2 cm x 0.3 cm. There was 0 to 25% granulation tissue and 51 to 75% slough. The wound was improving. A Weekly Wound Assessment, dated 12/14/22, indicated the resident had a diabetic wound to the right heel that was acquired in house. The wound measured 1.7 cm x 1.2 cm. There was 76-100% epithelial tissue present. The wound was improving. No current wound measurements were provided from the wound clinic or the facility. The clinical record including the August, September, October, and November 2022 EMAR/ETAR lacked documentation that the right heel wound treatment was completed as ordered on the following dates: - 08/20/22, - 08/21/22, - 09/11/22,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	- 09/19/22, - 10/10/22, - 11/02/22, - 11/28/22, and - 11/29/22. The clinical record lacked documentation that the resident had any preventative interventions in place for the right heel prior to the wound developing. An intervention to elevate the right heel off the bed with pillows while in bed was initiated on 09/12/22, after the wound was identified on 8/8/22.. A Wound Clinic Visit Note, dated 10/10/22 and 11/21/22, indicated the resident was seen for a wound check of a Stage 3 (full thickness skin loss involving damage or necrosis of subcutaneous tissue) pressure ulcer to the right heel. A Progress Note, dated 08/10/22 at 2:54 P.M., indicated a new order was obtained to cleanse the wound with normal saline or sterile water, apply alginate to the right heel wound bed, and cover with a clean dressing, daily. A Progress Note, dated 09/12/22 at 4:58 P.M., indicated the resident was seen by an outside wound clinic. New orders were obtained for Dakin's wet to dry dressing to the right heel daily, and make sure the right heel is elevated off the bed with pillows. A Progress Note, dated 11/07/22 at 12:49 P.M., indicated the resident's right leg was noted to be angry red, warm to touch, with 2+ pitting edema. The resident was to be seen at the outside wound clinic for an appointment later in the day. A Progress Note, dated 11/11/22 at 4:34 P.M.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	indicated the writer had received report from the local hospital. The resident had been receiving treatment for osteomyelitis and MRSA of the right foot. The nurse reported the resident had a PICC line in the right upper extremity and was receiving IV antibiotics. The treatment for the right heel was to administer Dakin's 1/4 strength solution to the wound daily. The complete Care Plan was provided by the DON on 01/06/23 at 3:06 P.M. A diabetic ulcer to the right foot Care Plan was developed on 01/04/23, indicated the following: - avoid exposure to temperature extremes: heating pads, hot water bottles, heat lamps, hot or cold solutions and socks, sunburn, icepacks, - avoid mechanical trauma, - diet as ordered, - encourage and assist resident to reposition frequently, - ensure appropriate protective devices are applied to affected areas, - labs as ordered, - meds as ordered, - monitor blood sugar levels, - monitor and document wound size, - monitor, document, and report any sign or symptoms of infection, - monitor, document, and report any changes in wound, - NAR (Nutritionally at Risk) to follow, and - refer to foot care nurse or podiatrist. An at risk for skin integrity Care Plan, with a start date of 02/22/22, indicated the following: - diet as ordered, started 11/17/22 - educate resident, family, caregivers of causative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	factors and measures to prevent skin injury, started 02/22/22, - encourage good nutrition and hydration to promote healthier skin, started 02/22/22, - follow facility protocols for treatment of injury, started 02/22/22, - keep skin clean and dry, use lotion on dry skin, started 02/22/22, - labs as ordered, started 02/22/22, - observe skin with daily cares, notify the nurse of any new or worsening areas, started 02/22/22, and - treatments as ordered, started 11/17/22. During an interview on 01/05/23 at 9:26 A.M., QMA (Qualified Medication Aide) 4 indicated the resident needed assistance with showers. She had a wound on one of her legs that she went to the wound clinic for. She was compliant with care. During an interview on 01/05/23 at 5:37 P.M., the Wound Clinic Nurse indicated the resident had been receiving wound care services for a Stage 3 pressure ulcer to the right heel since 09/12/22. The wound was a Stage 3 at the first appointment prior to debridement. Currently, the wound had greatly improved since the resident first came in for treatment. On 12/20/22, the wound clinic changed the resident's orders and indicated that the facility was no longer to change the dressings. It was only changed once a week at the wound clinic. The resident had been sent to the hospital from her appointment on 11/07/22 for osteomyelitis in the wound. During an interview on 01/06/23 at 10:06 A.M., RN 2 indicated she started following the resident's wound on 09/14/22. The wound was identified by the facility on 08/08/22 as a diabetic ulcer. The resident had started going to the wound clinic on 09/12/22. In November she was sent from a wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	clinic appointment to the hospital with osteomyelitis. If the wound clinic classified a wound as a pressure ulcer, then the facility should change their documentation of the wound. The treatments should be completed per the MD orders. During an interview on 01/09/23 at 2:32 P.M., RN 2 indicated she was unsure of what caused the wound on the resident's heel. 3. During an observation and interview on 01/03/23 at 12:34 P.M., Resident 13 was sitting in his wheelchair in his room. He was wearing non-skid socks. He indicated he had a blister on his left heel. He took off his sock and revealed an island dressing covering his heel that was dated 01/03/23. The clinical record was reviewed on 01/05/23 at 12:29 P.M. A Quarterly MDS assessment, dated 11/08/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, coronary artery disease, orthostatic hypotension, and transient visual loss. The resident was at risk for pressure ulcers and had two Stage 2 pressure ulcers. The resident required extensive assistance of one staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. The Weekly Wound Assessment records from the EHR (Electronic Health Record) were provided by the DON on 01/06/23 at 2:25 P.M. The records indicated the resident had a facility acquired suspected DTI (Deep Tissue Injury) to both the left and right heels. The left heel wound was first identified on 10/19/22. Wound descriptions were as follows:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	- 10/19/22, initial assessment, Left lateral heel noted with fluid filled blister to site with skin intact. No measurements were documented on the assessment. (A paper document, titled "Wound Assessments" was provided by RN 2 on 01/09/23, and indicated the wound measured 4 cm x 2.5 cm) - 11/23/22, Area noted with light pink and "patial" pale moist appearance with scattered scaly surrounding skin, size 3 cm x 2.5 cm (no depth listed); 0 to 25% slough; 51 to 75% epithelial tissue. - 01/04/23, Area noted with scabbing intact to site, size 0.7 cm x 0.7 cm; 76 to 100% epithelial tissue. The right heel wound was first identified on 11/16/22. Wound descriptions were as follows: - 11/16/22, DTI noted to right heel. No measurements were documented on the assessment. (A paper document, titled "Wound Assessments" was provided by RN 2 on 01/09/23, and indicated the wound measured 2 cm x 1.8 cm) - 11/23/22, right heel noted with improvement, area noted with scattered scaly skin with small light pink moist appearance, size 2 cm x 2 cm x 0.1 cm; 26 to 50% epithelial tissue; 26 to 50% granulation tissue. - 01/04/23, area noted with scab intact to site, size; 1.3 cm x 0.6 cm. The complete Care Plan, including resolved Care Plans, were provided by the DON on 01/05/23 at 12:30 P.M., and included, but were not limited to, the following: - A Care Plan for a blister to the resident's left			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	heel, with an initiated date of 09/07/22, and a resolved date of 11/04/22, indicated the resident had received antibiotic therapy for the wound with an initiated date of 09/12/22. - A Care Plan for being at risk for impaired skin integrity related to a history of open areas to his bilateral lower extremities, with an initiated date of 04/12/22, and a revised date of 06/24/22. The current interventions included: Diet as ordered, labs as ordered, and to observe the skin with daily care. No preventative treatments were initiated on the Care Plan prior to the development of the pressure ulcers to the resident's heels. During an interview on 01/09/23 at 11:00 A.M., RN 2 indicated the resident had a blister on his left heel that was a pressure injury blister that started on 09/07/22. It had healed then it reopened. When she identified a new wound she measured them, completed an initial wound assessment, and notified the physician, the family, and the DON. The current Pressure Prevention policy, with a revised date of 08/2022 was provided by the Chief Nursing Officer on 01/09/23 at 11:31 A.M. The policy indicated, "...PURPOSE...To maintain good skin integrity and avoid development of pressure ulcers...Care plan interventions shall be implemented based on risk factors identified in the nursing assessment..." The current "Pressure/Stasis/Arterial/Diabetic Wounds" policy, with a revised date of 09/01/22, was provided by the Administrator on 01/09/23 at 10:39 A.M. The policy indicated, "...PURPOSE...To provide weekly documentation of wound measurements and condition...Complete			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	event for each impaired area...Document description of wound...Length...Width...Depth...Re-assessment/ measurement weekly..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to follow physician orders related to antibiotic use for a UTI for 1 of 2 residents reviewed for UTI's. (Resident 30) Findings include: During an observation and interview on 01/03/23, Resident 30 indicated she had an indwelling urinary catheter. The urinary catheter bag was hanging under the resident's wheelchair and off the floor. The clinical record for Resident 30 was reviewed on 01/06/23 at 9:24 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, diabetes, UTI (Urinary Tract Infection), and anxiety. The resident had a urinary catheter. A Physician Progress Note, dated 11/15/22 at 10:18 P.M., indicated for the resident to continue Amoxicillin (an antibiotic) 500 mg (milligrams), twice a day, for 10 days, through 11/24/22, for a UTI. A Progress Note, dated 11/16/22 at 11:12 A.M., indicated the resident had an allergy to penicillin and the Nurse Practitioner was being notified to obtain a new order. The November 2022 EMAR (Electronic Medication Administration Record) lacked	F 0690	**F690 – Bowel/Bladder Incontinence, Catheter, UTI SS=D** *"The facility failed to follow physician orders related to antibiotic use for a UTI for 1 of 2 residents reviewed for UTI's. (Resident 30)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 30 treatment for UTI complete. **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 with UTI diagnosis have potential to be affected by this alleged deficient practice. · All residents with current UTI diagnosis were audited to ensure antibiotics being administered per physician orders. **3. What measures will be put in place or what systemic**	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	indication that the resident had received any antibiotics during November 2022. A Progress Note, dated 12/17/22 at 12:54 P.M., indicated the resident's urine culture results were received and the Nurse Practitioner was notified. The resident was started on an antibiotic for seven days. During an interview on 01/09/23 at 3:42 P.M., the DON (Director of Nursing) indicated the resident should have had a new order for the antibiotic or a note indicating the physician had been followed up with in regard to the penicillin allergy. The current facility policy titled, "Resident Change of Condition", with a revised date of 8/2022, was provided by the Administrator on 01/09/23 at 3:54 P.M. The policy indicated, "...It is the policy of the facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place..." 3.1-41(a)(2)		**changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following: o "Resident Change of Condition" **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 audit all residents with UTI twice weekly x3 months then once weekly x3months to ensure all residents with UTIs are being administered antibiotics per physician orders. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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, and the resident's goals and preferences. Based on interview, observation, and record review, the facility failed to ensure a resident with a PICC (Peripherally Inserted Central Catheter) line was monitored and dressing changes completed for 1 of 2 residents reviewed for IV (intravenous) medication administration. (Resident 27) Findings include: During an interview on 01/09/23 at 11:45 A.M., RN 2 indicated Resident 27 came back to the facility after a hospitalization in November with the PICC line. The resident received medication through the line while in the facility. The type of PICC line, the resident had, needed to be removed at the hospital. The MD gave orders, on 11/29/22, to send the resident out to have the PICC line removed. It took some time to arrange transportation to the hospital. In the meantime, the resident got sick again and required IV antibiotics before they sent her out to remove the PICC. The facility kept the PICC line in place and used it for medication administration. The resident currently (-1/09/23) had the PICC line still in place. If a resident had a PICC line, there should be physician's orders for the line itself and orders to change the dressing. There should be orders to monitor the line daily for signs of infection or any other complications. There were orders to flush the line with normal saline twice a day and orders for a heparin flush if needed. On 01/09/23 at 11:53 A.M., Resident 27's PICC line was observed with RN 2. There was a tunneled PICC line in the right upper area of the resident's chest. A gauze dressing covered by a transparent dressing was dated 01/08/23 and initialed. There were two needless connection ports visible	F 0694	**F694 – Parenteral/IV Fluids SS=D** *"The facility failed to ensure a resident with a PICC (Peripherally Inserted Central Catheter) line was monitored and dressing changes completed for 1 of 2 residents reviewed for IV (intravenous) medication administration. (Resident 27)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 27's PICC line dressing assessed and changed per policy. **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 with PICC lines have the potential to be affected by this alleged deficient practice. · All residents with PICC lines dressings were assessed to ensure dressing changed per policy, **3. What measures will be put in place or what systemic changes will be made to**	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	hanging below the dressing. The dressing was clean and dry and there were no signs of infection, but the entry point in the skin was unable to be visualized as it was covered by the gauze dressing that was in place. The resident's clinical record was reviewed on 01/08/23 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/02/22, indicated the resident required total staff assistance for all ADLs (Activities of Daily Living). The diagnoses included, but were not limited to, stroke, hemiplegia, seizure disorder, and respiratory failure. A progress note, dated 11/16/22, indicated the resident returned from the hospital at approximately 4:00 P.M. The resident had a tunneled PICC Line to the right upper chest. A progress note, dated 11/29/22, indicated the PICC line to the resident's right upper chest was unable to be removed at the facility. The MD was notified and gave an order to send the resident to the local hospital, when possible, to remove the PICC. The December 2022 EMAR (Electronic Medication Administration Record) indicated the resident received Zosyn (an antibiotic) intravenously four times a day for 8 days for a urinary tract infection from 12/14/22 through 12/21/22. The resident's current physician's orders included an open ended order with a start date of 12/31/22 to change the PICC line dressing every 7 days and as needed for soilage. The clinical record lacked documentation of dressing change orders prior to 12/31/22. The clinical record currently lacked monitoring orders for the PICC line.		**ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following o "Catheter Insertion and Care" **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 audit 3 PICC line dressings three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure PICC lines are being monitored and dressings are being changed per policy. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	The current facility policy, titled "CATHETER INSERTION AND CARE", with an effective date of 11/2020, was provided by the DON (Director of Nursing on 01/09/23 at 4:25 P.M. The policy indicated, "...dressings will be changed at specific intervals...to prevent catheter-related infections...change transparent semi-permeable membrane (TSM) dressings at least every 5-7 days and PRN (when wet, soiled, or not intact...If gauze is used, it must be changed every 2 days... 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview, observation, and record review, the facility failed to appropriately manage a resident's respiratory needs related to dating equipment for 1 of 5 residents observed for respiratory care. (Resident 29) Findings include: During an interview and observation on 01/03/23 at 12:24 P.M., Resident 29 indicated he used a BIPAP (Bilevel Positive Airway Pressure) machine. He tested positive for COVID-19 a couple of months ago. He had no other	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** **SS=D** *"The facility failed to appropriately manage a resident's respiratory needs related to dating equipment for 1 of 5 residents observed for respiratory care. (Resident 29)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	respiratory infections since that time. He had a tracheostomy at one time that was healed. The tubing attached to his oxygen concentrator had a piece of tape on it dated 12/14/22 and initialed "JR". During an observation on 01/04/23 at 8:50 A.M., the resident's oxygen tubing had a piece of tape on it dated 12/14/22 and initialed "JR". During an observation on 01/04/23 at 11:59 A.M., the oxygen tubing was still dated 12/14/22. The resident indicated Respiratory Therapy usually changed the tubing every week. He was in charge of cleaning his own mask. During an interview on 01/04/23 at 12:00 P.M., RN 2 indicated Respiratory Therapy changed the residents' oxygen tubing. During an interview and observation on 01/04/23 at 12:01 P.M., RT (Respiratory Therapist) 3 indicated oxygen tubing was changed on night shift every Wednesday by the RT on duty. The staff placed a tag on the tubing with the date when it was put into service. Staff were not required to initial the tubing, but some did. The tubing was observed with RT 3. The resident indicated he had received new tubing but had not put it in place yet. RT 3 indicated it was technically not the resident's responsibility to change the oxygen tubing leading off of the oxygen concentrator. The Care Plans were provided by the Administrator on 01/09/23 at 3:28 P.M., and indicated the resident was at risk for ineffective breathing patterns related to obstructive sleep apnea, respiratory failure, a history of tobacco use, and obesity. The interventions included, but		**practice?** · Resident 29s respiratory equipment changed and dated. **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 with respiratory equipment have the potential to be affected by the alleged deficient practice. · All respiratory equipment requiring routine changes and dates were inspected to ensure changed and dated per policy. All are changed and dated. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following: o "Oxygen delivery/handling" **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 audit 5 residents with respiratory	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	were not limited to, administer oxygen as prescribed or per standing order. The December 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was provided by the Administrator on 01/09/23 at 3:28 P.M., and included, but was not limited to, a physician's order to change the oxygen tubing to the BIPAP machine on night shift every Wednesday, with an active date of 08/17/22. The record documentation indicated the resident's tubing had been changed on the following dates: - 12/14/22 (signed off with staff member initials "jran"), - 12/21/22 (signed off with staff member initials "tbol"), and - 12/28/22 (signed off with staff member initials "RAS"). The Respiratory Surveillance Line List record was provided by the DON (Director of Nursing) on 01/04/23. The record indicated the resident had tested positive for COVID-19 and had symptoms of fever, body aches, and a headache, on 10/25/22. The current "Oxygen delivery/handling" policy, with a revised date of 09/2022, was provided by the Administrator on 01/09/23 on 3:54 P.M. The policy indicated, "...Purpose...To ensure the safe and accurate delivery of oxygen...Oxygen...tubing...will be changed weekly..." 3.1-47(a)(6)		equipment three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure respiratory equipment is being changed and dated per policy. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	
F 0727 SS=E	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
Bldg. 00	§483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide the required RN on duty for eight hours a day for 4 of the 16 days reviewed. Findings include: During an interview on 01/09/23 at 2:49 P.M., the ADON (Assistant Director of Nursing) and CNO (Chief Nurse Officer) indicated there should be RN coverage for 8 hours a day, every day. The as-worked nursing schedule indicated there had not been an RN on duty for eight consecutive hours on Saturday 12/03/22, Sunday 12/04/22, Saturday 12/17/22, and Sunday 12/18/22. During an interview on 01/09/23 at 3:19 P.M., the Administrator indicated there was no RN on the schedule for 12/03/22, 12/04/22, 12/17/22, and 12/18/22. During an interview on 01/09/22 at 5:03 P.M., the DON indicated the facility did not have a policy for RN coverage. They followed State and Federal	F 0727	**F727 – RN 8 Hrs/7 days/Wk, Full Time DON** **SS=E** *"The facility failed to provide the required RN on duty for eight hours a day for 4 of the 16 days 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. **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	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	regulations. 3.1-17(b)(3)		potential to be affected by this alleged deficient practice. · No residents have been affected by the alleged deficient practice. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS and ED will be in serviced on the following: o "State and Federal Guidelines related to RN staffing guidelines." **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 audit/monitor RN staffing schedule daily Mon-Fri x6 months and ongoing to ensure facility is providing 8 RN hours on duty per state and federal guidelines. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
			01/07/2023	
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review, the facility failed to demonstrate that ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers, that were previously cited on the last annual survey, for 1 of 10 deficiencies reviewed. (Pressure Ulcers) Findings include: During this annual recertification and complaint survey, from 01/03/23 to 01/09/23, one deficiency was a repeated citation from the last annual survey, F686. The facility's Quality Assurance Committee did not implement on-going appropriate measures to correct identified issues or prevent deficiencies as follows: Pressure Ulcers: Three residents acquired pressure ulcer wounds that the facility failed to prevent, identify, and appropriately administer treatments to. Cross reference F686 During an interview on 01/09/23 at 5:22 P.M., the Administrator and CNO (Chief Nurse Officer) indicated during QAPI (Quality Assurance and Performance Improvement) meetings the focus had been on wound care and dining services. A new wound provider would be starting at the end of the month, they would provide education to the nursing staff, complete skin sweeps, and admission assessments. QAPI for wound care	F 0867	**F867 – QAPI/QAA Improvement Activities** **SS=D** *"The facility failed to demonstrate that ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers, that were previously cited on the last annual survey, for 1 of 10 deficiencies reviewed. (Pressure Ulcers)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were affected by this alleged deficient practice. **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 with pressure ulcers have the potential to be affected by this alleged deficient practice. · All pressure ulcers reviewed and are being monitored and audited in QAPI to ensure ongong corrective actions are in place.	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	started immediately upon taking the Administrator position, the facility had been discussing wound care, high protein diets, dining services, and have had some inservices. She had not documented any audits for QAPI. During an interview on 01/09/23 at 6:03 P.M., the ADON indicated she had completed skin sweeps of all the residents in November and had planned on doing skin sweeps every other month. The residents were placed on a wound rounding list and their orders were reviewed for pressure relieving devices. The audits were currently blank. During an interview on 01/09/23 at 6:19 P.M., the ADON and CNO indicated the dietician was asked to assess the identified residents, and the residents' Vitamin C and protein was to be increased for wound healing. She had implemented additional and new interventions for residents with wounds and wound prevention. She had not completed any audits to ensure the interventions were effective. The current facility policy, titled "Quality Assurance and Performance Improvement (QAPI)", was provided by the Administrator on 01/09/23 at 6:17 P.M. The policy indicated, "...The primary goals of the QAPI committee are to: 1. Establish, maintain, and oversee facility systems and processes to support the delivery of quality of care and services..." 3.1-52(b)(2)		**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS will be in serviced on the following: o "Quality Assurance and Performance Improvement (QAPI)" **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 audit QAPI related to pressure ulcers three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure ongoing corrective actions are in place. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to offer a resident influenza and pneumococcal vaccines for 1 of 5 residents reviewed for immunizations. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 01/08/23 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/02/22, indicated the resident required total staff assistance for all ADLs (Activities of Daily Living). The diagnoses included, but were not limited to, stroke, hemiplegia, seizure disorder, and respiratory failure. The Special Treatments and Programs section of the assessment indicated the resident did not receive the influenza vaccine for the current influenza season in the facility. The vaccine was not offered. The assessment indicated the resident's pneumococcal vaccination was not up to date. The vaccine was not offered.	F 0883	**F883 – Influenza and Pneumococcal Immunizations SS=D** *"The facility failed to offer a resident influenza and pneumococcal vaccines for 1 of 5 residents reviewed for immunizations. (Resident 27)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 27 offered influenza and pneumococcal vaccine. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be**	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	The resident was initially admitted to the facility on 7/13/2022. The resident remained in the facility until she was hospitalized on 09/20/22 but returned on 09/22/22. The resident remained in the facility until she was hospitalized on 11/08/22 but returned on 11/16/22. The resident currently resided in the facility. During an interview on 01/09/23 at 5:03 P.M., the DON (Director of Nursing) indicated the resident must have been missed. The family was contacted today and indicated they did want the resident to receive the influenza and pneumococcal vaccines. During an interview on 01/09/23 at 5:08 P.M., the ADON (Assistant Director of Nursing) indicated on admission, staff would check the State immunization registry to verify a resident's vaccination status. If a resident was not up to date on their vaccinations, the facility would offer the vaccines. The current facility policy, titled "Influenza, Pneumococcal and COVID-19 Immunizations", with a revision date of 08/2022, was provided by the Administrator on 01/09/23 at 5:03 P.M. The policy indicated, "...Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of influenza, pneumococcal...immunization...A copy will be retained in their medical record...Upon admission each resident/resident representative will sign an informed consent form indicated acceptance/refusal of immunization. A copy will be retained in the medical record and results added to the preventative health record in EHR (Electronic Health Record)..." 3.1-18(b)		**taken?** · All residents have the potential to be affected by this alleged deficient practice. · All residents reviewed to ensure influenza and pneumococcal vaccines offered and administered if requested. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following: o "Influenza, Pneumococcal and COVID-19 Immunizations" **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 audit all new admissions daily Monday thru Friday x6 months and ongoing to ensure Flu and Pneumonia vaccines are offered and administered if requested. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
			recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on interview and record review, the facility failed to offer a resident the COVID-19 vaccine for 1 of 5 residents reviewed for immunizations. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 01/08/23 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/02/22, indicated the resident required total staff assistance for all ADLs (Activities of Daily Living). The diagnoses included, but were not limited to, stroke,	F 0887	**F887 – COVID-19 Immunization SS=D** *"The facility failed to offer a resident the COVID-19 vaccine for 1 of 5 residents reviewed for immunizations. (Resident 27)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 27 was offered and	02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	hemiplegia, seizure disorder, and respiratory failure. The resident was initially admitted to the facility on 7/13/2022. The resident remained in the facility until she was hospitalized on 09/20/22 but returned on 09/22/22. The resident remained in the facility until she was hospitalized on 11/08/22 but returned on 11/16/22. The resident currently resided in the facility. During an interview on 01/09/23 at 5:03 P.M., the DON (Director of Nursing) indicated the resident must have been missed. The family was contacted today and indicated they did want the resident to receive the COVID-19 vaccine. During an interview on 01/09/23 at 5:08 P.M., the ADON (Assistant Director of Nursing) indicated on admission, staff would check the State immunization registry to verify a resident's vaccination status. If a resident was not up to date on their vaccinations, the facility would offer the vaccines. The resident did test positive for COVID-19 in the beginning of November of 2022 and has since recovered. She was not hospitalized due to COVID-19. The current facility policy, titled "Influenza, Pneumococcal and COVID-19 Immunizations", with a revision date of 08/2022, was provided by the Administrator on 01/09/23 at 5:03 P.M. The policy indicated, "...Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of ...COVID-19 immunization...A copy will be retained in their medical record...Upon admission each resident/resident representative will sign an informed consent form indicated acceptance/refusal of immunization. A copy will		administered COVID-19 vaccine. **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 this alleged deficient practice. · All residents reviewed to ensure COVID-19 vaccine offered and administered if requested. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following o "Influenza, Pneumococcal and COVID-19 Immunizations" **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 audit all new admissions daily Monday thru Friday x6 months and ongoing to ensure COVID-19 vaccines are offered and administered if requested. The results of these audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
	be retained in the medical record and results added to the preventative health record in EHR (Electronic Health Record)..." 3.1-18(b)		reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 01/07/2023	