STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	12/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00391794 and IN00395721. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00391794 - Unsubstantiated due to lack of evidence. Complaint IN00395721 - Substantiated. Federal/State deficiencies related to the allegation are cited at F689 and F9999. Survey dates: December 05, 06, and 07, 2022 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 07 Medicaid: 17 Other: 13 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 15, 2022.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF SULLIVAN 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 Complaint Survey IN00395721 completed on Dec. 7, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 8, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Miller	Chief Nursing Officer	01/03/2023

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F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. This State rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to notify the division of an occurrence in which a cognitively impaired resident had been removed from the facility, placed in a car, and driven away; without staff's knowledge; by two individuals unrelated to the resident for 1 of 1 resident reviewed for an unusual occurrence in a sample of 4 residents reviewed for incidents. (Resident B) Findings include: During an observation and interview on December 05, 2022 at 9:30 a.m., Resident B was in his room seated in a wheelchair. A Wander Guard was positioned on his right wrist. At the time of the observation, Resident B pointed to the Wander Guard and indicated he had "honestly earned" the guard due to having taken a car trip "outside" that	F 9999	**F9999 – ADMINISTRATION AND MANAGEMENT** *"The facility failed to notify the division of an occurrence in which a cognitively impaired resident had been removed from the facility, placed in a car, and driven away; without staff's knowledge; by two individuals unrelated to the resident for 1 of 1 resident reviewed for an unusual occurrence in a sample of 4 residents reviewed for incidents. (Resident B)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B was assessed and no negative affect noted due to the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents were reviewed and no additional unusual occurrences found not reported.	12/08/2022

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	resulted in the "State Troopers" putting him in their car. He did not recall additional details regarding the event. During an interview on December 06, 2022 at 9:50 a.m., Employee 1 verified she had worked on November 24, 2022 and provided care to Resident B. Resident B had last been seen sitting at the entrance lobby area in his wheelchair. He had been wearing a sweatshirt, shorts, and "house slippers." The resident easily presented as a nursing home resident, "there was no way to confuse that." She received a telephone call from the Sheriff's department at approximately 4:50 to 5:00 p.m.. The Sheriff Deputy asked, if our facility had a "loose resident." It was at that time Employee 1 implemented a "head count" and determined Resident B was "missing." His empty wheelchair had been observed in the front entrance lobby area. The Sheriff Deputy reported two teenage boys, unrelated to the resident, had been "pulled over" in a town approximately five miles north of the nursing home. Resident B had been taken to a local hospital, found to have no injury, and returned to the nursing home. During an interview on December 05, 2022 at 11:00 a.m., the Social Service Director indicated she had come to the facility on November 24, 2022 because Resident B had been found by the Sheriff Deputy in a car with two "strangers." Resident B's mobility monitor had been positioned on his wheelchair due to swelling and discomfort of the appliance on his ankle. Resident B's clinical records were reviewed on December 05, 2022 at 10:15 a.m. Diagnoses included, but were not limited to Parkinson's disease, dementia, and dystonia.		**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · Executive Director was in-serviced by Corporate Support nurse on: o "Wandering and Elopement Policy and Procedure" o "Indiana Department of Health Incident Reporting 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?** · DHS/designee will conduct random audits on 5 resident incidents weekly for 4 weeks, then biweekly x8 weeks then monthly times x3 months to ensure all unusual occurrences have been reported to the Indiana State Department of Health. 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.	

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	December 2022, physician orders indicated an opened ended order; dated April 14, 2022; for a Wander Guard alarm to be placed on the resident at all times due to "elopement risk." On December 06, 2022 at 11:45 a.m. The Executive Director and Corporate Consultant were interviewed. During the interview, the staff verified on November 24, 2022; two teenagers, unrelated to Resident B, had unknowingly removed Resident B from the nursing facility. Knowledge of the event became evident when the Sheriff's office notified nursing facility staff. The incident had not been reported to the Division of Long Term Care. On December 05, 2022 at 1:45 p.m. the Administrator provided a copy of the facility's current Wandering and Elopement Policy and Procedure dated August 2022. A review of the procedure indicated, "It is the policy of the facility that staff who have residents under their care and responsible to prevent elopement [sic]. Elopement is defined at a resident that is away from the facility property and unsupervised [sic]. ... This Federal tag relates to Complaint IN00395721.		**5. Date of completion: 12/8/2022**	